CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD

Cambridgeshire County Council

Date:Thursday, 19 November 2015

Democratic and Members' Services
Quentin Baker
LGSS Director: Law, Property and Governance

10:00hr

Shire Hall
Castle Hill
Cambridge
CB3 0AP

Kreis Viersen Room
Shire Hall
Cambridge
CB3 0AP

AGENDA

Open to Public and Press

CONSTITUTIONAL MATTERS

1	**Apologies and Declarations of Interest** *Guidance for Councillors on declaring interests is available at http://tinyurl.com/ccc-dec-of-interests*	
2	**Minutes - 17th September 2015**	**5 - 14**
3	**Minutes Action Log Update** *to follow*	
	THEME – PRIORITY 1 – Ensure a positive start to life for children, young people and their families	
4	**A Person's Story**	**15 - 16**

5	**Health and Wellbeing Strategy – Priority 1 – Ensure a positive start to life for children, young people and their families**	**17 - 30**
	OTHER BUSINESS	
6	**Reflections on Priority 4 meeting from Police & Crime Commissioner** *oral*	
7	**Prevention Work for the Health System Transformation Programme**	**31 - 136**
8	**Planning Intentions for Cambridgeshire and Peterborough 2016-17**	**137 - 142**
9	**Update on Health and Wellbeing Board Development Day**	**143 - 144**
10	**Better Care Fund – Quarterly Report and Planning for 2016-17**	**145 - 146**
11	**Forward agenda plan**	**147 - 148**
12	**Cambridgeshire and Peterborough Health and Care System Transformation Programme**	**149 - 170**
13	**Dates of next meetings (all at 10am on Thursdays):** • 14th January 2016, South Cambridgeshire Hall, Cambourne CB23 6EA • 17th March 2016, East Cambridgeshire District Council, The Grange, Nutholt Lane, Ely CB7 4EE *oral*	

The Cambridgeshire Health and Wellbeing Board comprises the following members:

Councillor Tony Orgee (Chairman) Councillor Paul Clapp Councillor Mervyn Loynes Councillor Lucy Nethsingha and Councillor Joan Whitehead

For more information about this meeting, including access arrangements and facilities for people with disabilities, please contact

Clerk Name: Ruth Yule

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CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD: MINUTES

Date: **17th September 2015**

Time: **10.00 to 13.30**

Place: **Meeting Room 5, Bargroves Centre, Cromwell Road, St Neots**

Present: Cambridgeshire County Council (CCC)
Councillors P Clapp, L Nethsingha, T Orgee (Chairman) and J Whitehead
Dr Liz Robin, Director of Public Health (PH)
Adrian Loades, Executive Director: Children, Families and Adults Services (CFAS)

District Councils
S Ellington (South Cambridgeshire) and R Johnson (Cambridge City)

Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)
Dr John Jones
Dr Sripat Pai (substituting for Dr Neil Modha)

Healthwatch
Val Moore

Apologies: Councillors M Cornwell (Fenland), R Mathews (Huntingdonshire); C Malyon (Section 151 Officer), N Modha (CCG), M Berry (NHS Commissioning Board) and J Farrow (co-opted representative of Voluntary and Community Sector)

145. ELECTION OF VICE-CHAIRMAN/WOMAN

Councillor Ellington was elected Vice-Chairwoman for the municipal year 2015-16.

The Chairman welcomed Val Moore, Chair of Healthwatch Cambridgeshire, to her first meeting of the Board, and welcomed Dorothy Gregson, Chief Executive to the Police and Crime Commissioner, as the Board's honoured guest, representing the Commissioner, Sir Graham Bright, who apologised that he was unable to attend.

146. DECLARATIONS OF INTEREST

None

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147. MINUTES AND ACTION LOG UPDATE

The minutes of the meeting of 2nd July 2015 were signed as a correct record, and the Action Log update was noted.

148. A PERSON'S STORY

The Board received a report and was read an account of the experiences of a person who had suffered several episodes of depression and made several suicide attempts. After several years of regular visits to the GP and intermittent involvement of crisis teams and hospital-based psychiatrists, the person had received 12 weeks of

cognitive behavioural therapy (CBT) and been placed on a clinical trial, and was currently free of depression. The person had nothing but praise for the emergency teams, but not for other professionals, and had been kept going through the years of depression by the help and support of a friend and the friend's partner.

Points raised and noted in the course of discussing the person's story included

- it would have been helpful to have a member of the Mental Health team present to respond
- the CCG had mental health as a priority, with resources being put into it, because of stories such as this
- the author had told the story to the Mental Health Crisis Care Concordat group, which included the leader of the crisis team and other senior staff, where a useful discussion of the experiences outlined had taken place
- GPs were of critical importance in mental health treatment; it was important that they be well trained
- 75% of those dying from suicide had not seen a psychiatrist in the year before their death
- other factors affecting the person's wellbeing had included housing, welfare benefits, employment and loneliness – it was important to look at mental health issues within the wider context
- poor communication was a feature in this story as in other patient stories
- the author's friend had been an important positive factor – to help the system be joined up to meet the needs of those who had no such friend, part of the Board's role was to ensure that services joined up round a person, including referral to voluntary agencies
- vulnerable patients needed to know what sources of help were available and how to access them
- the aim of telling the story to the Board had been to raise the level of attention mental health and the Crisis Care Concordat received at senior level.

The Chairman expressed the Board's gratitude to the person who had been brave enough to provide the story, which gave food for thought, particularly about communication, about whether people felt that they were being listened to, and how they were treated.

The Board noted the story as context for the remainder of the meeting.

149. PROGRESS REPORT ON HEALTH & WELL-BEING STRATEGY PRIORITY 4: CREATE A SAFE ENVIRONMENT AND HELP TO BUILD STRONG COMMUNITIES, WELLBEING AND MENTAL HEALTH

Received a report updating members on progress with the Health and Wellbeing Strategy Priority 4: 'Create a safe environment and help to build strong communities, wellbeing and mental health'. Members noted that themes from the person's story just heard could be found in each stream of work described in the report.

In the course of discussion, members

- enquired whether the work of the various agencies described in the report was

changing the system response – for example, were GPs aware of the changes. It was important that individual service users could see that co-ordination between agencies was happening

- from a District Council perspective, reported that, as part of Local Health Partnership work, it had become apparent that a lot of council staff (in for example housing and social care) were quite frightened of any mention of mental health, thinking that it was something for specialists, so would not touch it. A Leaders' Seminar was being arranged about this problem, and workshops set up for staff to help them feel more comfortable when approaching people with mental health issues; the hope was that confidence amongst grass roots staff would grow
- noted that monthly meetings were held between partner organisations (including CCG, Cambridgeshire and Peterborough NHS Foundation Trust [CPFT] and MIND) in order to align approaches, while recognising that each organisation had its own performance indicators and priorities; care should be taken to avoid setting up duplicate or overlapping forums in addition to the existing ones
- drawing attention to the importance of suicide prevention work, expressed concern at whether this had sufficient priority in GP training, and at the level of support that GPs received. Members were advised that GPs were much engaged in the work that was going on; there were limits on GP numbers and on capacity and space in primary care to do more. Work was being undertaken with the voluntary sector and recovery coaches to ensure that nobody was discharged from hospital without access to sources of help
- enquired about work being done on the possible effects of the introduction of universal credit, which meant that people would receive their money monthly in arrears. Those with mental health problems would perhaps be less able than others to deal with these changes.

  The Executive Director CFAS undertook to circulate a briefing to HWB members, before the Board's next meeting, on the work being done on universal credit and provision of support in benefits sanction cases in Children, Families and Adults Services and in the District Councils . **Action required**

The Board noted the update.

150. REPORT FROM THE POLICE AND CRIME COMMISSIONER

Received a report which introduced the Police and Crime Commissioner's strategic vision to reduce demand on public sector services through an effective prevention agenda and set out how this vision could support the work of the Health and Wellbeing Board. Dorothy Gregson, Chief Executive, Cambridgeshire Office of the Police and Crime Commissioner (PCC) presented the report.

Arising from the report, members

- asked what assistance was given to people with mental health issues who were victims of crime, and what training in this was available to frontline police. The Chief Executive advised that a victims' hub had been established, through which a victim could have access to community psychiatric nurses (CPNs) and through which police officers could also obtain support
- noted that the Crisis Care Concordat group was undertaking an analysis of police training; it was necessary to be mindful of support for police officers, a significant proportion of whose calls were mental health related, which could have an impact

on their own mental health. It was also important that police officers were in a position to refer people to sources of support – the handback into the community was very important, as evidenced in the person's story already heard

- noted that the Police and Crime Commissioner's office monitored police sickness absences and were very aware of the stresses on police staff; cuts were making their jobs very different from a few years ago, and it was important to ensure that staff were flourishing
- enquired whether GPs were involved in low-level diversion of alcohol. The Chief Executive undertook to feed this point back to the office; the attitude to diversion was to use it to help people change their behaviour.

The Board noted the role of the Police and Crime Commissioner as a key stakeholder within the mental health agenda specifically through his focus on prevention.

151. CHILD AND ADOLESCENT MENTAL HEALTH TRANSFORMATION BID

As an urgent item of business, with the Chairman's and the Board's agreement, the Director of Public Health explained that numerous requests were being received to approve bids for central government funding, most recently the Child and Adolescent Mental Health Transformation bid. The Chairman added that this bid had to be approved by mid-October. Members noted that the funding would support work already being undertaken.

It was resolved unanimously to delegate to the Director of Public Health, in consultation with the Chairman of the Health and Wellbeing Board, authority to sign off the bid for Child and Adolescent Mental Health Transformation funding on behalf of the Health and Wellbeing Board.

152. NEW COMMUNITIES: NEW HOUSING DEVELOPMENTS AND MIGRANT POPULATIONS JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) 2015

Received a report presenting the proposed scope of the New Communities: New Housing Developments and Migrant Populations JSNA. The Board noted that, while the impact of the Syrian refugee crisis on Cambridgeshire was not yet clear, it was likely that there would be a high proportion of people with mental health needs, and a high proportion of children. The Board's advice was being sought on whether the JSNA should include an annex on refugees.

Members drew attention to the report considered by the Council's General Purposes Committee on 15th September on the CCC Strategy for Supporting New Communities. It was also pointed out that the Local Plans for Cambridge City and for South Cambridgeshire were still being considered by the Planning Inspector; the question was asked how far the JSNA work on new communities could be slotted into the emerging local plan work, given that the Councils had proposed that the inspectors' examination of the local plans be suspended until February 2016, and it was intended to complete the JSNA by March 2016.

The point was made that a JSNA covering both new communities and migrant populations would be extremely large, particularly given the number and extent of housing developments in the county and the need to consider their effect on the pre-existing communities. Officers advised that two working groups were covering different aspects of the report, and when it had first been decided to develop this JSNA, it had been recognised that it would equate to about three smaller JSNAs.

The Chairman pointed out that the issue of migrant populations did not overlap completely with new communities work, and rather than having refugees as an annex, there should be two separate documents.

The Board supported the proposed scope of the New Communities: New Housing Developments and Migrant Populations JSNA as outlined in the report, but as two separate JSNAs, one on New Communities and New Housing, the other on Migrants and Refugees.

153. ACCELERATING ACHIEVEMENT – PROGRESS UPDATE

Received a report updating the Board on the delivery of the Accelerating Achievement Strategy 2014-16 and inviting it to consider activities across the Health and Wellbeing Partnership that supported this work. Members noted the achievement gap in Cambridgeshire between vulnerable groups of pupils and other pupils, with those children who were entitled to free school meals and also had a special educational needs or disabilities achieving least well. The strategy aimed to reduce the gap by three percentage points by 2016.

In response to their questions and comments, members noted that

- considerable work on Looked After Children (LAC) had been undertaken as part of the action plan. There was a legal requirement to produce a personal education plan every six months for LAC, but Cambridgeshire produced one each term, looking at how the additional funding could best be used for the child
- the School Improvement Service had regular Keeping in Touch visits with headteachers and chairs of governors, which now included questions about how the pupil premium was making a difference to pupils' achievement. Pupil premium Plus for LAC was funded and monitored by the Head of Virtual School
- of groups not listed in the report, including children with mental health issues and LGBT children, work with children who had English as an additional language (EAL) was focussing on Eastern European and asylum seekers. The role of the Cambridgeshire Race, Equality and Diversity Service (CREDS) included supporting the cultural identities of children who were the only ones in a community with that identity; Stonewall provided support to transgender children; and work was being done with Child and Adolescent Mental Health Services
- there were gypsy/traveller children in 46% of the county's primary schools. The CREDS team had been trying to bring some of the adults in these communities into engagement with primary schools, and the Head of Virtual School was happy to visit sites to help spread the message about what was available.

Members thanked the Head of Virtual School for a useful report and welcomed the emphasis on progression as well as on absolute levels of attainment.

The Board noted the report.

154. SAFEGUARDING ADULTS BOARD (SAB) ANNUAL REPORT 2014/15

Received a report presenting the 2014/15 Safeguarding Adults Board Annual Report. Members noted that the report had been supplied in draft because it had not yet been presented to the SAB for final approval. The report included key work being undertaken with partner organisations, which included Healthwatch Cambridgeshire.

Examining the report, members

- commented on the relatively poor take-up of adult safeguarding training opportunities in contrast to well-attended children's safeguarding course. It was pointed out that the statutory safeguarding children framework had a much longer history than the adult framework. Members noted that changing training to support the Making Safeguarding Personal approach (rather than process-led) had led to better take up; the hoarding course had filled on the first day it was advertised
- noted that, as a consequence of the Supreme Court judgement in relation to Deprivation of Liberty Safeguards (DoLS), Cambridgeshire, like other local authorities, was now operating with a significant DoLS waiting list and was trying to gather suitably qualified staff to tackle this
- asked what the network of engagement was with care homes. Members were advised that there were regular provider forums, well-attended, at which the safeguarding message was communicated and providers had the opportunity to ask questions. However, the forums did not cover providers with whom the local authority did not place people, and there was a question of how best to engage them in a proactive preventative relationship. Members noted that Helathwatch Cambridgeshire was in discussion with care homes
- in relation to pressures on care homes, including the forthcoming national living wage, noted that the Care Quality Commission would expect care homes to continue to maintain sufficient staff; local authorities and providers had already started to raise the issue with the comprehensive spending review
- offered congratulations on many aspects of the report, in particular the nomination for one of the National Learning Disability and Autism Awards.

Drawing attention to the Safeguarding Adults Board work with Cambridge University colleagues, the Chairman suggested that there was more that the HWB could do to inform its own practice. The Service Director: Adult Social Care offered to provide a report on work in relation to safeguarding being undertaken with the universities.

The Board noted the Cambridgeshire Safeguarding Adults Board 2014-15 Annual Report and resolved unanimously to receive an update report later in the financial year on work in relation to safeguarding being undertaken with the universities.

155. CAMBRIDGESHIRE LOCAL SAFEGUARDING CHILDREN BOARD (LSCB) ANNUAL REPORT 2014-15

Received a report presenting the Local Safeguarding Children Board Annual Report for 2014-15. Members noted that the report had been supplied in draft because it was still to be presented to the LSCB on 22nd September 2015. Andy Jarvis, Business Manager for LSCB, attended to represent the LSCB Chair, Felicity Schofield, who sent her apologies.

Members noted that there was a statutory duty on the LSCB to present its annual report to the HWB. The main events of 2014-15 had been the Ofsted inspection and three serious case reviews. The LSCB's main priorities had been domestic abuse, child sexual exploitation, and safeguarding disabled children.

In response to the report, members

- congratulated the Business Manager on the report, which was much pithier and

more accessible than its predecessors

- drew attention to the importance of children's mental health, particularly in relation to self-harm and suicide
- enquired whether every member of staff working with children was currently aware of child protection policies. Members were advised that the LSCB had gone out to every agency to ask that very question, and was seeking replies from those that had not yet responded
- commented that considerable work on child sexual exploitation was being carried out in Wisbech, but not reflected in the report; every member of staff was being encouraged to report suspicions of child sexual abuse
- encouraged work to improve the transition between children's and adult services. The Executive Director CFAS said that it would be possible to have initial discussions between the Safeguarding Adults Board and the LSCB and bring a report to the HWB. One of the serious case reviews had included a hiatus in transition, with the young person almost having to re-register for the adult version of the service they had received as a child. **Action required**

The Health and Wellbeing Board resolved unanimously to confirm that, including the Safeguarding Adults Board, all three statutory partnerships shared the Health and Wellbeing Board Strategic priority to:

> "Develop integrated services across education, health, social care and the voluntary sector which focus on the needs of the child in the community, including the growing numbers of children with the most complex needs, and where appropriate ensure an effective transition to adult services."

156. BETTER CARE FUND UPDATE

Received a report presenting a copy of the Quarterly Report on the Better Care Fund (BCF) in the first quarter of 2015/16, submitted on 28 August. Members noted that the target of a reduction of 1% in non-elective admissions had not quite been achieved. This was believed largely to be due to the period of setting up and mobilisation that had followed the start of the UnitingCare contract on 1st April; it would take time for UnitingCare's initiatives to take effect.

The Board noted that the CCG had started discussions with UnitingCare on metrics for the user experience, and Healthwatch had also started work with UnitingCare. Healthwatch and CCG agreed to share their work with each other.

Members commented that the report had not been easy to understand, and sought assurance that progress was being made in the right direction, remarking that only the CCG and UnitingCare could make the figures move. The Chairman thanked officers for their report; the Board would await the next report with interest.

The Board noted the Better Care Fund Quarterly Report.

157. CAMBRIDGESHIRE AND PETERBOROUGH HEALTH AND CARE SYSTEM TRANSFORMATION PROGRAMME

Received a report updating the Board on the Health and Care System Transformation Programme; the CCG was leading a process to plan changes to the health system to improve outcomes for people and enable financial sustainability. Members noted the

early engagement work and analytical work being undertaken. The CCG's application for 'Urgent and Emergency Care' Vanguard had been successful, bringing with it funding and support for work on the management of emergency and urgent care.

Discussing the report, members of the Board

- expressed concern at the lack of progress since the report to the Board at its July meeting. The present report set out a clear description of the challenge, but no indication of how to solve it; events had been overtaking progress. The CCG Director of Corporate Affairs, attending the meeting on behalf of the Programme Director System Transformation Programme, acknowledged that developments such as the Vanguard bid and recent pressures at Addenbrooke's Hospital were making it necessary to adapt the transformation programme to events
- noted that the CCG Board had looked at the increasing budget pressures at its meeting on 15th September; money was forcing conversations between organisations, as no single organisation could solve the financial challenge alone
- observed that there were signs of change, such as some GP practices federating or joining into super practices
- commented that there was a lack of urgency in the report; it had been known for the last 18 months that there would be a shortfall in funding in 2019. The Board noted that more detailed conversations were taking place than were reported in the present public paper.

The Director of Public Health reported that she had been asked to lead on the development of a Prevention Scoping Strategy for the Cambridgeshire and Peterborough workstream tripartite group, working with the Executive Director CFAS. The strategy arising from this scoping work would be brought to meetings of both the Cambridgeshire and the Peterborough HWB.

The Board noted the report.

158. FORWARD AGENDA PLAN

Considered the HWB agenda plan, noting that a Board development day was planned for the morning of 29th October.

As well as adding the Prevention Scoping Strategy (minute 156 refers) to the agenda plan for 19th November 2015, it was suggested that, in view of the forthcoming publication of the Care Quality Commission (CQC) report on Cambridge University Hospitals NHS Foundation Trust (CUHFT), an update on developments at CUHFT be added to the November agenda. The Board was advised that both CUHFT and CQC had been invited to attend a meeting of the Health Committee on 5th November.

Action required

The Director of Public Health (DPH) advised that a bid by Cambridgeshire and Peterborough for participation in the first wave of the NHS Diabetes Prevention Programme was being submitted; the submission deadline was 18th September, and the needed to be approved by the DPH and the Chair of the HWB. She offered to circulate the bid form to Board members. **Action required**

159. DATES OF NEXT MEETING

Noted dates of the Board's forthcoming meetings (all at 10am on Thursdays):

- 19th November, Shire Hall, Cambridge CB3 0AP
- 14th January 2016, South Cambridgeshire Hall, Cambourne CB23 6EA
- 17th March 2016, East Cambridgeshire District Council, The Grange, Nutholt Lane, Ely CB7 4EE

Chairman

Agenda Item No: 4

A PERSON'S STORY

To: Health and Wellbeing Board

Date: 19 November 2015

From: Lenja Bell, pinpoint

1.0 PURPOSE

1.1 To introduce the story being presented to the Health and Wellbeing Board.

2.0 BACKGROUND

2.1 The Cambridgeshire Health and Wellbeing Board have requested that a person's story be presented at the start of each meeting. The story being presented at this meeting will set out a parent carer's experience of accessing health and social services for her disabled child.

2.2 The story is an illustration of how people experience health and social care services. A discussion regarding the specifics of this person's experiences is not envisaged; the generalised learning and insight that can be taken from the experience being more pertinent.

3.0 SUPPORTING PARAGRAPHS

3.1 The story being told offers the Board an opportunity to consider the experiences of a parent carer and the difficulty in navigating and accessing health and social care services. It will also look at what support is needed for these families, both for the children and the parents.

3.2 The story will be told directly by the parent carer.

4.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

4.1 This story relates to Priority One of the Health and Wellbeing Board; to ensure a positive start to life for children, young people and their families.

5.0 IMPLICATIONS

5.1 There are no direct implications arising from this report.

6.0 RECOMMENDATION/DECISION REQUIRED

6.1 The Person's Story is being told as context for the remainder of the meeting.

Source Documents	Location
Health and Wellbeing Strategy	http://www.cambridgeshire.gov.uk/info/20004/health_and_keeping_well/548/cambridgeshire_health_and_wellbeing_board

Agenda Item No: 5

HEALTH AND WELLBEING STRATEGY – PRIORITY 1 – ENSUREA POSITIVE START TO LIFE FOR CHILDREN, YOUNG PEOPLE AND THEIR FAMILIES

To: Health and Wellbeing Board
Date: 19 November 2015
From: Meredith Teasdale, Service Director Strategy & Commissioning, Children, Families and Adults

1 PURPOSE

1.1 To provide an update to the Health and Wellbeing Board on Priority 1 of the Health and Wellbeing Strategy – Ensure a positive start to life for children, young people and their families.

2 JOINT WORKING ARRANGEMENTS

2.1 Cambridgeshire has established a Children's Health Joint Commissioning Board (CHJCB) chaired by Councillor Nethsingha. Membership of the Board brings together the Local Authority (LA) and the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG). This Board ensures that there is a strong multi-agency approach to commissioning services for all children including those with physical and learning disabilities. This is supported by a joint Head of Service Child Health Outcomes post shared with Peterborough City Council and underpinned by a joint commissioning unit led by Peterborough City Council. The unit includes Cambridgeshire County Council, Peterborough City Council and CCG Officers. The unit sets the work programme based on CHJCB direction to ensure joint commissioning of children's health outcomes across Cambridgeshire and where appropriate Peterborough.

3 PRIORITY 1
Strengthen Our Multi-Agency Approach To Identifying Children Who Are In Poverty, Who Have Physical Or Learning Disabilities Or Mental Health Needs, Or Whose Parents Are Experiencing Physical Or Mental Health Problems

3.1 *Multi-agency approach to Child Poverty*

3.1.1 We have a strong and active multi-agency Child Poverty partnership, the Child Poverty Champions Group. Our second joint Child Poverty Strategy was developed in 2014, this was based upon both qualitative and quantitative evidence, in particular drawing upon the lived experiences of children and parents living in poverty.

3.1.2 Partners, including County Council, District Councils, Job Centre Plus, Citizens Advice Bureau, social housing providers and Cambridgeshire Police have jointly agreed the following four objectives to work towards over the next three years:

- Building communities: families in poverty can access a range of help from within their community – linking with other families, voluntary organisations and public services.
- Building futures: adults and young people have the skills and opportunities to access employment and become financially secure.
- Supporting the most vulnerable: for the most vulnerable families and where there is a risk of crisis, organisations step in quickly, coherently and decisively to find solution.
- Communication, information and advice: organisations understand the issues facing people in poverty and the impact this can have, and they make information, advice and support as easy to access as possible.

3.1.3 Partners have been working towards these objectives within their own organisations, with each other and as a whole partnership group. Four partnership projects were implemented in the first year, aiming to support vulnerable young people with money management skills, job search and job readiness skills, and cooking on a budget. The Champions Group also initiated work with the Together for Families Programme to address the incidence of benefit sanctions on vulnerable people, and to put in place a better system to identify and support families at risk of homelessness.

3.1.4 Our latest monitoring report shows that progress is being made against the three key performance indicators in our strategy, as follows:

Indicator	Previous period		Latest data		Progress
	Date	Cambs	Date	Cambs	
% of children in poverty	2011	12.6%	2012	11.9%	↑ Improvement
Numbers of 18-25 year olds in receipt of JSA	Mar 14	1485	Mar 15	805	↑ Improvement
% of children in workless households	2012	11.1%	2013	8.2%	↑ Improvement

3.2 *Multi agency approach to Children with physical and learning disabilities*

3.2.1 The Early Support pathway identifies the criteria for Early Support as:
'A child who has significant and complex additional needs and will require considerable on-going specialist support from across Education, Health and Care, including children who have great difficulty communicating, have sensory or physical difficulties and/or complex health needs, all of whom will need additional support with many aspects of daily life. It is probable that there will be a long-term impact on development/learning.'

3.2.2 Across Cambridgeshire on 30th June 2015 there were 918 children following the Early Support pathway. Family Support Plan's (FSP) are central to the Early Support pathway and to the development of an integrated and coordinated

approach across partners to manage the holistic needs of the whole family.They support parents to plan with professionals, manage parental expectations of how support will be offered and prepare for Education, Health and Care Plans if they are implemented. Parents are invited to all FSP meetings most parents do attend. The vast majority of professionals invited attends or provide information about their involvement and recommendations about their service's future involvement.

3.2.3 The Early Help review is enabling greater alignment of the work of Locality Teams and Special Educational Needs and Disability (SEND) services. The re-design of services into single teams will support closer links between schools, settings and families to identify and respond early to possible SEND in vulnerable groups. In line with the SEND Code of Practice (2015), the new Family Common Assessment Framework (CAF) sets out expectations for universal providers to track the progress of children and young people who may have SEND and implement targeted interventions. As part of the Local Offer and the Schools Information Report Toolkit, Cambridgeshire County Council (CCC) have published guidance on the identification of SEND and the new category of 'SEND Support'. To support this Cambridgeshire County Council are also producing a resource of early screening tools for use by schools and settings, which will be published in December 2015.

3.2.4 Cambridgeshire County Councilhave worked with parent carers and partners to produce a multi-agency framework for information on SEND. The framework is divided into age-ranges 0-5 years; 5-16 years and 16+. Each begins with a section on early concerns. A multi-agency Autism Offer was published September 2014. This was agreed by Schools, CCG, Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) and Cambridgeshire Community Services NHS Trust (CCS) as well as parent groups. A Social, Emotional and Mental Health Offer; Learning Offer; Hearing Impairment Offer and Visual Impairment Offer will be published in December 15 in conjunction with partners. These pathways bring clarity to parents and practitioners to the process and available services for children diagnosed with a specific need.

3.2.5 The Autism Education Trust Level 1 training programme has been delivered to a number of schools in Cambridgeshire. This focuses on raising the awareness and confidence of the workforce to identify and respond to possible communication and interaction difficulties, including autism. The programme has been further developed and delivery of this new training begins in January 2016.

3.2.6 Work is currently being undertaken between the Local Authority, Schools and CCG to ensure there is appropriate specialist nursing support in special schools. This is overseen by the Children's Health Joint Commissioning Board.

3.3 ***Multi-agency to identifying children who have mental health needs, or whose parents are experiencing physical or mental health problems***

3.3.1 A Joint Emotional Health and Wellbeing Board has been established for Cambridgeshire and Peterborough. This is ensuring the delivery of Cambridgeshire Mental Health Strategy but also providing governance for the Mental Health Transformation Plan and additional funding that Cambridgeshire and Peterborough are receiving for children and adolescent emotional health and wellbeing. The transformation plan which has just been submitted to NHS England covers the whole spectrum of services for children and young people's mental health and wellbeing from health promotion and prevention work, to support and interventions for children and young people who have existing or emerging mental health problems, as well as transitions between services. The plan sets out how the additional funds coming into Cambridgeshire and Peterborough for mental health will be used.

3.3.2 Agreement has been reached that the focus on the funds should be early intervention and supporting early pathways in Autistic Spectrum Disorder/ Attention Deficit Hyperactivity Disorder (ADHD) and vulnerable groups of children including Looked After Children. The additional funding should ensure the Advice and Co-ordination Team could be up and running faster in Cambridgeshire. This was supported by the recent outcome of the Care Quality Commission inspection.

3.3.3 The Joint Emotional Health and Wellbeing Board ensures:

- Strategic oversight across Cambridgeshire and Peterborough for the emotional health and wellbeing of children and young people.
- commissioning of system-wide emotional health and wellbeing services and offer guidance of good practice.
- strategic leadership for the redesign of emotional health and wellbeing services to meet national and local priorities
- the further development of local 'Transformation Plans' for emotional Health and Wellbeing Services
- monitoring of progress against the 'Transformation plans' (Children and Young People) in Cambridgeshire and Peterborough.

3.3.4 The Public Mental Health Strategy was approved by Health Committee in May 2015, the multi-agency strategy focuses on the promotion of mental health and the prevention of mental illness. With half of all mental illness arising before the age of fourteen years, a key feature of the strategy is promoting good mental health in children and young people and preventing later mental illness. Through work with the Cambridgeshire County Council the strategy seeks to promote a whole school approach to mental health, as recommended by Public Health England.

3.3.5 Additional investment has been made to give tailored support to secondary schools to identify their mental and emotional health needs and plan relevant curriculum and whole school activity. All primary schools will also have access to units of work specific to mental and emotional wellbeing, and funded mental health training is already available for staff. Furthermore an anti-stigma post is being funded, together with Peterborough City Council, which will sit within the voluntary sector; a key feature of this role will be to translate national campaigns to local schools and young people. All this work

contributes to the whole school approach to mental health that is being supported across the council and forms part of wider work to address the high levels of self-harm in Cambridgeshire.

3.3.6 The Youth Counselling services, commissioned through the Joint Commissioning Board and funded by the local authority, provide support to those with mental health needs across the county. Centre 33 and YMCA provide counselling services for 13-25 year olds and Stars provides bereavement support for 0-25 year olds. Recognising the high levels of self-harm in Cambridgeshire and increasing service demand, additional investment has been made to expand provision in the most deprived areas (Huntingdon North ward, North Fenland and Cambridge City) and support (LGBT) young people. Centre 33 deliver this contract variation together with SexYouality. Demand for all the youth counselling services continues to grow, as does the level of presenting need that providers report.

3.3.7 The Public Mental Health Strategy also considers the physical health needs of adults with severe mental illness (SMI); many of whom may also be parents. Currently people with SMI tend to have poorer physical health than those without SMI and are at greater risk of dying earlier, often from preventable causes. A new multi-agency group is being established to review evidence in terms of what works to improve the physical health of those with SMI. The group will look at key lifestyle areas including diet, physical activity, smoking and substance misuse and formulate and implement an action plan.

3.3.8 Work is also continuing to roll-out Mental Health First Aid (MHFA) training to frontline staff, such as social workers, housing officers and the police. This training assists in the identification of mental health problems and helps individuals to guide clients towards the right support or self-help as well as raising awareness of mental health. MHFALite is also being offered for free to a range of workplaces to further raise awareness and support people to seek appropriate support.

3.3.9 School Nursing Service has joined the Improving Access to Psychological Therapies (IAPT). IAPT standards are being used to indicate performance across all linked services. Key performance indicators have been agreed to monitor performance in this area. Through the contracting process School Nursing has indicated the rise in emotional well-being and mental health issues within schools and as a result of this all School Nurses have received additional training around identifying and supporting children who self-harm. The additional investment in Children Adolescent Mental Health services will provide more support and supervision to schools and School Nurses.

4.0 **PRIORITY 2**

Develop integrated services across education, health, social care and the voluntary sector which focus on the needs of the child in the community, including the growing numbers of children with the most complex needs, and where appropriate ensure an effective transition to adult services.

4.1 The Special Educational Needs and Disability (SEND) Commissioning Strategy (December 2014) was agreed by Cambridgeshire County Council Children and Young People Committee after extensive consultation. It sets out Cambridgeshire's approach and plans for the current and futures needs of children and young people with SEND and their families, to enable them to achieve good outcomes. The three themes identified in the strategy are 1) Integration of services; 2) Localism and 3) Personalisation.

4.2 *Integration of services*

- The re-design of SEND Specialist Services linked to the Early Help Review has enabled greater alignment between SEND Services and Locality teams to provide a co-ordinated offer of support for children and young people with SEND and their families. A targeted and family focused multi-disciplinary approach to meeting needs is being developed.
- The Autism Education Trust Training Programme is being co-delivered by Educational Psychologists; Special School colleagues and parent/carer trainers. Three levels of training in autism are offered to schools.
- The Marlborough Programme is addressing children's and young people's mental health needs as early as possible. The intervention involves services working together around the child and family. An evaluation report has been produced using Routine Outcome Measures with 40+ parents connected to five schools.
- Video- interactive guidance (VIG) and Video Interactive Reflective Practice (VERG) programmes have been developed jointly by Social Care Specialist Clinicians and Educational Psychologists to support early response to complex needs.
- The NHS Speech and Language Therapy Service, Specialist Teachers and Educational Psychologists are jointly developing a new county-wide integrated programme to deliver in-school support for secondary age pupils with Speech Language and Communication Needs(SLCN).
- A set of SEND workforce competencies have been developed with participation from representatives from education, health and social care.
- Adult Health and Adult Social Care professionals are identifying children who are carers for parents or a sibling and referring them to appropriate children's support services.

4.3 *Localism*

- The local authority has published an on-line Local Offer '. It is designed to be a 'front door' to clear and comprehensive information on services across education, health and care. It is being developed in partnership with parents/carers'; children and young people; partners across services and the voluntary and community sector

- There is a focus on suite of evidence based parenting programmes delivered by Family Workers in the local community which build family confidence and capacity. Family Workers delivered 60 courses across Cambridgeshire during 2014 in their local community.
- More than 80% of families with a child under 5 are registered at a Children's Centre, and able to access services, information, signposting and support. Of these families there is sustained engagement (i.e. multiple interactions over the course of a year) with over 60%, including 80% of the families registered who are also open to Social Care, 77% of registered teenage parents, parents of 2 year olds eligible for funded childcare, and families of children with SEND.

4.4 *Personalisation*

- Bespoke 1:1 Family Work following full CAF assessment supports families to improve well-being, family functioning, confidence and aspiration, as well as finding ways for family to go on to access universal services, local resources and support
- The Children's Centre Worker role has been developed as a key first point of contact for families in Children's Centres to build relationships, address some lower level, presenting concerns embed work with families and run group activities providing a place for families to continue to access support and services after a 1:1 programme of support.
- Effective partnership work with health visitors and midwives continues to be developed including further development and attendance at under 5s LARMs to enable joint planning, information, resource and skill sharing which is personalised for child and family.

4.5 ***Ensure an effective transition to adult services***

4.5.1 There is a new model and process for the transition of young people from children's to adult services. The new preparing for adulthood process was implemented in April 2015. The aims are:

- Preparing for Adulthood to be part of Education Health and Care Plans
- Plans grow and develop with the young person:
- A common language / plain English used by professionals in all services:
- Clear information available through the local offer
- The age of transition from children to adult services is now 18 rather than 19
- Children and young people will know from the age of 16 what support they can expect to receive at 18 and know in plenty of time before 18 what support will be put in place.
- Shared database to facilitate forward planning and joint working and to reduce duplication.
- Joint governance arrangements.

5.0 **PRIORITY 3**
Support positive and resilient parenting, particularly for families in challenging situations, to develop emotional and social skills for children

5.1 The Healthy Child Programme (HCP) is the national Public Health Programme, based on best knowledge/evidence to achieve good health outcomes for all children. The Government's aim is to enable local services to be shaped to meet local needs. The HCP offers every family a programme of screening tests, immunisations, developmental reviews and information and guidance to support parenting and healthy choices – all services that children and families need to receive if they are to achieve their optimum health and wellbeing.

5.2 Cambridgeshire County Council is responsible for commissioning public health services for school-aged children (5-19) primarily delivered by school nurses and for specific screening programmes including hearing screening, vision screening, sexual health, national child measurement and healthy weight management, Family Nurse Partnership and health visitors, including the element of the Healthy Child Programme that they lead for children aged 0 - 5 years. This presents new opportunities for bringing together a robust approach for improving outcomes for young people across both health and local authority led services and an integrated service with shared decision-making for children and families.

5.3 The 0-19 Healthy Child Programme offers a universal service for all children and families, and at a crucial stage of life, the HCP therefore presents an invaluable opportunity to identify families that are in need of additional support and children who are at risk of poor outcomes.

5.4 Alongside the Health Visiting Service, the Cambridgeshire County Council also commissions the Family Nurse Partnership (FNP) which is a voluntary, preventive programme for vulnerable young first time mothers. It offers intensive and structured home visiting, delivered by specially trained nurses, from early pregnancy until age two. FNP benefits the most needy young families in the short, medium and long term across a wide range of outcomes helping improve social mobility and break the cycle of inter-generational disadvantage and poverty. FNP uses in-depth methods to work with young parents, on attachment, relationships and psychological preparation for parenthood and uses behaviour change methods to encourage healthier lifestyles for themselves and their babies.

5.5 On 19 October 2015, the Together for Families programme launched the new Think Family guidance and tools.Think Family means improving outcomes for children, young people and families with multiple needs by considering and understanding the needs of all family members and co-ordinating the support they receive from children's, young people's, adults' and family services in a single family plan coordinated by a Lead Professional.

5.6 The principles of Think Family working are to have:

- **One Lead Professional** – nominated to co-ordinate the work with the family
- **One thorough family assessment** – which considers the needs of the whole family, how the issues inter-relate and the wider context and relationships which surround presenting issues

- **One overarching family support plan** –one overarching support plan managed by the Lead Professional and reviewed regularly with the family and professionals involved through team around the family meetings
- **A team around the family** – all professionals who are involved with any member of the family working together to the support plan with agreed goals
- **Limiting transfersfamilies experience through our services** - one coordinated intervention is more effective than services taking it in turns and transfers between teams consume time, energy and so incur cost
- **Commitment to putting the family's needs at the centre and overcoming professional difference**

5.7 As a result of the new guidance some of the key changes include:

- The introduction of the Family Common Assessment Framework
- Alignment of Family Support Plan templates
- One shared Outcomes Framework
- Clearer guidance and training around the Lead Professional role
- Closer centralised monitoring of the process through the Advice and Co-ordination Team
- More advice to professionals about services and processed through the Advice and Co-ordination Team.

6.0 **PRIORITY 4**
Create and strengthen positive opportunities for young people to contribute to the community and raise self esteem and enable them to shape the programmes with which they engage

6.1 A revised version of the Cambridgeshire County Council Corporate Parenting Strategy was published in June, along with a young people's version that was produced by Voices Matter (Cambridgeshire Children in Care Council made up of young people). 'Corporate Parenting' was first set out in the Children Act 1989 as a collective responsibility for all local authorities and it means that all Councillors, Officers and partners should be acting to provide the best possible care and protection for these children and young people. This means we should work to support these children to achieve the highest outcomes that any good parent would, with the mind-set of 'if this were my child'. The majority of Looked After Children begin their lives from a disadvantaged position because of their often difficult start in life. As a group, their attainment at school is well below that of their peers, they are less likely to be in education, training or employment and are less likely to be living healthy lifestyles. The strategy prioritises all these areas.

6.2 Compared to the previous strategy, there is much greater focus on children placed out of county as they have been identified as being disadvantaged compared to their peers, for example, they are less likely to receive health assessments in a timely manner. An additional outcome area has also been included to reduce teenage pregnancy in Looked After Children and Care Leavers and support their parenting if they do become parents. Approximately 25% of care leavers become teenage parents and 10% of children born to care leavers become Looked After themselves.

6.3 Implementation of the strategy has already begun and is being delivered through a number of implementation groups that focus on each outcome area. Progress will be reported to the Corporate Parenting Board and is also measured by Voice Matters who report to the Board. Voice Matters help shape the services delivered for Looked After Children and informs decision-making.

6.4 Healthwatch Cambridgeshire ensures that young people have their say about their experiences of health and care services, how they think things could be improved and offer opportunities to get involved. Some of the work of HealthwatchYouth Engagement Worker has included:

- 'My Own Mind'; a project undertaken with the students of Ely School to look at how young people felt about stress and anxiety and what helps them cope at difficult times
- Giving talks in schools and youth groups about how to have your say about health and care services. Some of this has been delivered alongside Public Health colleagues.
- Building up partnerships and networks with young people's organisations in the county including Centre33, YMCA, Romsey Mill, Addenbrooke's and SexYOUality.

6.5 The above activities are helping build Healthwatch Cambridgeshire's Young Person's Network; Youth Connect.This network currently has 60 members, receiving a fortnightly bulletin promoting opportunities to get involved in a range of local, regional and national projects.

7.0 PRIORITY 5
Recognise the impact of education on health and wellbeing and work to narrow local gaps in educational attainment

7.1 The Accelerating Achievement strategy sets out the Council's ambition to improve the educational achievement of vulnerable groups of children and young people. These include (but are not limited to) children entitled to Free School Meals (FSM), children who have Special Educational Needs or Disabilities (SEND), or are Looked After (LAC). Overall, the aim is that Key Stage 2 and Key Stage 4 attainment by children in vulnerable groups will have improved by three percentage points above the attainment of pupils not in vulnerable groups. This work has already begun to have an impact. To achieve this aim, the strategy describes two sets of objectives. One set focuses on how Cambridgeshire County Council will work with schools, settings, professionals and families to improve the achievement of children in vulnerable groups in general. The other set focuses on specific vulnerable groups, identifying the actions Cambridgeshire County Council will take in order to improve the achievement of children in those groups.

7.2 At Key Stage 2 in 2015 we saw absolute performance improve in nearly all of our target groups. A larger proportion of children eligible for free school meals, with special educational needs, speaking a Central or Eastern European language at home or from Gypsy / Roma ethnic backgrounds, achieved the required benchmark at the end of Key Stage 2. But we were still falling slightly short of our overall aim of three percentage points more than non-disadvantaged children. At Key Stage 4 we were not able to say how we compared to last year because of changes in how the results are reported. However, the general

trend was that the gap was reducing in FSM and SEN statement, but not in SEN non-statement

7.3 *Joint Strategic Needs Assessment (JSNA) vulnerable children*

7.3.1 A number of stakeholders requested a JSNA focusing on vulnerable children and families in Cambridgeshire. Children can experience many adverse 'risk factors' relating to a health, family or environment. These risk factors rarely occur in isolation and can combine to lead to relatively poor outcomes later in life. Establishing which children face different combinations of these risk factors would allow for a whole range of services to be better targeted and coordinated to improve positive outcomes later in life. This is a particular issue in Cambridgeshire as we know that children growing up in poverty achieve less well than almost anywhere else in the country.

7.3.2 The JSNA brought together data to establish whether it was feasible to identify children and young people in Cambridgeshire who have risk factors which make them potentially vulnerable to poor educational outcomes and to understand what services they are in contact with and how vulnerability factors are spread across the county. Poor attainment is more concentrated is the most deprived parts of the county, although there are parts of the county where there are lower levels of good attainment that are not necessarily in the most deprived areas. Focusing efforts on those with poor attainment at Early Years Foundation Stage (EYFS), Key Stage (KS) 2 and KS3/4, living in the most deprived parts of the county will only address 29% of poor attainment. The JSNA also looked at other vulnerability factors such as parental substance misuse and domestic violence, although detailed analysis at small geographic levels was not possible, Fenland remains the district area with the highest concentration of risk factors. The report gives a range of further recommendations in terms of data recording and information sharing to enable a more extensive analysis in future.

Source Documents	**Location**
Health and Wellbeing Strategy	http://www.cambridgeshire.gov.uk/info/20004/health_and_keeping_well/548/cambridgeshire_health_and_wellbeing_board

Appendix A: Health and Wellbeing Board themed meeting template

	Meeting theme: ***Priority 1 – Ensure a positive start to life for children, young people and their families***	
	Focus areas: • *Strengthen our multi-agency approach to identifyingchildren who are in poverty,who have physical or learningdisabilities or mental healthneeds, or whose parents areexperiencing physical ormental health problems.* • *Develop integrated servicesacross education, health,social care and the voluntarysector which focus on theneeds of the child in thecommunity, including thegrowing numbers of childrenwith the most complexneeds, and whereappropriate ensure aneffective transition to adultservices.* • *Support positive and resilientparenting, particularly forfamilies in challengingsituations, to developemotional and social skills forchildren.* • *Create and strengthenpositive opportunities foryoung people to contribute tothe community and raise theirself esteem, and enable themto shape the programmesand services with which theyengage.* • *Recognise the impact ofeducation on health andwellbeing and work to narrowlocal gaps in educational attainment*	
1.	**Overarching partnership delivering against this priority and how this links to the Health and Wellbeing Board**	The Cambridgeshire Children's Trust reports to the HWB Board against this priority
2.	**Recent Joint Strategic Needs Assessments (JSNAs)**	Vulnerable Children and Families JSNA (2015) The Mental Health of Children and Young People in Cambridgeshire JSNA (2013) Children and Young People JSNA (2010) These are available on http://www.cambridgeshireinsight.org.uk/jsna

3	**a) Integrated partnership strategy or strategies in the health and care system delivering on this priority** **b) Has this been formally adopted as an annex to the Health and Wellbeing Strategy?**	a) Emotional wellbeing and mental health strategy for children and young people 2014-16 b) Breaking the Cycle (2) Child and Family Poverty Strategy c) 'Together for Families' and 'Think Family'. These are programmes rather than strategies which promote working across agencies. The Emotional wellbeing and mental health strategy for children and young people has been adopted as an annex to the HWB strategy. Breaking the Cycle (2) Child and Family Poverty Strategy has been agreed by the Children's Trust.
4.	**Joint commissioning and section 75 arrangements**	A Children's Health Joint Commissioning Unit has been established, led by the Executive Director of People and Communities, Peterborough City Council, with input and oversight from Cambridgeshire County Council, Peterborough City Council and the C&P Clinical Commissioning Group.
5.	**Alignment of NHS Cambridgeshire and Peterborough Clinical Commissioning Group's (CCG) commissioning plans with this priority**	The CCG's plan to commission child and adolescent mental health services align with the Children's and Young People's Emotional Wellbeing Strategy. The joint commissioning unit will enable alignment and integration of the CCG's commissioning intentions for CYP with local authority plans, particularly in relation to children's public health services.

Agenda Item No: 7

PREVENTION WORK FOR THE HEALTH SYSTEM TRANSFORMATION PROGRAMME

To: Health and Wellbeing Board

Date: 19 November 2015

From: Dr Liz Robin, Director of Public Health
Emma de Zoete, Consultant in Public Health

1.0 PURPOSE

1.1 The purpose of this paper is to outline the first draft of a health system prevention strategy that the Health System Transformation Programme has asked the public health team to develop.

2.0 BACKGROUND

2.1 The Cambridgeshire and Peterborough health economy has been identified as one of England's 11 most challenged health economies and faces a funding shortfall of at least £250 million by 2019.

2.2 Prevention, at all levels has been recognised at critical to building a sustainable health system, through reducing.

2.3 The public health team has been asked to assess the contribution that prevention in its widest sense can make to closing the financial gap across the Cambridgeshire and Peterborough health system, building on current local authority based public health transformation programmes and estimating the NHS savings which can be achieved, as well as considering where additional prevention work across the NHS would enable a higher level of savings with additional NHS investment. This work encompasses interventions at primary, secondary and tertiary levels.

3.0 OBJECTIVES OF THE HEALTH SYSTEM PREVENTION WORK AND INTERDEPENDENCIES

3.1 The objectives of the health system prevention strategy are:

- To identify the savings to the NHS, where possible, from current and planned prevention initiatives
- To identify areas/interventions for potential additional NHS investment in prevention which would maximise savings to the local NHS over the next 3, 5, 10 year and beyond.
- Identify areas and initiatives for potential stretch and outline the strategy for delivering these including projected savings to the NHS, where possible.

3.3 The strategy incorporates the work that the Cambridgeshire and Peterborough Public Health Reference Group (PHRG) has done in identifying priority areas (obesity/diet/ physical activity and community engagement), evaluating where there is best evidence of impact, and reflects the relevant planned prevention work outlined by the action plan agreed by the PHRG.

3.4 The work relates to the ongoing transformation of preventive services by local authorities and the CCG, including lifestyles services in both Cambridgeshire and Peterborough, new workplace health programmes. Implementation is dependent on voluntary sector and district council engagement, along with the NHS.

4.0 RISKS AND LIMITATIONS

4.1 This work identifies cost savings to the NHS from interventions which improve health or the wider determinants of health and can demonstrate they avoid health service activity, particularly secondary care activity.

4.2 Return on investment modelling for the local population requires a number of assumptions to be made and there is a degree of uncertainty, which has been expressed in the document, surrounding the findings.

4.3 There is a likelihood of double counting of impact of prevention on NHS activity, with an unknown proportion of patients with co-morbidities and multiple lifestyle problems receiving multiple interventions. However some general conclusions have been drawn about the range of potential savings.

4.4 The complexity of estimating NHS savings, particularly given the tight timescales, has been difficult for this piece of work. Advice and support has been sought from the Public Health England local Knowledge and Intelligence Team and the national Public Health England Health Economics team. However, there remain a number of areas which need further work. Public Health England is undertaking a similar piece of work, although it has not been possible to establish their timescale.

5.0 KEY POINTS

5.1 Scope of the work

5.11 The focus of the draft health system prevention strategy is on:

- interventions that have the best evidence;
- interventions with the greatest potential NHS savings;
- interventions where the information is available to model reasonable estimates of NHS savings, or;
- where the scale of the issue suggests interventions will have an impact (even if the evidence is not currently conclusive).

5.12 There are many prevention initiatives where we have a strong evidence base where we simply do not have the information to enable us to estimate savings to the NHS, but we think there are likely to be some. This strategy does not try to quantify savings, other than to the NHS.

5.13 It is also unlikely to be entirely comprehensive, in that there are other interventions we have not had time to address in this strategy. In particular, savings from better management for those diagnosed with diabetes, patients with transient ischaemic attack (TIA) treated within 24 hours, and early diagnosis of people with familial hypercholesterolaemia are gaps. However, these are likely to be being addressed in other CCG work programmes.

5.2 Potential overlap with other programmes

5.21 There are also prevention initiatives which are not within the scope of this work, as they are being taken forward through other programmes of work. In particular, integrating care for older people and resulting reductions in emergency admissions are not included here, as this is being taken forward through the Uniting Care Partners (UCP) contract. There are other areas within this strategy however that highlight and attempt to quantify potential opportunities which cross over with the UCP contract. The section on falls management and malnutrition screening and treatment are areas where UCP activity would play an important role in any delivery.

5.22 There is an overlap between this strategy and the work streams of the System Transformation Programme and the Emergency Care Vanguard. The strategy set out in this document will therefore be taken forward through a range of work programmes.

5.3 Key findings

5.31 The key findings are set out in the executive summary of the attached draft strategy (Appendix 1). The strategy recommends a number of actions based on interventions which produce an NHS net saving. These are:

- Maximise the opportunities for lifestyle interventions identified through health checks across Cambridgeshire and Peterborough.
- Expand Peterborough weight management services to reach NICE recommended levels.
- Extend the health check to those aged 25-39 in the Peterborough South Asian population. Focus on the most deprived areas first.
- Increase the lifestyle interventions for those with diagnosed hypertension, and at high risk of diabetes.
- Expand workplace health initiatives within NHS employers to reduce abseentism.
- Expand malnutrition screening and treatment in older people.
- Increase the number of people accessing stop smoking services (adults, older people and pregnant women).
- Increase the number of women with long acting reversible contraceptives (LARCs)
- Improve referral and uptake of IAPT services for people with long term conditions

5.52 We are still working on the following areas:

a) Expand falls prevention work to a greater % of the older population.

b) Increase the uptake to % of people eligible accessing and completing cardiac rehabilitation.

c) Increase the number of people receiving anti-coagulant treatment for Atrial Fibrillation.

d) Increase the numbers of people on a self-management programme with chronic obstructive pulmonary disease (COPD).

5.4 Longer term savings - Obesity, diet and physical activity

5.41 The system transformation programme identified that if obesity levels were kept static this could save 30% of the obesity related healthcare costs, the equivalent of £7m a year. The strategy looks at the possible interventions to keep obesity static, and found that although there is evidence of effective local programmes it is not possible to say if weight loss is maintained and therefore to quantify the impact on the NHS.

5.42 The headline findings for obesity, diet and physical exercise are:

- Current weight management services see approximately 1-2% of the population who are obese.
- For a variety of reasons it is not possible currently to robustly estimate the cost savings to the NHS of reductions in weight loss, although we can estimate the effectiveness of some of current programmes.
- There is little information about the long term impact of weight management programmes. However, recent health economic modelling of 'lifestyle interventions' focused on support to change lifestyle behaviour (notably diet, and physical exercise) have been found to be potentially cost saving to the NHS, with the largest savings from intensive interventions over the lifetime horizon.
- Peterborough weight management services are currently limited and should be immediately expanded to reach NICE recommended levels.
- We need to ensure that we maximise the opportunities for lifestyle interventions identified through health checks across Cambridgeshire and Peterborough.
- It is recommended that a 'lifestyle interventions' are available at a much larger scale, including intensive health trainer options, for those identified as at risk of diabetes, or with hypertension through a health check or opportunistically. This should be underpinned by initiatives which help create an environment which encourages a healthy weight. These initiatives should include the promotion of active travel.

5.43 There is evidence looking at disease specific interventions, such as diabetes prevention and hypertension prevention and management that lifestyle interventions that reduce the key lifestyle risks will become potentially cost saving to the NHS at 10 years and more certainly over a lifetime horizon. There is also evidence that screening and lifestyle intervention for the South Asian population aged 25-39 will generate long term savings, and this is costed in the strategy for the Peterborough population.

5.5 Overall net savings the NHS from work to date

5.51 The overall net savings to the NHS from the **work to date** suggest that the following savings can be made. These savings are based, in many cases, in increased investment. There is considerable costing work still underway, as listed above.

Short Term Total Potential Net Savings Summary Table (savings after costs have been removed)

	16/17	**17/18**	**18/19**
NHS activity saving	£1.1m	£1.3m	£1.26m
NHS productivity saving	£0.16m	£1.8m	£1.8m
Total	**£1.26m**	**£3.1m**	**£3.0m**

5.52 The additional investment needed to generate these savings would be approximately £694k over the next three years. There is a large NHS productivity saving estimated from introducing workplace health programmes.

5.53 As described above, it is not possible based on the current evidence base to estimate the cost reductions associated with weight loss, and much of the modelling work on improving diet and physical activity suggests that many of the savings to the NHS will be long term over a period of ten to twenty years or even the full lifecourse. Overall, this work does not conclude that keeping obesity static will generate the short term savings estimated by the system transformation programme, and instead focuses on where robust savings can be generated elsewhere.

5.54 It is also important to note that the figures above are all potential **net** savings to the NHS, having taken out the cost of the investment. In some cases the investment costs may not all fall to the NHS, and therefore the NHS will see a larger saving. Equally, funding through the NHS for preventive initiatives such as improved diagnosis and management of atrial fibrillation will generate savings for local authorities, in this case due to a reduction in the number of people having a stroke.

6.0 TIMESCALES

6.1 A first draft of the health system prevention strategy will be presented to the System Transformation Programme Board on 16 November 2015.

6.2 The draft strategy will also be presented to the Peterborough Health and Wellbeing Board during December 2015.

6.3 A final version of the prevention strategy will be presented to the Cambridgeshire and Peterborough Public Health Reference Group and for approval to Cambridgeshire and Peterborough Health and Wellbeing Board meetings in January 2016.

7.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

7.1 The prevention work touches on some aspects of the Cambridgeshire Health and Wellbeing Strategy. Priority 3 of the strategy is particularly aligned with this work; 'Encourage healthy lifestyles and behaviours in all actions and activities while respecting people's personal choices'.

8.0 RECOMMENDATION

8.1 The Health and Wellbeing Board is asked to note and comment on the first draft of the health system prevention plan.

Source Documents	Location
See references for the attached document.	Health System Prevention Plan – draft 1 (attached)

Health system prevention strategy for Cambridgeshire and Peterborough

Draft version 1.0 – 9 November 2015

Contents

1. Executive summary: headlines and recommendations

Headlines

Actions proposed

- Maximise the opportunities for lifestyle interventions identified through health checks across Cambridgeshire and Peterborough.
- Expand Peterborough weight management services to reach NICE recommended levels.
- Extend the health check to those aged 25-39 in the Peterborough South Asian population. Focus on the most deprived areas first.
- Increase the lifestyle interventions for those with diagnosed hypertension, and at high risk of diabetes.
- Expand workplace health initiatives within NHS employers to reduce absenteeism.
- Expand malnutrition screening and treatment in older people.
- Increase the number of people accessing stop smoking services (adults, older people and pregnant women).
- Increase the number of women with LARCs
- Improve referral and uptake of IAPT services for people with LTCs.

Work still in progress on developing these options

- Expand falls prevention work to a greater % of the older population.
- Increase the uptake to % of people eligible accessing and completing cardiac rehabilitation.
- Increase the number of people receiving anti-coagulant treatment for Atrial Fibrillation.
- Increase the numbers of people on a self-management programme with COPD.

Obesity, diet and physical activity

- Current weight management services see approximately 1-2% of the population who are obese.
- For a variety of reasons it is not currently possible to robustly estimate the cost savings to the NHS of reductions in weight loss, although we can estimate the effectiveness of some of current programmes.
- There is little information about the long term impact of weight management programmes. However, recent health economic modelling of 'lifestyle interventions' focused on support to change lifestyle behaviour (notably diet, and physical exercise) have been found to be potentially cost saving to the NHS, with the largest savings from intensive interventions over the lifetime horizon.
- Peterborough weight management services are currently limited and should be immediately expanded to reach NICE recommended levels.
- We need to ensure that we maximise the opportunities for lifestyle interventions identified through health checks across Cambridgeshire and Peterborough.
- It is recommended that 'lifestyle interventions' are available on a much larger scale, including intensive health trainer options, for those identified as at risk of diabetes, or with hypertension through a health check or opportunistically. This should be underpinned by initiatives which help create an environment which encourages a healthy weight. These initiatives should include the promotion of active travel.

Diabetes prevention

- People at high risk of developing type 2 diabetes can be identified through the NHS Health Check and the disease could be prevented in 30-60% through appropriate behaviour change support[1].
- Improve screening and lifestyle interventions for populations with high risk of hypertension, high glucose levels, South Asian population. Focus on the most deprived areas first.

Cardiovascular disease

- Current uptake for Cardiac Rehabilitation is 48.3% in line with the national average. However, there may be cost savings associated with increasing this to 65%.
- There are opportunities to improve the diagnosis and treatment of Atrial Fibrillation. This is potentially cost saving to the NHS as well as local authorities. Work should focus on increasing the numbers of patients diagnosed and treated for AF and

[1]PHE Cardiovascular intelligence pack.

reducing variation between GP practices. Peterborough should be the initial focus of this work.

- Modelling work finds the national interventions to reduce salt intake are cost saving at all time horizons including year one.
- Lifestyle interventions, general adult population and focused on those with diagnosed hypertension, have been shown to be potentially cost saving at 10 years and over a lifetime horizon.
- The opportunity provided in the health check to diagnose and treat hypertension, including through lifestyle interventions, should be maximised.
- A variety of lifestyle interventions for those diagnosed with hypertension should be available. This would mean an expansion to existing lifestyle services, such as health trainer/coaches. Work to target this group should focus initially on Peterborough.

[PH: we are doing further modelling work on hypertension, cardiac rehabilitation and AF diagnosis and management]

Long term conditions

- International evidence finds that psychological interventions for long term conditions can on average reduce health care costs by a range of 20-30% across studies.
- Self-management programmes in patients with COPD have been found to reduce all cause hospitalisations by up to 40%.
- A self-management programme should be offered to those diagnosed with COPD. This should be evaluated for its economic impact on health costs.
- Routine management of LTCs should include the identification of those requiring further assessment for depression and anxiety.
- There should be maximum utilisation of the IAPT LTC team, and there should continue to be a focus on rapidly increasing referrals. There should be a focus on those with multiple long term conditions.
- There should be an economic evaluation of the impact on healthcare costs of identification and treatment for common mental health disorders in those with multiple long term conditions.

Workplace health

- The potential mental health productivity savings, assuming no current action in this area, amount to nearly £5.7m across the large NHS employers in Cambridgeshire and Peterborough.
- The evidence and modelling is clear that investing in workforce health will generate short term productivity savings to the NHS. These are estimated, with the package

modelled here to be approximately £3.9m over three years, with an investment of £335k.

- NHS employers should see considerable productivity savings from investing in workplace health. In particular this needs to focus on improved management and awareness of mental health and illness.

Smoking

- There are an estimated 105,548 people across Cambridgeshire and Peterborough who smoke. There is a high quality, high ranking evidence that stop smoking services are cost effective, are good value for money and provide a good return on investment.
- Sub-national programme work, such as tobacco control, is critical to ensuring savings to the NHS. Nationally and locally we should continue to invest in this.
- We should maximise our prevention opportunities and increase the number of people setting a quit date through stop smoking services (adults, older people and pregnant women) in Cambridgeshire by 5%, and in Peterborough to the Cambridgeshire average.
- An additional investment of £346k, only £175k of which is new investment, is needed to generate a saving over £356k over the next two years.
- There are additional savings to the NHS to be made from stopping people smoking before operations, and this group should be a target population.

Alcohol

- Maximise opportunities to provide brief advice on alcohol to more GP practice patients. If 10,000 more patients were to receive this advice, it is estimated this would save the NHS £217k (above the cost of the intervention) over seven years with the vast majority of the savings in years 2-5.

[PH: We are doing further work to define local stretch targets and to model the cost savings]

Falls

- Injurious falls in older people have a high cost impact for health and social care services, estimated at £83million for 2016, with increasing costs forecast for the ageing population locally.
- There is important and robust evidence indicating net savings for falls interventions targeted at community dwelling older adults across a range of UK and international settings.

- In particular three areas of intervention for preventing falls in community-living older people have been trialled and indicated cost savings: home-based exercise (the Otago Exercise Programme) in over 80-year-olds, home safety assessment and modification in those with a previous fall, and specific multi-factorial programmes.
- Further development of models to estimate the cost savings to the NHS of local multi-component falls interventions accurately is in progress.
- Potential savings may require delivery of preventative approaches on a much wider scale than current provision.

[PH: Further work to develop models is in progress]

Malnutrition in older people

- An estimated 13,000 to 18,300 older people are malnourished in the Cambridgeshire & Peterborough population, and more are at risk
- Potential cost savings may be achieved by increasing proportion screened for malnutrition among inpatients, outpatients and new GP registrations to 90% and providing appropriate treatment; investment of £524k and savings in the order of £543k primarily from reducing length of stay in acute care. At worst this intervention should not cost the NHS additional funding, and will improve quality of life for older people.

Sexual health

- For every £1 invested in contraception services, there is a £11.09 saving to the NHS, rising to £13.42 for LARCs.
- It is proposed that we increase the number of women with long-acting reversible contraceptives (LARCs) by approximately 859 a year in Cambridgeshire & Peterborough. This should generate savings of £935k in 2016/17, £1.15m in 2017/18 and £1.26m in 2018/19.
- This would require an additional investment of £115k. However, the additional investment needed for Cambridgeshire, is already within the Council budget proposals for 2016/17.

Breastfeeding – promoting initiation and duration

- Low breastfeeding rates in the UK lead to an increased incidence of illness that has a significant cost to the health service. Investment in evidence-based multi-faceted

interventions has been shown to generate savings to the health economy in the short term by reducing hospital admissions for four acute childhood illnesses[2].

- There is evidence to suggest that breastfeeding can contribute to longer term savings through its impact on key health outcomes including childhood obesity, but this is difficult to quantify.
- The focus should be on joint commissioning with local authorities to improve breastfeeding support, implementing or piloting interventions in both acute and community settings. These interventions should include strengthening breastfeeding support and advice in acute settings, and easily accessible breastfeeding peer support programmes focused on the most deprived areas of the CCG.

[2]Renfrew MJ, et al. ''Preventing disease and saving resources: the potential contribution of increasing breastfeeding rates in the UK' (2012) UNICEF. Available at: http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&ved=0CCcQFjABahUKEwjxtcW__PHIAhXLtxQKHRZqBNk

Investment and saving opportunities identified

The two tables below summarise the short term savings identified through work to date. **Work is ongoing to model potential savings from cardiac rehabilitation, atrial fibrillation diagnosis and management, hypertension management, self-support for COPD, initiatives to reduce malnutrition and falls prevention.**

Short Term Total Potential Net Savings Summary Table (savings after costs have been removed)

	16/17	17/18	18/19
NHS activity saving	£1.1m	£1.3m	£1.26m
NHS productivity saving	£0.16m	£1.8m	£1.8m
Total	**£1.26m**	**£3.1m**	**£3.0m**

				Investment				Net NHS Savings				Comments
	Lifestyle	Intervention	Area	2016/17	2017/18	2018/19	Total	2016/17	2017/18	2018/19	Total	
Short term	Smoking cessation	Increase uptake in Local Stop Smoking Services by 5% (excludes subnational £136k per year which is not new investment)	CCC	£21,904	£157,904		£179,808	£161,250	£161,250		£322,499	
		Increase uptake in Local Stop Smoking Services to CCC levels (excludes subnational £35k per year, which is not new investment)	PCC	£65,589	£100,589		£166,178	£16,307	£16,307		£32,614	
	Sexual Health	Increase uptake of LARC's	CCC	£70,000	£90,000	£100,000	£260,000	£770,000	£990,000	£1,100,000	£2,860,000	£260k of CCC LARC investment is not new NHS investment.
			PCC	£15,000	£15,000	£15,000	£45,000	£165,000	£165,000	£165,000	£495,000	
	Workplace	Mental health promotion, increase in healthy lifestyles and weight management	NHS Trust	£111,580	£111,580	£111,580	£334,741	£163,500	£1,887,070	£1,887,070	£3,937,640	NB: These are productivity savings to the NHS.
	SHORT TERM TOTAL		**CCC**	£91,904	£247,904	£100,000	£439,808	£931,250	£1,151,250	£1,100,000	£3,182,499	New invesment in fact £179,808 see above on LARCs.
			PCC	£80,589	£115,589	£15,000	£211,178	£181,307	£181,307	£165,000	£527,614	
			NHS Trust	£111,580	£111,580	£111,580	£334,741	£163,500	£1,887,070	£1,887,070	£3,937,640	
			Total	**£284,073**	**£475,073**	**£226,580**	**£985,727**	**£1,276,057**	**£3,219,626**	**£3,152,070**	**£7,647,753**	NB: 3.9m of this isnet saving is in productivity savings to the NHS.
Longer term	Diabetes	Focus on South Asian population aged 15-39 years for diabetes interventions	PCC	£33,839	£33,839	£33,839	£101,517					This includes a targetted focus using health check plus referral to a health trainer where diabetes is diagnosed
	Lifestyle interventions & environment to support healthy weight		PCC & CCC									Further work possible on potential increase in interventions for long term savings.
	LONGER TERM TOTAL			**£33,839**	**£33,839**	**£33,839**	**£101,517**	**£0**	**£0**	**£0**	**£0**	

2. Introduction

Why have we produced a health system prevention strategy?

The Cambridgeshire and Peterborough health economy has been identified as one of England's 11 most challenged health economies and faces a funding shortfall of at least £250 million by 2019.

Prevention, at all levels has been recognised as critical to building a sustainable health system, through reducing demand on the health system. NHS England's Five Year Forward View states that 'The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health.'

It is well understood, that significant proportions of ill health and health service activity are potentially preventable. A recent Public Health England Lancet publication about the global burden of disease found that 40% of the NHS workload is potentially preventable, yet the proportion of health expenditure directed at prevention, although hard to estimate reliably, is probably closer to 4%[3].

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, such as coronary heart disease, show that approximately half the interventions that reduce ill health occur in the health system. So although the health system only forms part of the prevention picture, in many cases it is a critical part.

Objectives of the strategy

The objectives of producing the strategy were to do the following:

- To identify the savings to the NHS, where possible, from current and planned prevention initiatives.
- To identify areas/interventions for potential additional NHS investment in prevention which would maximise savings to the local NHS over the next 3, 5, 10 years and beyond.
- Identify areas and initiatives for potential stretch and outline the strategy for delivering these including projected savings to the NHS, where possible.

[3]Changes in health in England, with analysis by English regions and areas of deprivation, 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013. John N Newton et al. The Lancet. September 15, 2015 http://dx.doi.org/10.1016/S0140-6736(15)00195-6.

What are the areas of focus?

This strategy specifically focuses on the contribution prevention can make to closing the financial gap across the Cambridgeshire and Peterborough health system. This is essentially about how we can improve the health of the population and use NHS resources for maximum impact. It focuses on initiatives where there is evidence that a particular prevention initiative can save the NHS money, and this can be quantified. It proposes areas where the NHS could 'invest to save' to maximise its prevention opportunities. It does not therefore focus on quality of life improvements which are not shown to be cost saving to the NHS, although all the proposals in this document show evidence that they will improve quality of life.

Therefore the areas of focus have been carefully chosen for the following reasons:

- The interventions have the best evidence that they work
- They are the interventions with the greatest potential to generate NHS savings
- Information is available to model reasonable estimates of NHS savings
- or, the scale of the issue suggests interventions will have an impact (even if the evidence is not currently conclusive)

This strategy does not start from a blank piece of paper. It builds on current local authority and NHS joint based Public Health Transformation programmes.

What is included and what is not in this strategy?

There are many prevention initiatives where we have a strong evidence base, however we simply do not have the information to enable us to estimate savings to the NHS, but we think there are likely to be some. Support for post-natal depression is a good example. Equally there are prevention initiatives that will produce savings in terms of reduced disability to social care, such a stop smoking initiatives or diabetes prevention, as well as to the NHS. This strategy does not try to quantify savings, other than to the NHS. It is also unlikely to be entirely comprehensive, in that there are other interventions we have not had time to address in this strategy. Equally this document does not outline the health of the local population. This is covered in depth in the Joint Strategic Needs Assessments (JSNA).

Additionally there are many initiatives, often for children and young people, which are cost saving to the wider public sector (employment, economy and criminal justice) although not necessarily directly to the NHS, but will undoubtedly improve overall health. Parenting programmes focusing on the early identification and management of conduct disorder are a good example. Initiatives for children with strong evidence of an NHS saving have been hard to identify although there are many that show a benefit to longer term life chances which will in turn impact on long term health.

There are also prevention initiatives which are not within the scope of this work, as they are being taken forward through other programmes of work. In particular integrating care for

older people and resulting reductions in emergency admissions not included here, as it is being taking forward through the UnitingCare Partners (UCP) contract. There are other areas within this strategy however that highlight and attempt to quantify the potential opportunities with the UCP contract.

There is an overlap between this strategy and the work streams of the System Transformation Programme and the Emergency Care Vanguard. The strategy set out in this document will therefore be taken forward through a range of work programmes.

Details of the prevention initiatives considered in this work and the reasons for including or not including them are provided in the table at Appendix A.

3. Obesity, diet and physical activity

Headlines

- Current weight management services see approximately 1-2% of the population who are obese.
- Peterborough weight management services are currently limited and should be immediately expanded to reach NICE recommended levels.
- We need to ensure that we maximise the opportunities for lifestyle interventions identified through health checks across Cambridgeshire and Peterborough.
- For a variety of reasons it is not currently possible to robustly estimate the cost savings to the NHS of reductions in weight loss, although we can estimate the effectiveness of some of current programmes.
- There is little information about the long term impact of weight management programmes. However, recent health economic modelling of 'lifestyle interventions' focused on support to change lifestyle behaviour (notably diet, and physical exercise) have been found to be potentially cost saving to the NHS, with the largest savings from intensive interventions over the lifetime horizon.
- It is recommended that 'lifestyle interventions' are available on a much larger scale, including intensive health trainer options, for those identified as at risk of diabetes, or with hypertension through a health check or opportunistically. This should be underpinned by initiatives that help create an environment which encourages a healthy weight. These initiatives should include the promotion of active travel.

Background

Excess weight, diet and physical activity all have a significant impact on health. Obesity is a major determinant of premature mortality and avoidable ill health, increasing the risk of diabetes, heart disease, cancer, muscle and joint problems and depression.

Key Facts

- It is estimated that being moderately obese reduces life expectancy by about three years and being severely obese by 10 years or more.
- In England, and in Cambridgeshire and Peterborough, most people are overweight or obese.
- Obesity is estimated to cost the NHS £5 billion a year and type 2 diabetes (often caused by obesity) a further £9 billion.
- Physically active people have a 20-35% lower risk of cardiovascular disease, reduced risk of diabetes, obesity, osteoporosis and colon/breast cancer, and better mental health.

Current position

What is the scale of the problem?

Overall levels of adult obesity in Cambridgeshire and Peterborough are in line with the national average. This masks variation within the CCG. For example there are higher than average percentages in Fenland (72%) and Huntingdonshire (69%) and lower than average percentages in Cambridge (54%), and there is similar variation within Peterborough. Obesity is highly correlated with deprivation and black and Asian ethnic backgrounds associated with higher risks of obesity and obesity related co-morbidities.

Table 1- Proportion of adults and children overweight or obese in Cambridgeshire and Peterborough

Age	Classification	Time period	Source	Cambridgeshire	Peterborough	England
Adults	Excess weight *	2012	1	65%	66%	64%
	Obese only	2012	1	23%	24%	23%
Children (4-5 years old)	Excess weight *	2013/14	2	21%	25%	23%
	Obese only	2013/14	2	8%	11%	10%
Children (10/11 years old)	Excess weight *	2013/14	2	29%	30%	34%
	Obese only	2013/14	2	16%	17%	19%

Source: 1.Public Health Outcome Framework, Fingertips, PHE
2. NCMP Local Authority Profile, Fingertips, PHE

How is the prevalence of obesity expected to change locally?

- The prevalence of obesity (BMI≥30) is forecast to continue to rise, however the latest data suggest the increase may be slower than previous national forecasts suggested.
- The projected rise for Cambridgeshire and Peterborough is from a baseline of 22.2% in 2012 to 23.8% in 2018, reaching nearly 28% by 2031.
- The greatest increase will be in the over 75s and 45-54s, with the prevalence in adults aged 25-44 remaining relatively stable.

The following figure and table show the proportional increase and the number of people this represents in our population. The estimates in table 2 below take account of the fact that our population is growing.

Table 2: Projected prevalence of obesity (BMI>30) and overweight (BMI>25) in C&P (% of >16s)

	2012	2013	2014	2015	2016	2017	2018	2021	2026	2031
% adults with BMI >30	22.2	22.5	22.8	23.1	23.3	23.6	23.8	24.6	26.0	27.7
% adults with BMI >25	65.1	65.4	65.6	65.8	66.0	66.1	66.3	66.9	68.1	69.4

Source: Cambridgeshire and Peterborough CCG estimates based on 2003-2012 data.

Table 3: Estimates of the number of people who will be obese by 2021 in Cambridgeshire and Peterborough

2012 Actual	2013	2014	2015	2016	2017	2018	2019	2020	2021
165,820	167,839	171,389	174,991	178,687	182,265	185,789	189,287	192,874	196,502

The health consequences and costs of rising obesity

Sixteen percent of NHS costs relate to diseases associated with overweight/obesity. Of these, 60% relate to diabetes, coronary heart disease and stroke; 30% to osteoarthritis and 10% to cancers. These diseases are complex and their causes are multi-factorial. While around 80% of the disease burden due to diabetes can be attributed to overweight/obesity, for heart disease and stroke the proportion is closer to one third and for osteoarthritis it is around 20%.

The population attributable fraction (PAF) below (an estimate of the proportion of the burden of that disease that is attributable to obesity) illustrates how we cannot think about tackling obesity separately from preventing diabetes, hypertension and other diseases. Diabetes has the highest obesity PAF; nearly 80% of the burden of the disease can be attributed to overweight and obesity (note that the PAF for Type 1 Diabetes alone would be low; this figure is driven by the predominance of Type 2 Diabetes).

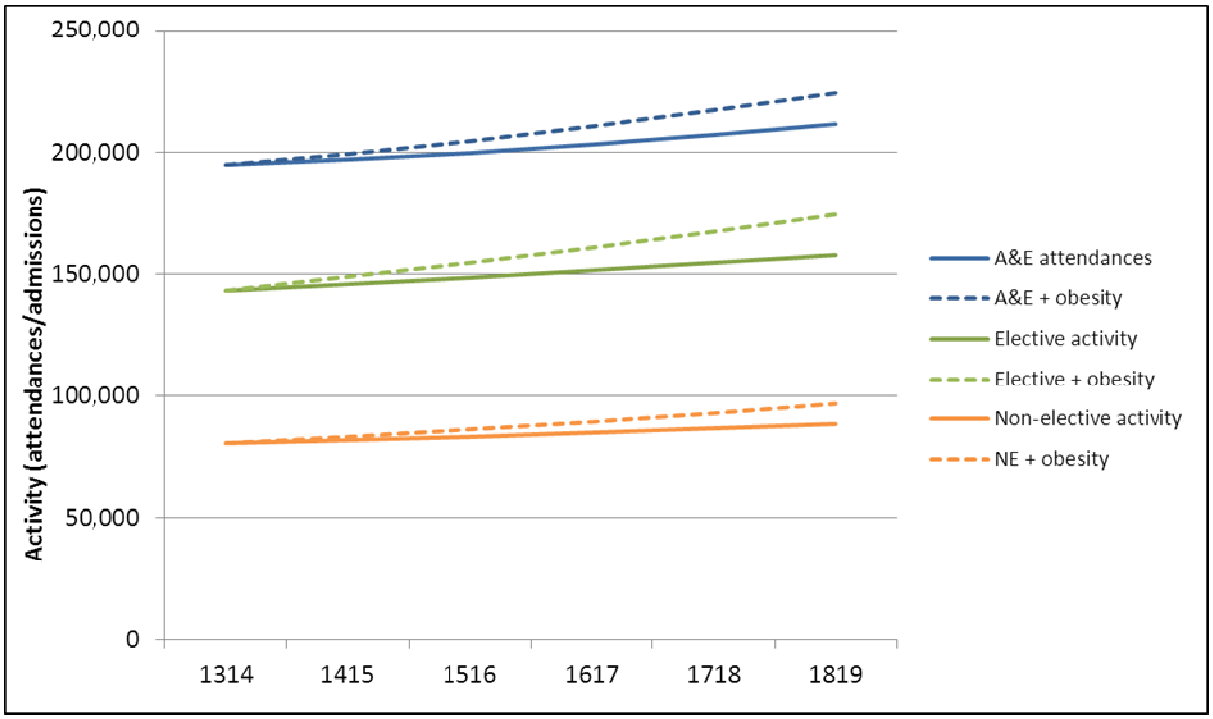
Table 4: Fraction of disease attributable to overweight and obesity (from WHO Burden of Disease, based on PAF for DALYs lost for specific diseases to overweight and obesity)

Disease	PAF
Ischaemic heart disease	34
Ischaemic stroke	34
Breast cancer	12
Colon/rectum cancer	16
Hypertensive disease	58
Corpus uteri cancer	49
Osteoarthritis	21
Diabetes mellitus	79

Overall, 6.3% of NHS costs can be attributed to overweight and obesity specifically. No single disease accounts for the majority of obesity-related NHS costs. There is little published research on the relative use of health services by obese patients, however the evidence suggests that excess use of services relates to the consequences of obesity, rather than to obesity per se. A recent systematic review found that obese individuals have 30% higher health costs than individuals of a healthy weight[4]. This estimate has been used to estimate 30% higher health service usage.

The demand for health services is rising faster than can be explained by demographic change alone. Rising acuity results, in part, from population ageing, but the increasing prevalence of obesity is also a key factor. The figure below presents a forecast of the CCG-commissioned A&E, elective and non-elective activity across all providers, and the estimated impact of obesity.

Figure 1: Forecast acute activity to 2018/19 with projected obesity related activity



The table below shows how many people would need to be moved out of the obese category to keep obesity levels static, and reduce related NHS costs. For 2016 the number of people is 5,524 and for 2019 it would be 11,216.

[4]Withrow D & Alter DA. The economic burden of obesity worldwide: a systematic review of the direct costs of obesity. obesity reviews 2011;12:131–141

Table 5: Obesity prevalence

	2012 Actual	2013	2014	2015	2016	2017	2018	2019	2020	2021
Static prev	165,820	167,519	169,393	171,256	173,163	174,911	176,534	178,071	179,646	181,208
Increase prev	165,820	167,839	171,389	174,991	178,687	182,265	185,789	189,287	192,874	196,502
Difference	0	320	1,995	3,734	5,524	7,354	9,255	11,216	13,228	15,294
	0.0%	0.2%	1.2%	2.2%	3.2%	4.2%	5.2%	6.3%	7.4%	8.4%

Interventions and cost savings to the NHS

Current public health spend and activity

There are an estimated 165,820 people within the CCG population who are obese. We know the following about our current weight management services:

- Weight management services in Cambridgeshire are multi-component in design and offer services to people with obesity as outlined in NICE guidelines and Department of Health (2006).
- Services much more limited in Peterborough. NICE estimates of activity levels are based on average national activity at 2011 and so do not address the scale of the issue described above.
- We estimate that current weight management services (Tiers 2 and 3) are currently reaching 1-2% of the obese population across the CCG.
- We know that there is activity taking place within GP practices in relation to diet, weight and physical activity. Approximately 20,000 health checks are undertaken a year across Cambridgeshire and Peterborough.
- In Cambridgeshire 2014/15, 83% of the target was achieved and the percentage of health checks offered and converted into completed was 38%. There has been a considerable improvement in the quality of data returned and numbers referred onwards to services following a health check; which has been attributed to the ongoing training programme.
- Health check completion (45.8% of eligible population) and uptake (48%) in Peterborough is above or on average with England, with good onward referral to available lifestyle services.
- Many people choose to access evidence based commercial weight management programmes (such as Weight Watchers) independently of anything offered through the NHS.

In Cambridgeshire, annual Public Health spend on diet, physical activity and obesity is £1,005,000.

An evaluation of weight management services (Tiers 1-3) in Cambridgeshire (June 2011-May 2013) found that:

- All services have good outcomes as far as weight loss in people completing the programmes, and the results are comparable with those reported in studies used for benchmarking obesity services.
- On average 25-30% of participants achieved over a 5% weight loss on completion (average of approx. 4kg), as well as an increase in active days and average daily vegetable consumption.
- The cost effectiveness of the services is difficult to determine without long term follow up. However, the services are likely to be cost effective if weight loss >5% of body weight is maintained.

Current weight management and obesity services are limited in Peterborough.

A return on investment model for health trainers developed by a lecturer at the Judge Institute found that for the £488k invested by Cambridgeshire, they estimated that there would be a net saving to the NHS of £372k. The savings were largely from behaviour change processes. The vast majority of the work of the health trainers is on weight management, promoting physical activity and diet.

The cost effectiveness of weight management programmes

Significant health benefits can be achieved from modest amounts of weight loss. Realistic targets for weight loss for adults are usually seen to be a maximum weekly weight loss of 0.5–1 kg, and a total loss of 5–10% of original body weight over the period of the intervention.

The NICE economic models estimate that a 12-week programme costing £100 or less will be cost-effective for adults who are overweight or obese under 2 conditions. First, the weight loss, compared with what it would have been without the intervention, must be maintained for life. Second, at least 1 kg of weight is lost and this weight difference is maintained for life (that is, the person's lifetime weight trajectory is lowered by at least 1 kg). [PH42 costing report]

In a hypothetical scenario, only used to give an indication of the scale of the issue, where we wanted to reduce the weight in an additional obese 11,216 people by 2019, the number to keep obesity static, there would need to be an additional 37,386 referrals to weight management services and services would need to be seven and a half times the size they are now. This would not necessarily lead to a situation where obesity would be kept static; it would instead lead to some weight reduction within this group. It is not possible to estimate what proportion of the additional 30% health costs associated with obesity would be reduced through this weight loss. It is also not clear from the evidence whether this weight loss would be maintained.

Physical Activity

Illness as an outcome of physical inactivity has been conservatively calculated to be between £0.9-1 billion per annum in direct costs to the NHS (in 2006-07 prices), mainly based on costs associated with ischaemic heart disease and stroke (Scarborough 2011).

Active transport (cycling or walking to work) is a key way of increasing individual daily activity. Active travel schemes have been found to have a cost benefit of between 5 -6 to one (DfT 2014).

However many cost benefit models focus on reductions in premature mortality (e.g. WHO Health Economic Assessment Tool) or wider benefits such as absenteeism, productivity and quality of life rather than specific cost savings to the NHS. It has been possible to model the impact of brief advice to improve physical activity in the workplace section of this report, as the cost savings are in improved productivity to the NHS.

Jarrett (2012) estimated the NHS costs that could be averted by a large shift towards active travel in England and Wales, based on reducing incidence of key diseases and therefore the costs of treating these conditions. A shift in walking from 0.6 km/day to 1.6 km/day, and in cycling from 0.4 km/day to 3.4 km/day (similar to current levels in Copenhagen) could result in changes in numbers of incident cases of type 2 diabetes, dementia, cerebrovascular disease, breast and colorectal cancer, depressions and ischaemic heart disease. The study estimated that over 20 years, the expenditure averted would be over £17 billion. Most of these savings are due to a decrease in the expected number of cases of Type 2 diabetes. Reductions in incidence of Type 2 diabetes, cerebrovascular disease, depression and ischaemic heart disease would be seen over a shorter time period than cancers and dementia. The model did not include any impact for existing diagnosed patients.

Work already planned

Peterborough weight management services

An obesity needs assessment for the Peterborough and Borderline system has been completed, and outlines the tiered weight management services needed to meet NICE standards in Peterborough. The model proposed builds upon existing services in Peterborough that encourage physical activity, weight loss and healthy lifestyles. A CCG investment of £100k has been agreed to support the development of tier 3 weight management services and this will be taken forward as part of broader integrated lifestyle and behaviour change service developments over the coming year.

Encouraging a healthy weight

It is widely recognised that at the whole population level, obesity prevention and health promotion advice, support, information and incentives should be available to encourage a

healthy weight. These should include factors that affect the wider determinants of health including environment design and planning.

The model should work across the life course and therefore include support to children and young people for weight management from tier 1 through to tier 3.

Many partners, including district councils and the voluntary sector, fund initiatives to promote healthy lifestyle and reduce the number of people who are overweight and obese.

A Public Health Reference Group (PHRG) has been set up in Cambridgeshire and Peterborough to provide whole system leadership and multi-agency co-ordination for public health initiatives), focused on improving outcomes for residents and reducing health inequalities. Its membership includes District Councils, local academics, the voluntary sector, Police and Crime Commissioners office, Health Watch, the CCG and both local authorities. It reports to the Health and Wellbeing Boards.

The PHRG has chosen to focus on obesity, diet and physical exercise initially. Working with the public health team the PHRG has undertaken a review of the evidence in these areas. The summary of this is attached at Appendix B. Given the gaps in evidence around long term impact, the group has chosen to focus on a wide range of initiatives that will support creating an environment that promotes a healthy weight.

This review has led to a draft action plan for the next 6 months (October 2015-March 2016), which is currently being refined. Currently this work programme focuses on Cambridgeshire only.

The draft plan includes work in the following areas:

- Commissioning of a package of initiatives that will enable early years' services to provide children/families/carers with access to and information about a healthy diet.
- A package of interventions as part of a Workplace Programme for Local Authorities over two years.
- Increasing community engagement in physical activity programmes through a range of initiatives that could be supported or provided by different organisations.
- Training of staff in primary care to make brief interventions for lifestyle behaviour change

This work is funded through the Public Health grant, as outlined in the Cambridgeshire County Council business plan and is subject to council approval of the budget early next year.

Point of Care testing for lipids and HbA1c has been commissioned and will be available in all GP practices providing health checks from 2015/16. This will improve patient experience through the whole health check being completed in one practice visit and enable better recording. Secondly the introduction of a new data collection system in practices will

improve the accuracy of the patient invite system, data recording and collation. A range of outreach health checks is also being provided, there is staff training from a commissioned Coronary Heart Disease specialist nurse, and in Fenland a mobile service has been established and is visiting factories to offer health checks especially to those more hard to reach groups.

Where should the strategic focus be to reduce obesity related NHS service demand?

- We need to continue to provide high quality weight management programmes within Cambridgeshire and to maximise the opportunity of health checks to refer people onto weight management programmes.
- We need to provide multi-component weight management services to people with obesity as outlined in NICE guidelines to people living in Peterborough
- It is clear that these current weight management programmes, which reach 1-2% of the obese population, are not provided to a scale which would mean they could influence obesity related demand curves.
- The Public Health Reference Group has developed a strategy influencing the wider determinants of obesity. Many of the initiatives the group is taking forward may not show evidence of short term or direct NHS savings, but overall will help create an environment which supports a healthy weight. Again, arguably these current initiatives are not at a scale where they will be large enough to influence the overall obesity and overweight prevalence level within the population.
- Initiatives to create a wider environment that supports a healthy weight should include active travel initiatives.
- Some of the most cost saving interventions are more effective when introduced as national initiatives, such as reducing salt content within food and sugar levels within drinks.

Recommendation

That the health system consider investing in 'lifestyle' interventions, to reduce the overweight and obese population, including weight management, so that the scale of the interventions available better reflects the needs of the population.

The details of how lifestyle interventions influence diabetes and hypertension and have been found to be cost saving are outlined in the following sections.

The overall changes reflect the best evidence of where lifestyle interventions are cost saving to the NHS and the proposal would consist of:

A range of lifestyle interventions, including intensive health trainer options, available for those identified as at risk of diabetes, or with hypertension through a health check. In Cambridgeshire this would mean scaling up the current health trainer service, to provide more

'health coaches' and a range of other initiatives for people to access to reduce and maintain a healthy weight. A corresponding increase in specialist weight management services would also be needed.

In Peterborough this would mean:

- A health trainer/coach programme introduced as well as a wide range of initiatives to help people maintain a healthy weight. Specialist weight management services would also need to be expanded to meet the additional population entering the pathway.
- Ensuring full GP practice engagement with MECC and Let's Get Moving initiatives.
- Exploring point of care testing for Peterborough GP practices providing health checks, as this makes onward referral to other services quicker and easier.

[PH: We can develop investment options in these types of models – it will not be possible to model savings, other than in terms of specific diseases (see sections on diabetes and hypertension)]

4. Diabetes

Headlines

- People at high risk of developing type 2 diabetes can be identified through the NHS Health Check and the disease could be prevented in 30-60% through appropriate behaviour change support[5].
- Improve screening and lifestyle interventions for populations with high risk of hypertension, high glucose levels, South Asian population. Focus on the most deprived areas first.

Background

Diabetes mellitus is a chronic and complex multi-system disorder of glucose metabolism requiring medical input throughout the life-course. Diabetes is associated with serious complications including coronary heart disease, stroke, peripheral vascular disease and retinopathy, nephropathy, and neuropathy. It is important to note that there are two predominant types of diabetes.

Key Facts

- **Type 1 diabetes** typically occurs in children and young adults, is due to absolute insulin deficiency and contributes to approximately 10% of total diabetes prevalence; **type 2 diabetes** makes up approximately 85-90% of total diabetes prevalence, is associated with obesity and insulin resistance, and typically occurs in older adults aged over 35 years. Type 2 diabetes is the type of diabetes discussed here.
- If current trends persist, one in three people will be obese by 2034 and one in ten will develop Type 2 diabetes.
- Type 2 diabetes is often preventable. People at high risk of developing type 2 diabetes can be identified through the NHS Health Check and the disease could be prevented in 30-60% through appropriate behaviour change support[6].
- There is strong international evidence which demonstrates how behavioural interventions, which support people to maintain a healthy weight and be more active, can significantly reduce the risk of developing the condition.
- The cost of treating overweight patients with diabetes is about one and a half times that of treating normal-weight patients with diabetes. The cost of treating patients with diabetes who are obese is more than three times as high as for treating patients without diabetes who are of normal weight[7].

[5]PHE Cardiovascular intelligence pack.
[6]PHE Cardiovascular intelligence pack.
[7]PHE Cardiovascular intelligence pack.

Current position

In 2013/14 5.4% of people aged 17+ years were recorded as having a diabetes diagnoses in Cambridgeshire and 6.3% in Peterborough.It is estimated that there are 7,304 people with undiagnosed diabetes in NHS Cambridgeshire and Peterborough CCG. GP practice prevalence of observed diabetes ranges from 1.2% to 12.0%.

The focus here is on the prevention of diabetes rather than the management of diabetes once diagnosed. However, the National Diabetes Audit Data shows that many of the eight care processes recommended by NICE do not appear to be being provided in Cambridgeshire and Peterborough to the same level as elsewhere in the county, and the CCG does not rank well in comparison with other areas. Overall in 2012/13 54.9% of people with diabetes had the eight recommended care processes in NHS Cambridgeshire and Peterborough CCG compared to 59.5% in England. This means that at least 12,953 people did not receive the 8 care processes.

For example reporting on people with diabetes whose blood glucose levels are well controlled for 2013/14 there were 58.3% of people in this group in Cambridgeshire, and 47.9% in Peterborough. Cambridgeshire ranked 128th out of 152 counties and Peterborough was the bottom of the table nationally. The England average was 61.5%. There were similar results for blood pressure control in people with diabetes.

The focus here is on diabetes prevention however, intensive blood glucose control can reduce the risk of diabetic complications and decrease treatment costs over periods from 10 years to a lifetime, and some US studies showing a quicker return on investment[8]. There may therefore be opportunities related to intensive blood glucose control and blood pressure control amongst diabetics, to improve care and reduce overall NHS costs.

Interventions and cost savings to the NHS

NICE guidance on diabetes prevention highlights many interventions which are cost effective in the short term. It was not able to estimate long-term savings for the guidance.

However, it argues that the main savings are anticipated to arise as a result of providing intensive lifestyle-change programmes. Some and, in time, possibly all the costs of assessment and lifestyle interventions may be offset by delaying someone's progression to type 2 diabetes. In the short term, savings will relate mainly to the costs that would otherwise have been incurred in monitoring and treating people who have progressed to type 2 diabetes. Savings will increase in the longer term, as the number of complications and related medical conditions (such as stroke and heart disease) are reduced.

[8] Evidence based diabetes care in Cambridgeshire: clinical and cost issues for a diabetes service. A commentary based on a review of the literature, Nita Forouhi

There are a couple of interventions which the costing and modelling work commissioned for the development of the guidance, and some more recent work, which show interventions which are potentially cost saving.

a) Large-scale, region-wide multi-component programme (Hartslag Limburg) was found to be highly cost-effective but possibly cost-saving (depending on assumptions around cost of maintenance intervention[9]). Hartslag Limburg was a programme which targeted a regional population of 185,000 with a mix of 590 lifestyle programmes including low cost lifestyle seminars and cycle tours to high cost exercise and diet programmes. Sixty percent of the investment was on improving exercise. The more intensive interventions produced the greatest weight loss, and significant improvements in health were found between the intervention and reference group after five years.

b) A US study (Zhou et al. 2012) projected long-term savings from implementing a community-based diabetes prevention programme nationwide. The modelling in this study identified that a cumulative break-even point would be achieved in year 13.

c) Recently, Breeze et al [10]compared the cost-effectiveness of lifestyle interventions, designed to prevent diabetes, across different high-risk population sub-groups and different intervention intensities. Overall, they found the diabetes prevention interventions are likely to be cost-saving. The six population sub-groups defined as at high risk for diabetes used were adults aged 40-65 years, low socio-economic status, HbA1c>42mmol/mol (6%), Finnish Diabetes Risk score >0.1, BMI >35 kg/m2, South-Asian.

   They found that diabetes prevention programmes are potentially cost-saving over a lifetime horizon, regardless of risk criteria or intervention intensity. Cost-effectiveness increases with intervention intensity. The most cost-effective options were to target South-Asian people and those with HbA1c levels >42 mmol/mol (6%) over a lifetime. However, there are net savings in the first ten years from targeting people with HbA1c and with high value Finnish risk score, but the other groups targeted cost more than their savings over ten years. However, all the groups targeted offer a return on investment over a lifetime. The low socio-economic status and South Asian groups take longer to recover costs despite generating high lifetime costs savings.

[9] SHAR Prevention of type 2 diabetes: preventing pre-diabetes among adults in high-risk groups Report on Use of Evidence from Effectiveness Reviews and Cost-effectiveness Modelling

[10] SHAR Prevention of type 2 diabetes: preventing pre-diabetes among adults in high-risk groups Report on Use of Evidence from Effectiveness Reviews and Cost-effectiveness Modelling

They argue that combining criteria could optimise health savings. They found that interventions for individuals identified by FINDRISC score>0.1 or HbA1c>42 mmol/mol(6%) have the greatest cost savings after 1-10 years.

The long term benefits are as much about reducing the risk of other diseases as well as diabetes. The health benefits of interventions in the South Asian population had a large impact on reducing cardiovascular disease but less impact on lifetime diabetes. By contrast, intervening with those with HBA1c>42 mmol/mol (6%) has a large impact in reducing diabetes diagnosis, but it is slightly less effective in reducing CVD events.

They used a meta-analysis of lifestyle interventions (Dunkley et al), which means that their exact definition of a lifestyle intervention is difficult to establish, as there was a large range of interventions included in the meta-analysis. However, intervention costs, with intensive lifestyle support costing £157 per person, are broadly in line with our existing tier 2 health trainer costs.

d) Risk assessment and intervention in South Asians of 25-39 years of age appears to be cost-effective and cost-saving over the longer term (20 years +), with future cost savings more than offsetting the cost of finding, testing and undertaking intensive lifestyle-change interventions with this group. NICE modelling found that even assuming a 50% higher intervention cost (to take account of longer course delivery times for non-English speaking participants) makes little difference to the results and would not alter the conclusion.[11]

Work already planned

The NHS Diabetes Prevention Programme aims to identify those at high risk and refer them into an evidence-based behavioural intervention to help them reduce their risk. The CCG and Local Authority public health team submitted an expression of interest to be part of the first wave of national implementation of the Programme.

There is also an Integrated Community Diabetes Service which has been introduced in CamHealth LCG. The service consists of a number of inter-related components including a diabetes specialist nurse (DSN) clinic at all practices, home visits by a DSN and Healthcare Assistant when requested by the practice, dietician clinics at all practices, podiatrist support and access to Podiatrist's clinics, virtual case reviews and MDT clinics both led by consultant diabetologist. Supporting work in primary care includes the identification, review and

[11] NICE PH38 and SHAR Prevention of type 2 diabetes: risk identification and interventions for individuals at high risk

referral of at risk patients, diabetes prevention and management work, and self-management through personal health plans.

Where should the strategic focus be?

The evidence suggests that interventions that:

- maximise the opportunity that the health check provides to identify people at risk of diabetes, particularly with HbA1c>42mmol/mol (6%)
- provide intensive lifestyle change programmes for those at high risk
- and focus on high risk population groups such as those from the South Asian, and low socio-economic status population.

What would this mean for Cambridgeshire and Peterborough?

Table 6 - Numbers in the South Asian population in Cambridgeshire and Peterborough aged 25-39

	South Asian population aged 25-39
Cambridgeshire	4,512
Peterborough	4,854
Total	9,366

Source: 2011 census resident population

The highest concentration of the South Asian population, also in the more deprived areas of the CCG with the poorest health, are in Peterborough. This would therefore be the priority group to focus on initially.

A health check currently costs approximately £26, so it would cost approximately £126,204 to extend health checks to the South Asian population aged 25-39. Given the scale of the additional checks this is likely to be split across 3-5 years with people in the South Asian population reaching age 25 joining the cohort to receive a heath check. The aim would be for all those in the age group to receive one health check over the next 3-5 years.

Table 7 – estimate of diabetes prevalence in South Asian populations aged 25-39

		Diabetes	Type II (90%)
Estimate of Diabetes in South Asian pops 25-39 (Diagnosed and Undiagnosed)	Cambridgeshire	632	569
	Peterborough	680	612
	Total	**1311**	**1180**
	Rounded up	**1300**	**1200**

Source: Holman 2010 for diagnosed/undiagnosed within South Asian population

The model assumes that an additional 4,854 health checks would be offered, and based on current take up rates, 2,354 would be undertaken. From these we estimate that there will be 165 cases of potential future diabetes identified and that 50% of this group will accept a health trainer style intervention. The figures below are all approximate costs.

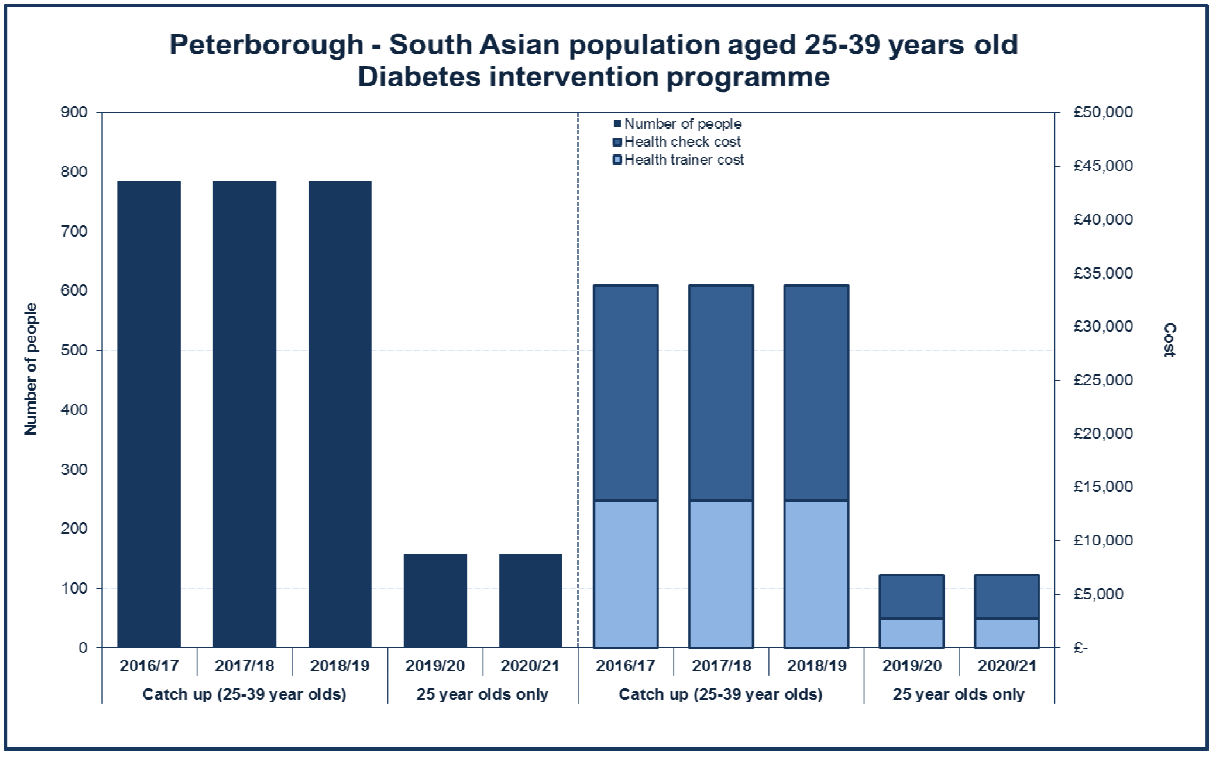
There would also need to be point of care testing available for health checks. This would cost approximately £243k over 3 years (£81k a year), based on Cambridgeshire costs, for all 25 practices.

Table 8 – costs of health checks

Peterborough	Number
South Asian population aged 25-39 years	4,854
Annual uptake of health check 2014/15	48.5%
Estimated number of health checks	2,354
Average cost of a health check	£25.60
Total cost for health checks	**£60,267**
Estimated prevalence of diabetes in South Asian population	14.0%
Estimated number of people to refer to health trainers	330
Assume 50% uptake to health trainer	165
Average cost of health trainer (caseload approx 110 people per trainer)	**£41,250**
Total cost of package	**£101,517**

The figure below shows how the 'catch up' for the 25-39 year olds in Peterborough could be spread over three years. After then the numbers drop to only those reaching the age of 25.

Figure 2 – Peterborough – South Asian population, diabetes intervention



The evidence suggests that this programme may prevent over 470 cardiac events, and 10 diabetes diagnosis, and certainly be cost saving over a lifetime.

Where should the strategic focus be?

People at high risk of developing type 2 diabetes can be identified through the NHS Health Check and the disease could be prevented in 30-60% through appropriate behaviour change support[12]. The strategic focus and recommendations in the obesity section should help prevent diabetes.

In addition, it is clear that there are long term NHS savings to be gained from screening and providing an intensive lifestyle intervention for the South Asian population aged 25-39.

Recommendations

- Health checks should be extended to those aged 25-39 years from the South Asian population in Peterborough, with the initial focus in the GP practices with the highest concentration of the South Asian population in the most deprived areas. This will cost approximately £100k over the first three years (excluding point of care testing) but will be cost saving in the long term.

[12]PHE Cardiovascular intelligence pack.

5. Cardiovascular disease

Headlines

- Current uptake for Cardiac Rehabilitation is 48.3% in line with the national average. However, there may be cost savings associated with increasing this to 65%. **[PH: Work is being undertaken to calculate the potential savings from reductions in re-admissions costs from the eligible population locally].**
- There are opportunities to improve the diagnosis and treatment of Atrial Fibrillation. This is potentially cost saving to the NHS as well as local authorities. Work should focus on increasing the numbers of patients diagnosed and treated for AF and reducing variation between GP practices. Peterborough should be the initial focus of this work. **[PH: We are developing a model to estimate local costs saved to the NHS and Social Care from improved AF diagnosis and management]**
- Modelling work finds the national interventions to reduce salt intake are cost saving at all time horizons including year one.
- Lifestyle interventions, general adult population and focused on those with diagnosed hypertension, have been shown to be potentially cost saving at 10 years and over a lifetime horizon.
- Maximising the opportunity provided in the health check to diagnose and treat hypertension, including through lifestyle interventions, should be maximised.
- A variety of lifestyle interventions for those diagnosed with hypertension should be available. This would mean an expansion to existing lifestyle services, such as health trainer/coaches. Work to target this group should focus initially on Peterborough. **[PH: we are doing some further work to try to apply the savings identified in the hypertension modelling work to the local population]**

Background

Cardiovascular disease (CVD) is an umbrella term for all disease of the circulatory system including coronary heart disease (CHD), heart failure, stroke and peripheral arterial disease. CVD causes more than a quarter of all deaths (160, 000) in the UK each year and there are an estimated 7 million people living with CVD in the UK.

CVD is generally due to reduced blood flow to the heart, brain or part of the body caused by atheroma (fatty deposits) or thrombosis (blood clots) which block the arteries. Having one cardiovascular condition increases the risk of developing another. The assessment and management of risk and access to prevention and treatment services influences mortality rates and need for care and support.

A number of common risk factors are recognised as increasing the likelihood of developing CVD:

- Fixed factors such as family history, gender, ethnicity and ageing;
- Lifestyle factors such as smoking, obesity, nutrition, lack of physical activity, high alcohol consumption;
- Wider determinants such as deprivation, poverty, poor education and working conditions;
- Physiological metabolic risk factors, which may develop in response to those above, such as high blood pressure (hypertension), diabetes (high blood sugar), and hyperlipidaemia (high blood fats).

There is evidence that interventions at the level of the population at risk, and with individuals, can be effective in changing behaviour; clinical interventions and treatments can be effective in managing the metabolic risk factor[13]s.

Current position

Cambridgeshire

CVD causes around 300 deaths every year in people aged under 75 in Cambridgeshire, and we estimate that 190 of these are preventable. This rate is lower than the national average, other than in Fenland.

Peterborough

Peterborough has significantly high mortality rates for cardiovascular deaths under the age of 75 and for all causes of mortality considered preventable.

The prevalence of CVD rises with age and is also higher in more deprived populations. South Asian populations in the UK are known to have higher rates of premature coronary heart disease (CHD).

The data on prevalence shows that CVD risk factors are relatively high in the younger and more deprived population in Borderline and Peterborough LCGs, who may not be diagnosed with CVD yet, but are at high risk of developing disease and requiring services as they age.

The figure below illustrates the position in Peterborough.

[13]https://www.peterborough.gov.uk/upload/www.peterborough.gov.uk/healthcare/public-health/CardiovascularDiseaseJSNASummary-October2015.pdf?inline=true)

Figure 3: Public health outcome framework – health care and premature mortality

Indicator	Period	England	East of England region	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
4.03 - Mortality rate from causes considered preventable (Persons)	2011 - 13	140.9	162.4	178.5	149.1	159.7	162.3	150.5	207.2	164.6	215.1	184.5	154.1	183.1
4.03 - Mortality rate from causes considered preventable (Male)	2011 - 13	233.1	200.8	215.4	186.8	199.1	209.7	194.4	253.1	204.1	283.2	218.1	192.2	232.1
4.03 - Mortality rate from causes considered preventable (Female)	2011 - 13	139.9	126.4	138.3	113.7	126.3	127.3	126.5	161.2	126.8	150.0	153.1	118.8	138.1
4.04i - Under 75 mortality rate from all cardiovascular diseases (Persons)	2011 - 13	78.2	69.9	73.1	60.5	62.6	69.7	71.6	110.8	59.5	98.4	84.7	60.0	95.2
4.04i - Under 75 mortality rate from all cardiovascular diseases (Male)	2011 - 13	109.5	97.8	92.1	84.3	83.0	98.1	106.8	158.8	89.0	134.5	119.0	80.0	134.1
4.04i - Under 75 mortality rate from all cardiovascular diseases (Female)	2011 - 13	48.5	43.7	54.6	36.5	42.6	41.5	44.4	71.1	45.2	64.1	52.6	38.1	59.2
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Persons)	2011 - 13	50.9	45.2	49.0	38.0	43.8	42.0	43.9	79.4	45.4	68.0	51.3	41.5	62.6
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Male)	2011 - 13	75.7	67.6	84.4	59.3	59.5	68.1	65.3	113.7	67.0	104.3	75.8	63.0	88.5
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Female)	2011 - 13	26.5	24.6	35.2	18.6	28.4	21.7	34.0	46.1	24.1	33.3	33.3	20.3	29.0

Source: Public Health and Outcomes Framework

Interventions and cost savings to the NHS

Cardiac Rehabilitation

Key Facts

A range of NICE guidelines and quality standards recommend cardiac rehabilitation (CR) for specific cardiac conditions and treatments based on range of research evidence demonstrating the positive outcomes of CR. These include:

- a 26% relative reduction in cardiac mortality over five years
- a reduction in cardiac-related morbidity
- an improvement in functional capacity and quality of life.

Current activity

In Cambridgeshire and Peterborough in 14/15:

- 62% of the population eligible for CR are being referred appropriately
- Of in-scope and appropriate referrals, 78% started CR

- Uptake is 48.3%, similar to the uptake for England reported by NACR 2014 (46%) Around 66% of patients starting CR complete the programme in-year; this is 31% of the eligible (baseline) population.

Research has also suggested that the delivery of a comprehensive CR service has the potential to reduce unplanned cardiac readmissions by 30%. However, uptake rates remain well below this 65% nationally and locally. The indicative cost of delivering good quality CR is £498 per patient. The Department of health's 'Cardiac Rehabilitation Commissioning Pack' gives the average weighted cost of a cardiac re-admission as £3,637.

Potential cost savings

There has been national work which modelled the potential impact of increasing uptake on unplanned cardiac re-admissions [14]estimating the number and cost of emergency cardiac readmissions reduced by increasing uptake to 65%. It estimated that in the cohort of eligible patients for CR in the East of England the cost of re-admissions was approximately £37m (2009/10), and that with a 65% uptake this would fall by £11.2m. These savings are offset by the cost of this increased uptake which is estimated to be £8.2m. This suggests there is a potential net saving of approximately £3m across the East of England from a 0% uptake baseline. The table below shows the results of this modelling work.

Table 9: Modelled reduction in cardiac readmissions and associated financial savings

Table 3: Modelled reduction in cardiac readmissions and associated financial savings as a result of delivering a 'gold standard' CR service to 65% of eligible patients

Region	Cohort of patients eligible for CR	Total numeric reduction in readmissions	Readmission rate with new model	Financial savings from readmissions	Total financial savings from new service including readmission savings
East Midlands	21,710	2,626	24%	£9,549,307	£2,818,121
East of England	26,604	3,093	24%	£11,248,150	£2,999,580
London	28,412	3,769	27%	£13,706,398	£4,897,257
North East	14,304	1,863	27%	£6,776,822	£2,341,867
North West	35,546	4,595	26%	£16,711,288	£5,690,251
South Central	16,256	1,589	20%	£5,779,557	£739,384
South East	19,455	2,102	22%	£7,646,429	£1,614,406
South West	26,451	2,937	23%	£10,681,869	£2,480,736
West Midlands	25,324	3,254	26%	£11,835,162	£3,983,456
Yorkshire and the Humber	24,719	2,954	24%	£10,745,153	£3,081,027
England	**238,781**	**28,782**	**24%**	**£104,680,135**	**£30,646,086**

Source: Hospital Episode Statistics, the NHS Information Centre for Health and Social Care. Analysis provided by the National Cancer Services Analysis Team (NatCanSAT) www.natcansat.nhs.uk

[14]Making the Case for cardiac rehabilitation: modelling potential impact on readmissions. NHS Improvement. March 2013.

Recommendation

There should continue to be a focus on increasing the CR uptake to 65% and number of eligible people who complete a cardiac rehabilitation programme.

[PH: Work is being undertaken to calculate the potential savings from reductions in re-admissions costs from the eligible population locally].

Atrial Fibrillation

Key Facts

- Atrial fibrillation increases the risk of stroke by about 6 fold, and strokes caused by AF are often more severe with higher mortality and greater disability. Anticoagulation substantially reduces the risk of stroke in people with AF.
- Despite this, AF is underdiagnosed and undertreated. Around 25-30% of people with AF are unaware they have the condition and less than half of patients are adequately treated – many do not receive anticoagulants and of those who do, many are undertreated.
- AF is an important risk factor for stroke and is associated with about 15% of all strokes. Only 30% of people with known AF admitted with a stroke are on anticoagulant treatment at the time of their stroke.
- Atrial Fibrillation (AF) is one of the top 10 reasons for hospital admissions in the UK, and the prevalence of AF roughly doubles with each decade from age 50-59.

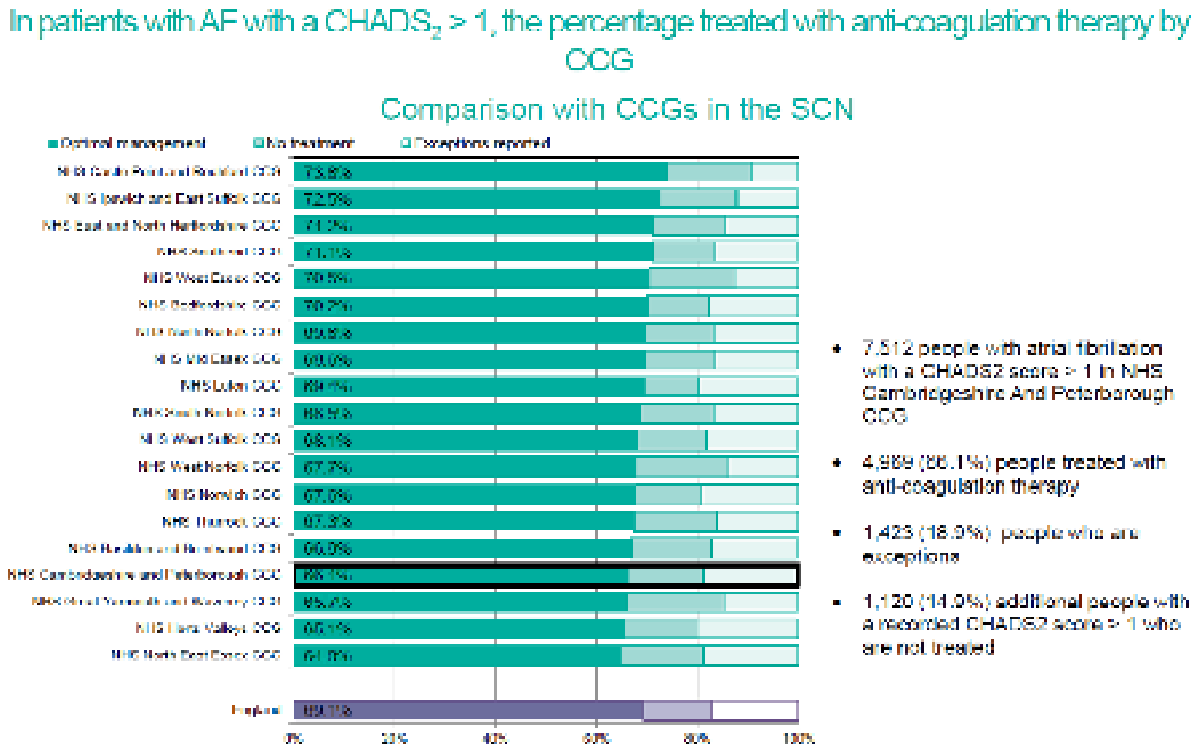
Current activity

In 2013/14 there were 12,941 people diagnosed with a stroke within Cambridgeshire and Peterborough CCG, with around 7,500 people with undiagnosed atrial fibrillation, known to be one of the significant contributory factors of stroke in patients.

The diagnosed prevalence of AF in the CCG is 1.5% and the estimated prevalence is 2.3%, therefore there is some opportunity to improve diagnosis and management of AF with the expectation of reducing the incidence of stroke in our local population. The figures below benchmark the CCG against other CCGs and illustrate that:

- There are 1,120 people diagnosed with AF who appear to be untreated in Cambridgeshire and Peterborough.
- There were 147 strokes in 14/15 in people with known AF not on anticoagulation.
- The CCG appears to be a low user of GRASP-AF.

Figure 4: inpatients with AF



Source: CVD Intelligence Pack. PHE March 2015

Figure 5: AF strokes in CCG

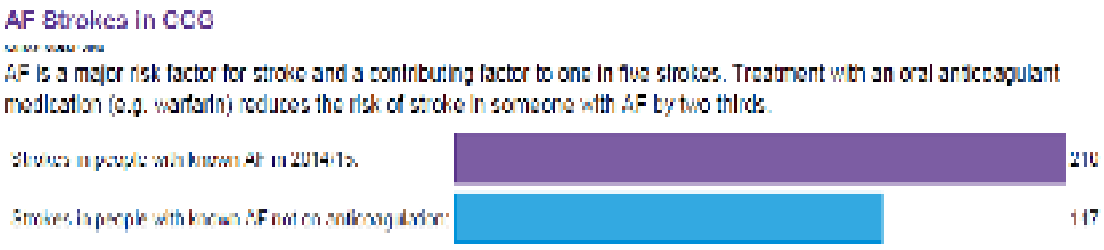
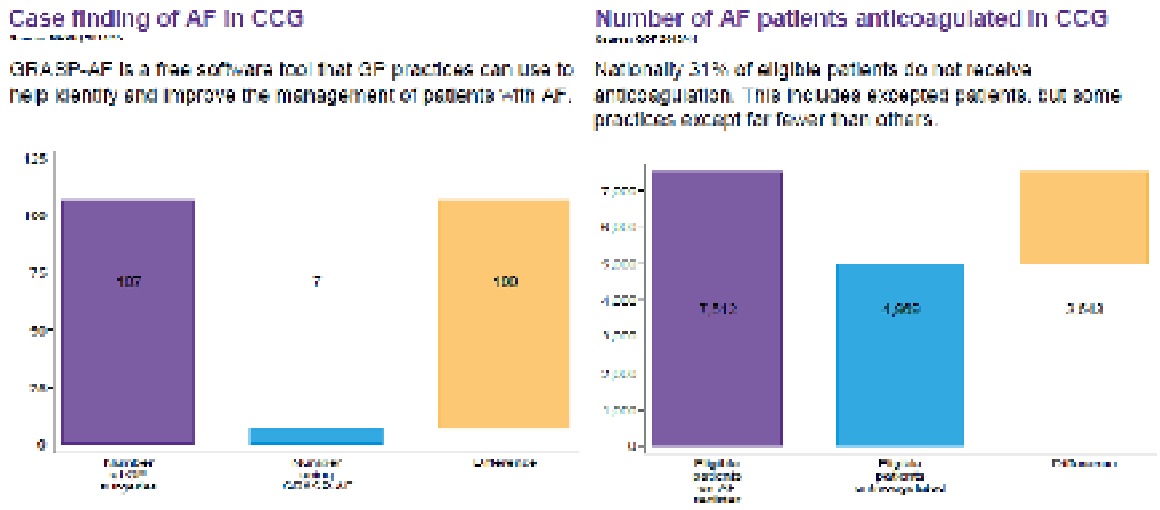


Figure 6: Case finding of AF



Source: AF How can we do better? Stroke Association Partnership

Potential cost savings

NHS England estimates the cost of increasing the prescription of anti-thrombotics (warfarin) by supporting GPs to identify patients with atrial fibrillation, to be £169k per 100,000 population.

Warfarin tablets are inexpensive. The main costs of anti-coagulation with warfarin relate to the cost of anti-coagulant monitoring. NICE estimates that the total cost of maintaining one patient on warfarin for one year, including monitoring, is £383. The number of patients needed to treat (NNT) for one year to prevent one stroke is approximately 37 for primary prevention and 12 for secondary prevention. NNT for one year for a mixed population comprising primary and secondary prevention patients is 25.

Based on these figures and the cost of one year's anti-coagulant therapy, the cost of preventing one stroke is estimated at £10,000 to £14,000 per annum.

The cost benefits of stroke prevention are more difficult to calculate. The management of patients following a stroke is very expensive for the NHS and Personal Social Services (PSS). The Department of Health estimate that the total costs in the first year of care for treating the 12,500 strokes in England that are attributable to AF to be £148 million. This comprises:

- £103 million of direct hospital costs
- £45 million of additional costs for care requirements post-discharge, such as district nursing, community based rehabilitation and pharmaceuticals prescribed in the community.

The National Audit Office reported in 2005 that stroke care costs the NHS about £2.8 billion a year in direct care costs. This is more than the cost of treating coronary heart disease and costs the wider economy some £1.8 billion more in lost productivity and disability. In

addition, the annual informal care costs (costs of home nursing and care borne by patient's families) are around £2.4 billion.

Based on the above figures, it is estimated that the cost of each stroke due to AF is £11,900 in the first year after stroke. These figures suggest that anti-coagulant treatment of AF is not only cost effective but that it is associated with an overall cost saving when its benefits in stroke prevention are taken into account.

More recent analysis of the acute and long-term costs of a stroke in atrial fibrillation patients (add ref) found that the costs for the three months post stroke on average were £10,413, and annual health care costs after this time were non-significantly smaller than those incurred before the event (£2400 vs. £3356). After stroke 13% of patients were newly admitted into long-term warden, nursing, or residential care, resulting in annual costs of £6880 (averaged across the 136 patients surviving past the acute period).

The work concluded that although annual post-acute phase hospital and primary health-care costs in stroke patients with prior atrial fibrillation were not significantly different to those incurred before the stroke, long-term nursing/residential care costs were substantial[15].

[PH: We are developing a model to estimate local costs saved to the NHS and Social care from improved AF diagnosis and management]

Recommendation

There are opportunities to improve the diagnosis and treatment of Atrial Fibrillation. This is potentially cost saving to the NHS as well as local authorities. Work should focus on increasing the numbers of patients diagnosed and treated for AF, and reducing variation between GP practices. Peterborough should be the initial focus of this work.

[PH: We are developing a model to estimate local costs saved to the NHS and Social care from improved AF diagnosis and management].

Hypertension

Key Facts

In England it is estimated that:

[15] Population-based study of acute- and long-term care costs after stroke in patients with AF. Luengo-Fernandez R1, Yiin GS, Gray AM, Rothwell PM. Int J Stroke. 2013 Jul;8(5):308-14.

- Hypertension, or high blood pressure, affects more than 1 in 4 adults in England.
- 5 million people have undiagnosed and untreated hypertension
- 40% of people with diagnosed hypertension receive sub-optimal treatment
- Only one in five people whose 10 year CVD risk exceeds 20% receive statins

Hypertension means that blood pressure is consistently higher than the recommended level. If it is not treated, it can lead to heart failure, and/or increases the chance of having a heart attack or stroke.

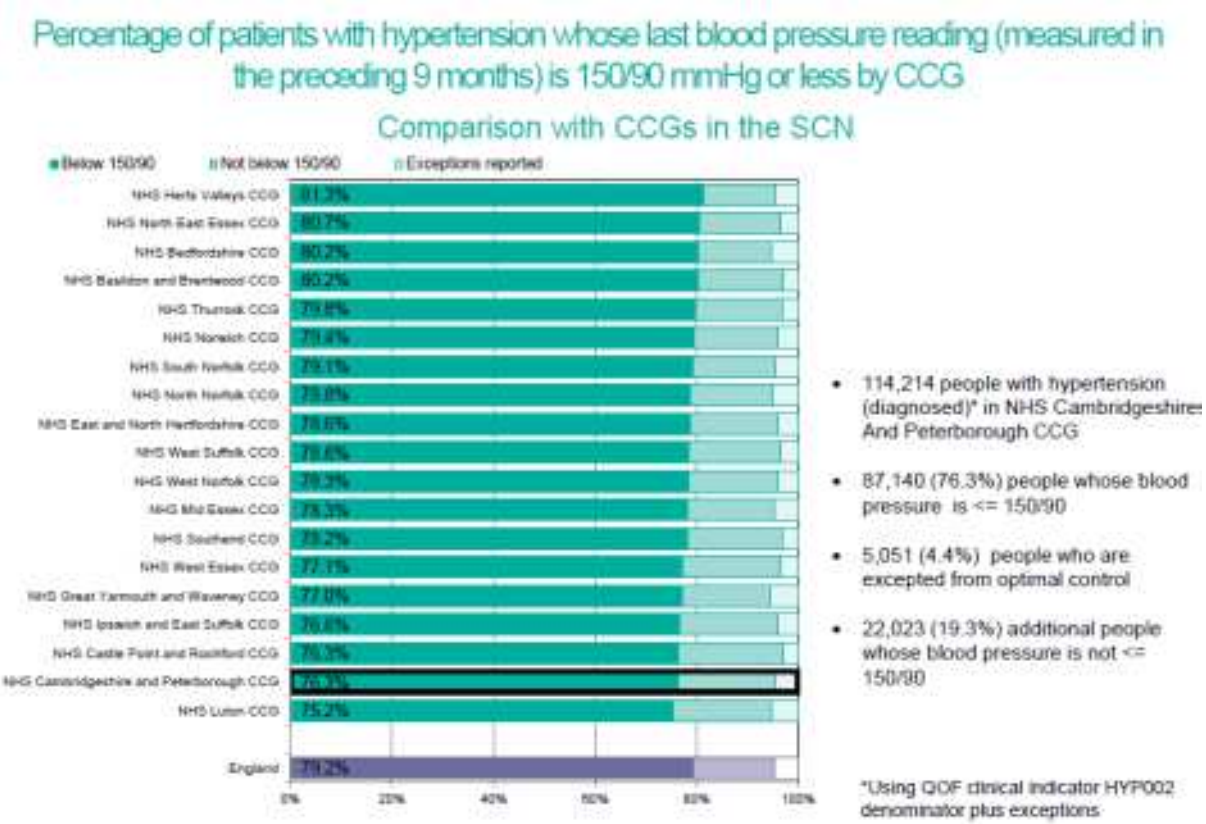
Coronary heart disease (CHD), stroke, vascular dementia (VaD) and chronic kidney disease (CKD) are the main conditions attributable to hypertension. The NHS cost burden resulting from hypertension in England is estimated to be £2.1 billion, looking at these four diseases.

Current Activity

In 2013/14 approximately 55% of people with hypertension were diagnosed in Cambridgeshire and Peterborough, compared to 56% nationally. It is estimated that there are 92,241 people with undiagnosed hypertension in NHS Cambridgeshire and Peterborough CCG. There is considerable variation in GP practice diagnosis of hypertension.

In total, including exceptions, there are 22,023 people (excluding exemptions) whose blood pressure is not <= 150/90 in Cambridgeshire and Peterborough at their latest blood pressure reading. There is a GP practice range of between 10.2% and 44.9%. If all practices were to achieve as well as the average of the best achieving practices, in terms of treating hypertension, then an additional 6,641 people would have their hypertension controlled.

Figure 7: Percentage of patients with hypertension whose last blood pressure reading is 150/90 mmHg or less by CCG



Source: Cardiovascular Intelligence pack March 2015

In 2013/14 there were 889 people with a new diagnosis of hypertension who have been given a CVD risk assessment whose CVD risk exceeds 20%. 125 of these people were not already on statins, or exempted from statins. If all practices were to achieve as well as the average of the best achieving practices, then an additional 195 people would be treated (this is above 125 as it includes exceptions).

Potential cost savings

Looking at cost effectiveness work on hypertension prevention, there is recent work which demonstrates the potential impact of lifestyle change interventions across the population and within high risk groups.

A cost-effectiveness review of blood pressure interventions (A Report to the Blood Pressure System Leadership Board), finds that models of 'lifestyle interventions' focused on support to change lifestyle behaviour (notably diet, and physical exercise), are potentially cost saving to the NHS at 10 years and over the lifetime horizon. National interventions to reduce salt in food were found to be cost saving at all time horizons, including at one year.

The cost effectiveness findings of the review are summarised below:

Based on commonly accepted thresholds of value for money for health investments, the key findings in relation to cost effectiveness are that:

- The ICERs (see below for definition) for many of the included interventions increase substantially over longer time horizons.

- National interventions to reduce salt in food are cost saving across all time horizons, both in the general adult population and in adults diagnosed with high blood pressure.
- **In the general adult population, health lifestyle changes are potentially cost-effective at 10 years and cost saving over the lifetime time horizon.** Testing is more cost effective in GP and Pharmacy settings rather than in community settings. Education and awareness campaigns are cost effective over a lifetime time horizon.
- **In adults with diagnosed high blood pressure health, lifestyle improvement interventions become cost effective within 5 years, and potentially cost saving within 10 years.** Drug therapy adherence interventions become cost saving over a lifetime but are not cost effective in shorter time horizons. Similarly, self-management support programmes are only cost effective over the lifetime time horizon. Surprisingly primary care management programme interventions (over and above standard care) are not cost-effective at any time horizon. This appears to be due to their high cost in the studies found.
- Sensitivity analysis found that the vast majority of the ICER findings were robust when the costs and benefits were varied.

Source: Cost Effectiveness Review of Blood Pressure Interventions. A report to the Blood Pressure System Leadership Board. November 2014.Optomity Matrix.

ICER: Incremental cost effectiveness ratio - the ratio of the change in costs of a therapeutic intervention (compared to the alternative, such as doing nothing or using the best available alternative treatment) to the change in effects of the intervention.

This paper also modelled three implementation scenarios and found the following:

Implementation scenarios
Modelling of the impact of three implementation scenarios specified by the BPSLB found that in England, over 10 years:

1. A 5mmHg reduction in average population blood pressure would result in a gain of 45,000 QALYs and 140,000 life years, and a reduction of £800m in health care costs and £60m in social care costs.

2. A 15% increase in the proportion of adults who have had their high blood pressure diagnosed would result in a gain of 7,000 QALYs and 22,000 life years, and a reduction of £112m in health care costs and £11m in social care costs.

3. A 15% increase in the proportion of adults on treatment controlling their blood pressure to 140/90mmHg or less would also result in a gain of 7,000 QALYs and 22,000 life years, and a reduction of £112m in health care costs and £11m in social care costs.

The interventions to achieve health lifestyle changes found to be potentially cost saving at ten years are a mixture interventions (largely from a meta-analysis of 105 trials in 2006) including a mixture of advice and supervised activities, related diet, physical activity, relaxation, alcohol restriction, and salt restriction.

Recommendations

- Lifestyle interventions, general population, and focused on those with diagnosed hypertension have been shown to be potentially cost saving at 10 years and over a lifetime horizon.
- Maximising the opportunity provided in the health check to diagnose and treat hypertension, including through lifestyle interventions, should be maximised.
- A variety of lifestyle interventions for those diagnosed with hypertension should be available. This would mean an expansion to existing lifestyle services, such as health trainer/coaches. Work to target this group should focus initially on Peterborough.

[PH: we are doing some further work to try to apply the savings identified in the hypertension modelling work to the local population]

Work already planned

Work to date

The CCG Tackling Health Inequalities in Coronary Heart Disease Programme Work stream priorities for 2015/16 are:

a) **Lifestyle Management** (including monitoring of the health check programme and smoking cessation programme)
b) **Primary Care interventions**. Risk reduction in CVD through BP/lipid management.
c) **Stroke Prevention** through effective management of Atrial Fibrillation.
d) **Cardiac Rehabilitation** - The Programme Board will continue to have a watching brief on this programme of work until full transfer of the data and reporting to Uniting Care from April 2016. Further work has already been identified for 15/16 on data and reporting, developing a further understanding of referral patterns, reasons for non-referral of eligible patients, up-take and non-completion of the programme also needs to be addressed across providers.

Where should the strategic focus be?

The evidence suggests that CR, AF diagnosis and management, and hypertension diagnosis, management and prevention are potentially cost saving and there is scope to improve performance locally.

Recommendations

- There should continue to be a focus on increasing the CR uptake to 65% and number of eligible people who complete a cardiac rehabilitation programme. **[PH: Work is**

being undertaken to calculate the potential savings from reductions in re-admissions costs from the eligible population locally].

- There are opportunities to improve the diagnosis and treatment of Atrial Fibrillation. This is potentially cost saving to the NHS as well as local authorities. Work should focus on increasing the numbers of patients diagnosed and treated for AF and reducing variation between GP practices. Peterborough should be the initial focus of this work. **[PH: We are developing a model to estimate local costs saved to the NHS and Social Care from improved AF diagnosis and management]**
- Lifestyle interventions, general population, and focused on those with diagnosed hypertension, have been shown to be potentially cost saving at 10 years and over a lifetime horizon.
- Maximising the opportunity provided in the health check to diagnose and treat hypertension, including through lifestyle interventions should be maximised.
- A variety of lifestyle interventions for those diagnosed with hypertension should be available. This would mean an expansion to existing lifestyle services, such as health trainer/coaches. Work to target this group should focus initially on Peterborough. **[PH: we are doing some further work to try to apply the savings identified in the hypertension modelling work to the local population.]**

6. Long term conditions

Headlines

- International evidence finds that psychological interventions for long term conditions, can reduce average health care costs in the range of 20-30% across studies.
- Self-management programmes in patients with COPD have been found to reduce all cause hospitalisations by up to 40%.
- A self-management programme should be offered to those diagnosed with COPD. This should be evaluated for its economic impact on health costs.
- Routine management of LTCs should include the identification of those requiring further assessment for depression and anxiety.
- There should be maximum utilisation of the IAPT LTC team, and there should continue to be a focus on rapidly increasing referrals. There should be a focus on those with multiple long term conditions.
- There should be an economic evaluation of the impact on healthcare costs of identification and treatment for common mental health disorders in those with multiple long term conditions.

Background

Long Term Conditions

Long term conditions (LTCs) include any ongoing, long term or recurring condition requiring constant care that can have a significant impact on people's lives, limiting their quality of life[16]. Those with multiple long term conditions are at a higher risk of poor health outcomes. Recent studies have found the prevalence of multi-morbidity (the co-existence of two or more LTCs) varied from 12.9% in participants 18 years and older, to 95.1% in a population aged 65 years and older. The Department of Health estimates that those with multiple LTCs are due to rise from 1.9 million in 2008 to 2.9 million in 2018.

Long Term Conditions and Mental Health

Common mental disorders (CMD's), which include depression and anxiety, are highly prevalent with long term conditions. Evidence consistently demonstrates that people with long term physical health conditions (LTC's) are two to three times more likely to experience mental health problems than the general population, with much of the evidence relating to common mental health disorders such as anxiety and depression.

Compared with the general population, people with diabetes, hypertension and coronary artery disease have double the rate of mental health problems, and those with chronic

[16]CCC/C&P CCG (2015). Long Term Conditions Across the Life Course JSNA

obstructive pulmonary disease, cerebrovascular disease and other chronic conditions have triple the rate. People with two or more long term conditions are seven times more likely to have depression[17].

The additional impact of mental illness, which can exacerbate physical health problems, is estimated to raise the total health care costs by at least 45% for each person with a long-term condition and co-morbid mental health problem. This would result in 12-18% of all NHS expenditure on long-term conditions being linked to poor mental health (£8-13 billion each year[18]).

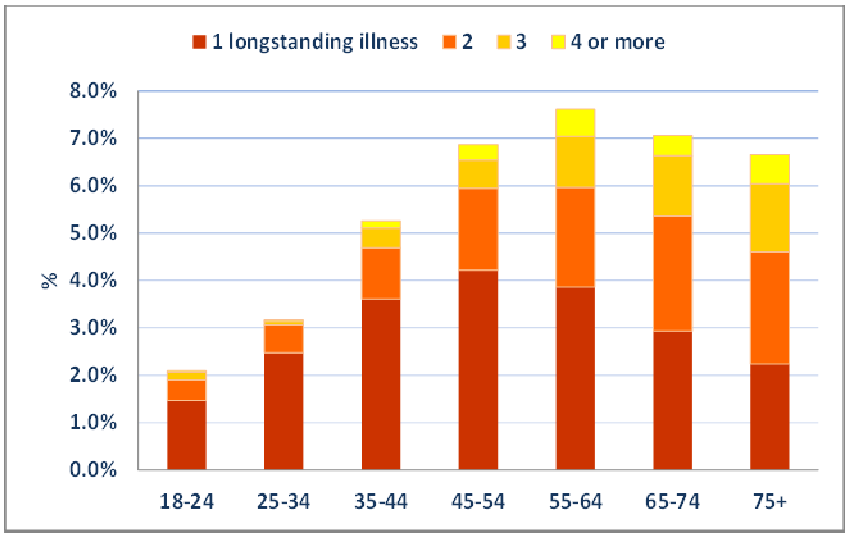
Current position

Local context

Long Term Conditions

Based on national prevalence data applied to the CCG population, 108,700 (18.8%) 18-64 year olds are living with one longstanding illness, a further 56,800 (9.8%) are thought to be living with two or more[19]. Long term conditions are more prevalent in older age groups, and Figure 8 shows the proportion of people with 1 or multiple longstanding illnesses by age group. The proportion of people living with more than one longstanding illness rises with increasing age.

Figure 8: The proportion of people with one, two, three or four or more longstanding illnesses by age group, Health Survey for England (2012)



Source: Health Survey for England (2012)

[17]The King's Fund. (2012) Long-term conditions and mental health: The cost of co-morbidities.
[18]The King's Fund. (2012) Long-term conditions and mental health: The cost of co-morbidities.
[19]Health Survey for England (2012) estimates applied to registered population. FHS Registration System (Exeter) April 2015.

Long Term Conditions and mental health

Those with LTCs are at a higher risk of developing a mental illness; Table 10 shows the proportion of the CCG population aged 18-64 years that have multiple longstanding illnesses with and without limitation and/or mental ill health. 3.4% (1,900 people) are estimated to have two or more LTCs and mental ill health, whereas 28.4% (16,100 people) are thought to have two or more LTCs, mental ill health and limitation.

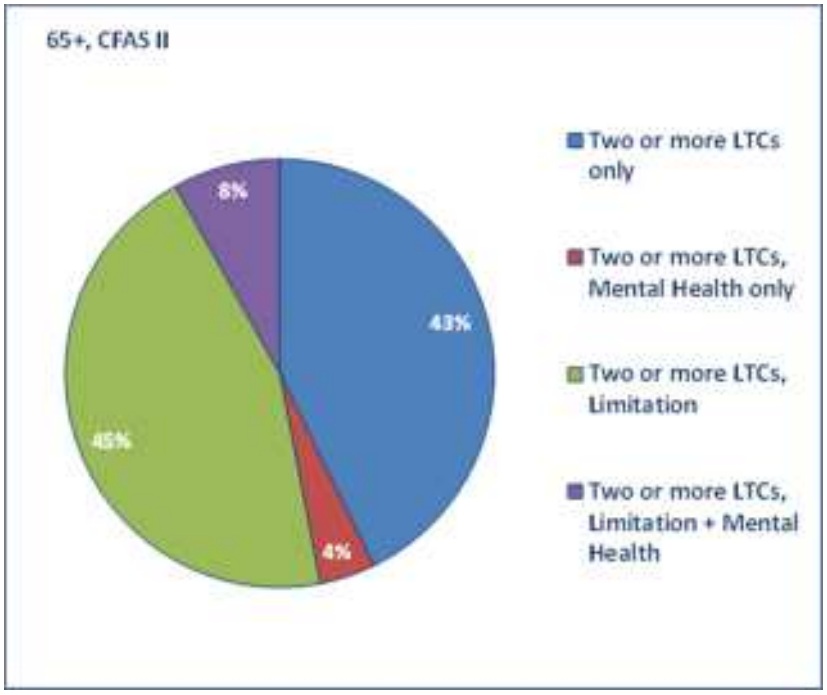
Table 10: Proportion of people aged 18-64 years with multiple (two or more) long standing illnesses with and without limitation and/or mental ill health (based on GHQ-12 score of four or more)

People aged 18-64 years with 2+ LTC	%	95% CI	Estimate of number of people in C&PCCG aged 18-64 years (2015) and range (95% CI)	
Two or more LTCs only	30.7	(26.7 - 34.9)	17,400	(15,200 - 19,800)
Two or more LTCs, mental ill health only	3.4	(2.1 - 5.3)	1,900	(1,200 - 3,000)
Two or more LTCs, limitation	37.6	(33.4 - 42.0)	21,300	(19,000 - 23,800)
Two or more LTCs, limitation + mental ill health	28.4	(24.6 - 32.5)	16,100	(1,400 - 18,400)
Total	100		56,700	

Source: Health Survey for England (2012) estimates applied to registered population. FHS Registration System (Exeter) April 2015.

Figure 9 shows data from a local study for over 65s with two or more LTCs. The data suggests that there are around 38,600 people aged 65 and over with two or more LTCs and limitation, an additional 3,600 people with mental ill health and an additional 6,900 with multiple LTCs, limitation and mental ill health (dementia, anxiety and depression). In total, it is estimated that 65,800 people aged 65 and over in C&P CCG have two or more LTCs.

Figure 9: Proportion of people aged 65 and over with multiple (two or more) LTCs with and without limitation and/or depression or anxiety (based on GMS AGECAT)



Source: MRC Cognitive Function and Ageing Study (CFAS II) (100% = people with two or more LTCs)

Overall this means that locally there are an estimated 18,000 adults with two or more long term conditions with mental ill health and/or limitation, and a further 10,500 people aged 65 and over in these groups. Prevalence of common mental health disorders is 16% in the adult population, and 10.6% in those aged 65-75 years[20]. Even at the population level of risk 3,993 people (2,880 adults and 1,113 older people) amongst this group will have common mental health disorder. Given that the risk of common mental health disorders in this group is a minimum of two of three times higher than the general population, these figures are likely to be much higher than this estimate.

Interventions and cost savings to NHS

Self-Management for Long Term Conditions

There are substantial costs associated with long-term conditions that will vary depending on the setting and condition, for example the total annual cost of COPD to the NHS is over £800 million[21]. COPD is the second most common cause of emergency admissions to hospital and one of the most costly inpatient conditions to be treated by the NHS[22]. Asthma is also responsible for large numbers of attendances to Emergency Departments, and admissions,

[20]Psychiatric Morbidity Survey 2010.
[21]NHS Medical Directorate (2012). COPD Commissioning Toolkit A Resource for Commissioners.
[22]Department of Health (2011) An Outcomes Strategy for Chronic Obstructive Pulmonary Disease (COPD) and Asthma in England.

the majority of which are emergency admissions, and 70% of which may have been preventable with appropriate early interventions[23].
An evidence review was carried out as part of the Long Term Conditions JSNA to consider self-management support interventions, particularly exploring which self-management support interventions may improve health outcomes for those with multiple conditions[24]. The review highlighted that evidence for significant reductions in utilisation following self-management support interventions was strongest for respiratory disorders and cardiovascular disorders. The evidence surrounding cost savings was more limited.

Chronic Obstructive Pulmonary Disease (COPD)

Locally, self-management programmes for COPD have been run as part of a Health Foundation funded programme. The evaluation does not provide detail on the cost-effectiveness or cost savings of this work, and indicates that this is an area for further work. A Cochrane review has, however, shown that self-management programmes in patients with COPD are associated with improved health-related quality of life and a reduction in respiratory-related and all cause hospital admissions[25]. They looked at a range of self-management programmes in this work. Respiratory-related hospital admissions were 43% less likely in the intervention compared to control groups, and all cause hospitalisations were 40% less likely. Since this Cochrane review, several studies have been published regarding the contents of self-management interventions for patients with COPD, it is now thought education alone is not sufficient to achieve behaviour change[26].
The use of psychological interventions for those with COPD is being utilised in some areas of the UK. Data from unpublished work shows a respiratory wellbeing clinic in the London Borough of Sutton and Merton using cognitive behavioural therapy, psycho-education and physical health promotion for people with COPD. The service has reported a reduction in depression and anxiety symptoms, improved quality of life and better management of the condition. Cost savings have also been reported that, if applied to high-cost users, could save £5 for every £1 invested in the clinic[27]. This data is not from a published study, therefore should be interpreted with caution.

COPD is costly to the local health care system; around 14,400 people (aged 40 and over) are recorded on disease registers for COPD in general practices across the CCG[28]. Within the CCG, of the 1,660 hospital episodes where COPD was the primary diagnosis, 1,480 (89%) were emergency admissions. Emergency admissions with COPD as primary diagnosis

[23]An Outcomes Strategy for COPD and Asthma in England (2011) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216139/dh_128428.pdf
[24]CCC/C&P CCG (2015). Long Term Conditions Across the Life Course JSNA.
[25]The Cochrane Collaboration (2014) Self management for patients with chronic obstructive pulmonary disease (Review).
[26]The Cochrane Collaboration (2014) Self management for patients with chronic obstructive pulmonary disease (Review).
[27]Mental Health Network NHS Confederation (2012). Long-term health gains. Briefing Issue 237.
[28]Quality and Outcomes Framework (2013/14).

resulted in 9,150 bed days and a cost of £3.6m in 2013/14, and 52% of emergency admissions occur in people aged under 75 years.

This suggests there may be a potential reduction in healthcare costs of up to £1.4m by introducing self-management interventions in patients with COPD. The NHS savings would depend on the cost of the intervention put in place.

Asthma

Studies have shown that education or self-management programmes can have a significant impact on hospital admissions for adults with asthma in particular. However, not all studies of self-management demonstrate reduced hospital or A&E department use, and it is as yet unclear as to what the key elements of a self-management intervention for Asthma are.

Diabetes

DAFNE and DESMOND are structured education programmes for diabetic management. There is some evidence to suggest that DAFNE may be cost effective and cost saving for type 1 diabetes mellitus, although the evidence is limited and not sufficiently robust to model for the local population.

Psychological Interventions for those with Long Term Conditions

Those with long term conditions are known to be at higher risk of developing a mental illness which contributes to greater costs to the health service. Poor mental health, in the presence of a long term physical health condition, is associated with an approximate 45% increase in service usage costs to the NHS[29]. In terms of type 2 diabetes, £1.8 billion of the cost can be attributed to poor psychological health. Mental health co-morbidity increases physical costs by 50% per diabetes patient.

Robust UK evidence establishing cost savings for psychological interventions and screening for those with long term conditions is not available. However, on the basis of studies undertaken outside of the UK it is evident that savings sufficient to cover the cost of the intervention are likely. From a large US meta-analytical study of psychological interventions for long term conditions, average health care cost savings were found to be in the range of 20-30% across studies[30]. Psychological interventions ranged from psycho-education treatments to those categorised as behavioural medicine interventions. Only a small proportion of studies reported that the costs of psychological treatment exceeded the cost savings. Most of the psychological interventions lead to reductions in health care costs, and these reductions were typically large enough to fully cover the costs of the psychological interventions themselves.

[29]The King's Fund. (2012) Long-term conditions and mental health: The cost of co-morbidities.

[30]Chiles et al. (1999) The Impact of Psychological Interventions on Medical Cost Offset: A Meta-analytic Review. American Psychological Association.

A recent local review of the evidence base for the inclusion of mental health interventions in the management of long term physical health conditions (LTC) recommended that:

- The routine clinical management of long term health conditions should include the successful identification of those requiring individual assessment for depression /anxiety. NICE recommend the use of depression identification questions for this purpose and these should be incorporated into the initial patient assessment within pathways of care for long term health conditions.
- Across most of the conditions, evidence supports the beneficial role of psychological interventions, but is inconclusive in determining the most effective intervention for a specified patient group.
- It is recommended that NICE guidance be applied, offering a choice of psychological intervention dependent on patient preference and assessed severity of depression /anxiety.
- Access to commissioned psychological interventions directly from care pathways for long term health conditions should be reviewed to ensure that direct and timely access is available.
- Pulmonary Rehabilitation has been shown as an effective management strategy to improve symptoms of depression/anxiety in those with Chronic Obstructive Pulmonary Disease (COPD). Evidence would support a recommendation that patients diagnosed with COPD should have un-delayed access to a programme of Pulmonary Rehabilitation.
- The use of a multicomponent cardiac rehabilitation programme for those patients with heart failure and post myocardial infarction will improve quality of life. Evidence supports the inclusion of exercise and psychological interventions to improve outcomes for depression and anxiety.

A full list of the review findings are attached at Appendix B.

Work already planned

Current Public Health spend and activity

There is no direct Public Health spend on self-management of long-term conditions or mental health interventions for those specifically with LTCs, however, there is a range of assets available to support self-management, as identified in more detail in the Long Term Conditions JSNA[31]. The CCG also commission an IAPT Long Term Conditions Team.

Self-Management for Long Term Conditions

There are a range of assets available for supporting self-management in Cambridgeshire including, but not limited to:

[31]CCC/C&P CCG (2015). Long Term Conditions Across the Life Course JSNA. Section 8.4.

- Support groups for specific conditions in the county and regionally e.g. Breathe Easy and Diabetes groups. These groups operate in different ways and provide many different arrays of support.
- A strong and active voluntary and community sector that provide social and practical support in multiple forms.

IAPT Long Term Conditions Team

Since February 2014, Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) 'Increasing Access to Psychological Therapies' (IAPT) service has included the IAPT Long Term (physical health) conditions team to offer specialist input. The IAPT LTC team includes three high intensity CBT therapists and three psychological wellbeing practitioners, working to address psychological needs in patients with LTCs.

Early service data shows in total, 690 IAPT patients had an LTC recorded against their case from April to October 2014. Of the 690 patients, 575 were seen by CPFT Adult IAPT and 197 were seen specifically by the specialist LTCs team in IAPT.

Where should the strategic focus be?

The evidence suggests that there is a high level of common mental health disorders amongst those with long term conditions, and particularly those with multiple long term conditions.

The evidence to date, which is largely non-UK evidence, finds that psychological interventions can reduce healthcare costs by 20-30%. There is good evidence that rehabilitation programmes such as cardiac rehabilitation and pulmonary rehabilitation which include psychological and physical exercise components can be cost saving.

Where a common mental health disorder is identified treatment as usual, through psychological therapies, such as IAPT, and drug treatment should be maximised.

Recommendations

- A self-management programme should be offered to those diagnosed with COPD, this should include psychological interventions and a clear pathway to IAPT. This should be evaluated for its economic impact on health costs.
- Routine management of LTCs should include the identification of those requiring further assessment for depression and anxiety.
- There should be maximum utilisation of the IAPT LTC team, and there should continue to be a focus on rapidly increasing referrals. There should be a focus on those with multiple long term conditions.

- There should be an economic evaluation of the impact on healthcare costs of identification and treatment for common mental health disorders in those with multiple long term conditions.

7. Workplace health

Headlines

- The potential mental health productivity savings, assuming no current action in this area, amount to nearly £5.7 across the large NHS employers in Cambridgeshire and Peterborough.
- The evidence and modelling is clear that investing in workforce health will generate short term productivity savings to the NHS. These are estimated, with the package modelled here to be approximately £3.9m over three years, with an investment of £335k.
- NHS employers should see considerable productivity savings from investing in workplace health. In particular this needs to focus on improve management and awareness of mental health and illness.

Background

Workplace health is a significant public health issue. Every year more than a million working people in the UK experience a work-related illness. This leads to around 27 million lost working days, costing the economy an estimate £13.4 billion. Estimates from Public Health England put the cost to the NHS of staff absence due to poor health at £2.4bn a year – accounting for around £1 in every £40 of the total budget. This figure is before the cost of agency staff to fill in gaps, as well as the cost of treatment, is taken into account.

There are a number of large NHS employers in Cambridgeshire and Peterborough:

- Cambridge University Hospitals NHS Foundation Trust
- Peterborough and Stamford Hospitals Trust
- Cambridgeshire and Peterborough NHS Foundation Trust
- Cambridgeshire Community Services NHS Trust
- Papworth Hospital
- Hinchingbrooke Health Care NHS Trust

As of June 2015, in total these organisations employed 22,738 people[32].

There is a high level of evidence that workplace initiatives can improve people's health and wellbeing, and deliver cost savings. NICE has developed and issued a series of guidance documents on workplace health and in September 2015, Simon Stevens, Chief Executive of NHS England announced the launch of a programme to improve the health of the NHS workforce.

[32]Health and Social Care Information Centre - http://www.hscic.gov.uk/

> "Health-promoting workplaces are obviously good for millions of employees and ultimately for taxpayers too, so the time is right for all employers – including the NHS – to raise our game."
>
> **Simon Stevens, Chief Executive of NHS England**

Current position

The table below shows the number of people employed in each of the main NHS employers in Cambridgeshire and Peterborough, as of June 2015.

Table 11 – Headcount of NHS employees by NHS organisation, as of June 2015

NHS employer	Abbreviation	Headcount as of June 2015
Cambridge University Hospitals NHS Foundation Trust	CUHFT	9,509
Peterborough and Stamford Hospitals Trust	PSHFT	4,021
Cambridgeshire and Peterborough NHS Foundation Trust	CPFT	3,665
Cambridgeshire Community Services NHS Trust	CCS	1,955
Papworth Hospital	Papworth	1,899
Hinchingbrooke Health Care NHS Trust	Hinchinbrooke	1,689
TOTAL	-	22,738

Source: Health and Social Care Information Centre

Table 12 shows the average absence rate by organisation, as well as the estimated prevalence rates for smoking, excess weight, obesity, physical inactivity, alcohol, not eating five a day and mental illness.

Table 12: average absence rate by organisation, with estimated prevalence

Trust	Headcount	Absence % Average 12 months (Jun14 - May 15)	Estimated number						
			Smoking	Excess weight	Obese	Inactive	Higher risk drinking	Estimated not eating 5 a day (CCG level)	Mental Illness
CUHFT	9,509	3.0%	1,284	6,181	2,054	2,339	2,273	6,514	1,540
CPFT	3,665	4.5%	556	2,386	813	957	851	2,511	594
Hinchingbrooke	1,689	3.8%	256	1,100	375	441	392	1,157	274
PSHFT	4,021	3.9%	836	2,634	969	1,255	844	2,754	651
CCS	1,955	4.7%	297	1,273	434	511	454	1,339	317
Papworth	1,899	3.6%	288	1,237	421	496	441	1,301	308
Total	22,738		3,518	14,810	5,065	5,999	5,256	15,576	3,684

Interventions and cost savings to NHS

Mental health interventions

There is strong evidence that mental health interventions in the workplace can improve people's wellbeing and there is potential to deliver cost savings.

The NICE business case tool for promoting mental wellbeing at work estimated that mental ill health costs UK employers almost £1 million per year. For an organisation with 1000 employees, the annual cost of mental ill health was estimated to be more than £835,000. Identifying problems early – or preventing them in the first place, could result in cost savings, largely as a result of reduced absenteeism, of 30%. This is equivalent to cost savings of more than £250,000 per year.

Knapp (2011)[33] looked at a workplace-based enhanced depression care intervention consisting of the completion by employees of a screening questionnaire, followed by care management for those found to be suffering from, or at risk of developing depression and/or anxiety disorders. Using a model based on a white collar organisation of 500 employees, this found that in year 2 there is a cost saving of £63,578. This figure incorporates health and social care costs, absenteeism and presenteeism, and productivity losses.

Weight management and physical activity

In 2010, 26% of adults in England were obese. On average, obese people take 4 extra sick days per year[34]. In an organisation of 1000 employees who work the national average week of 39.1 hours[35]and are paid the national average hourly wage of £15.52[36], this equates to more than £126,000 a year in lost productivity.

Physical activity counselling and activity programmes are modelled in two ways: disease-specific cost effective evidence, and cost savings are based on the absenteeism model. York Health Economics has identified a study that modelled a 20% to 25% level of improvement in physical activity as cost saving for the employer at 1 year (absenteeism only)[37].

Smoking

NICE advice suggests reducing levels of smoking among workers will help reduce cardiorespiratory diseases, which is one of the largest causes of sickness absence. Some evidence suggests that, on average, a person who smokes will have 33 more hours off sick per year than a non-smoker[38]. For an organisation of 1000, in which 25% smoke and are paid the national average hourly wage of £15.52, this absence equates to a loss of more than £128,000 a year.

There is a high quality, high ranking evidence that stop smoking services are cost effective, good value for money and have a good return on investment.

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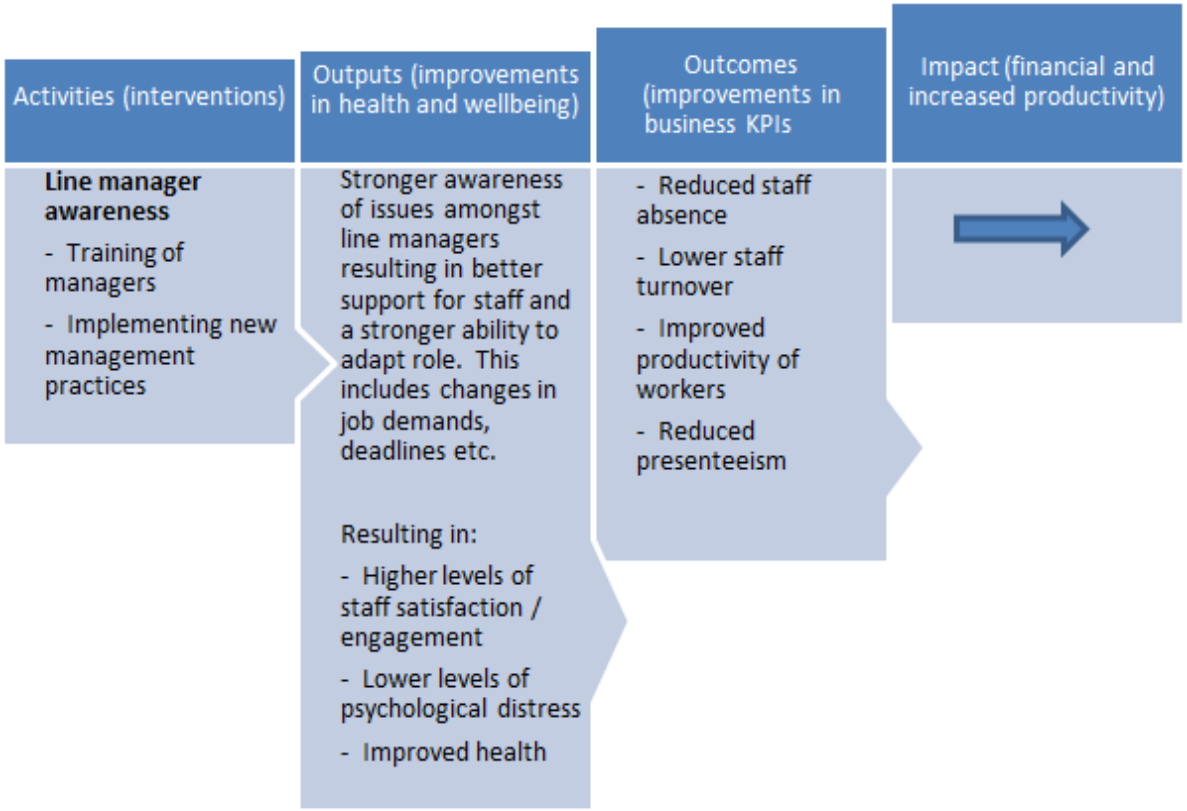
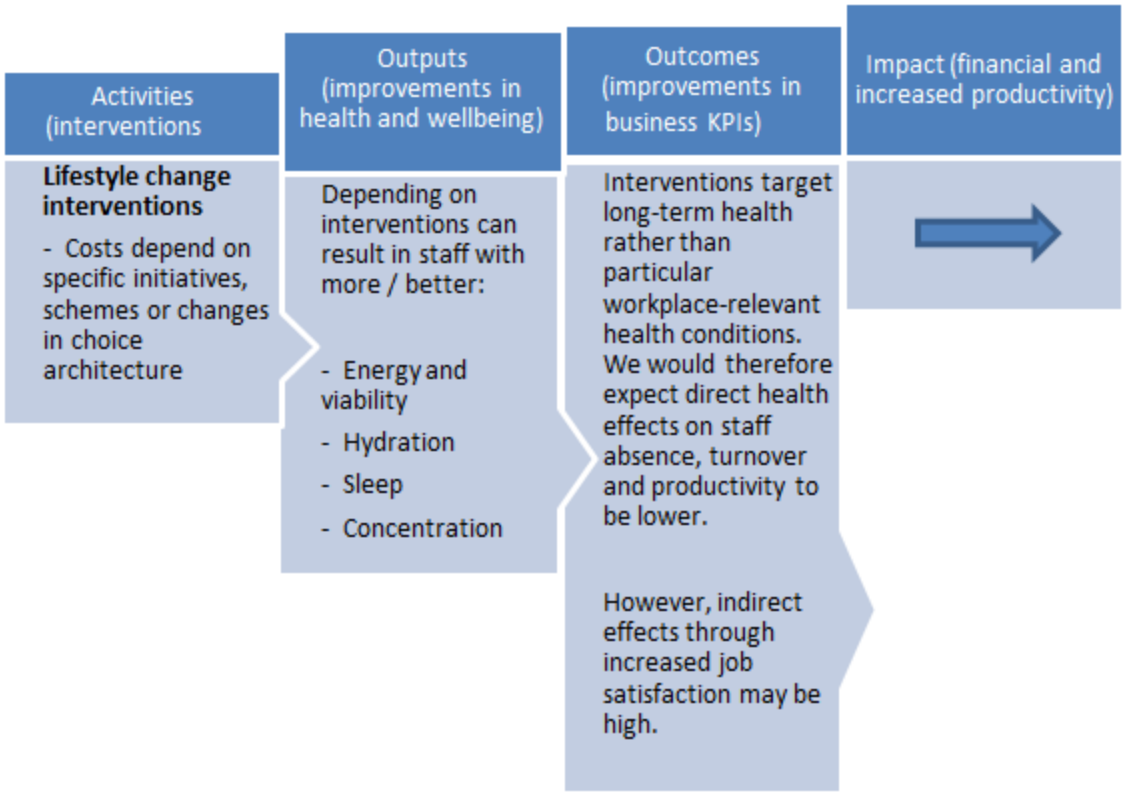
[33] Knapp, 2011: Mental health promotion and mental illness prevention: The economic case. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215626/dh_126386.pdf
[34]Obesity and sickness absence: results from the CHAP study.
[35]2011 annual survey of hours and earnings.
[36]NICE business case tool for workplace interventions to promote smoking cessation.
[37]An Economic Analysis of Workplace Interventions that Promote Physical Activity, 2008 - https://www.nice.org.uk/guidance/ph13/evidence/economic-modelling-report-369939277
[38]NICE business case tool for workplace interventions to promote smoking cessation.

Figure 10 below, produced by the Work Foundation in 2014, illustrates the outputs and outcomes of broad interventions such as lifestyle change and line manager awareness of mental health.

Figure 10 – Change diagram illustrating outputs and outcomes of interventions to improve line manager awareness and lifestyle change programmes





Current public health spend and activity

In Cambridgeshire, annual public health spend on general workplace health in the population is £45,000.

Peterborough carried over a small reserve, £90,000 of which is committed in principle for a workplace health programme over the next two years.

Interventions and cost savings to the NHS

Information in this section sets out the costs and potential savings for potential interventions in the workplace. It should be noted, however that the savings figures presented in this section are based on the assumption that organisations do not currently deliver preventative interventions. This may not be the case, as it is possible organisations already invest in similar initiatives via occupational health departments. The information presented below also does not take into account the potential impact of increasing stress levels in the workplace. **All the figures below are provisional.**

Table 13 shows the estimated productivity loss for mental ill health, obesity and smoking to each of the main local NHS employers and, the potential savings related to mental health. It is only possible to calculate these robustly for mental health. Broad potential savings are given for smoking and obesity above. The potential mental health productivity savings,

assuming no current action in this area, amount to nearly £5.7 across the large NHS employers in Cambridgeshire and Peterborough.

Table 13: estimated productivity loss for mental ill health, obesity and smoking

Productivity costs	Costs / Loss of productivity			Potential savings
	Mental Ill Health	Obesity	Smoking	Mental Ill Health
CUHFT	£7,940,015	£995,373	£657,262	£2,382,005
CPFT	£3,060,275	£383,641	£253,325	£918,083
Hinchingbrooke	£1,410,315	£176,799	£116,744	£423,095
PSHFT	£3,357,535	£420,906	£277,932	£1,007,261
CCS	£1,632,425	£204,643	£135,130	£489,728
Papworth	£1,585,665	£198,781	£131,259	£475,700
Total	£18,986,230	£2,380,144	£1,571,651	£5,695,869

Mental health

Based on our local experience, and the evidence base, we have put together a suggested mental health intervention package. The package would include:

- Mental Health First Aid Lite Training (a cost of £450 per 25 people). This is an evidence based package that raises awareness of mental health and illness.
- Health Champions (training costs £1000 per day for 20 people). A Health Champion is a volunteer who acts as a point of contact and health promoter within the organisation. They are trained to have a basic understanding of the principles of health and wellbeing and how best to promote them with their colleagues. There would also be a health champions' peer support network.
- ACAS training for managers. This is to enable managers to support people with a long term condition (including mental health) to make a successful return to work and manage their condition within their working lives. Training costs £1000 per day for 12 people and the figures below are based on 25 people being trained for every 500 employees.

Physical activity

The package also includes physical activity interventions. Physical activity has been shown to improve productivity and the savings from a programme to increase physical activity by 10% in the inactive are estimated below. This assumes there are no current interventions in place to address this inactive proportion.

The ROI tool classes a brief intervention as 'verbal advice, discussion, negotiation or encouragement with or without written or other support or follow up. It could be opportunistic and can take between 1-20 minutes'.

Table 14: Estimated savings from a programme to increase physical activity by 10% in the inactive

Trust	Number of targetted people	Cost (@ £9.92 per person)	Productivity savings			Net productivity savings		
			2 year	5 year	10 year	2 year	5 year	10 year
CUHFT	234	£2,321	£31,496	£76,693	£137,002	£29,175	£74,372	£134,681
CPFT	96	£950	£12,140	£28,789	£52,804	£11,190	£27,839	£51,854
Hinchingbrooke	44	£438	£5,595	£13,267	£24,335	£5,157	£12,829	£23,897
PSHFT	125	£1,245	£13,319	£31,585	£57,933	£12,074	£30,340	£56,688
CCS	51	£507	£6,476	£15,357	£28,167	£5,969	£14,850	£27,660
Papworth	50	£492	£6,290	£14,917	£27,360	£5,798	£14,424	£26,868
Total	600	£5,951	£75,314	£178,608	£327,599	£69,363	£172,657	£321,648

Weight management

The table below estimates the number of obese people in each organisation. It makes a number of assumptions about the proportion who might wish to attend weight management services. The costs here reflect a combination of group weight management as well as one to one health trainer costs.

Table 15: Estimated number of obese people in each organisation

Trust	Estimated number of obese people	Estimated cost of weight management Tier 1-2 service
CUHFT	2054	£41,079
CPFT	813	£16,254
Hinchingbrooke	375	£7,491
PSHFT	969	£19,381
CCS	434	£8,670
Papworth	421	£8,422
Total	5065	£101,298

The table below provides a summary of the costs and savings to the NHS of implementing a workforce health programme.

There are a number of key assumptions behind this table:

- That there is no current activity in these areas.
- That savings are spread over three years with 20% of savings in year 1, and remaining savings split between years 2 and 3.
- That physical activity is increased by 10% in the inactive.

Table 16: summary costs/savings of workforce health programme

		Investment				Net NHS savings based on Mental Health savings and productivity savings from increased physical activity			
NHS Trust	**Training**	**2016/17**	**2017/18**	**2018/19**	**Total**	**2016/17**	**2017/18**	**2018/19**	**Total**
Cambridge United Foundation Trust	Mental Health First Aid Lite	£11,411	£11,411	£11,411	£34,232	£115,483	£762,354	£762,354	£1,640,192
	Health champions	£7,924	£7,924	£7,924	£23,773				
	ACAS	£13,207	£13,207	£13,207	£39,621				
	Weight management	£13,693	£13,693	£13,693	£41,079				
	Total cost	£46,235	£46,235	£46,235	£138,705				
Cambridgeshire and Peterborough Foundation Trust	Mental Health First Aid Lite	£4,398	£4,398	£4,398	£13,194	£44,364	£311,622	£311,622	£667,609
	Health champions	£3,054	£3,054	£3,054	£9,163				
	ACAS	£5,090	£5,090	£5,090	£15,271				
	Weight management	£5,418	£5,418	£5,418	£16,254				
	Total cost	£17,961	£17,961	£17,961	£53,882				
Hinchingbrooke	Mental Health First Aid Lite	£2,027	£2,027	£2,027	£6,080	£20,445	£143,610	£143,610	£307,665
	Health champions	£1,408	£1,408	£1,408	£4,223				
	ACAS	£2,346	£2,346	£2,346	£7,038				
	Weight management	£2,497	£2,497	£2,497	£7,491				
	Total cost	£8,277	£8,277	£8,277	£24,831				
Peterborough and Stamford Foundation Trust	Mental Health First Aid Lite	£4,825	£4,825	£4,825	£14,476	£48,137	£341,790	£341,790	£731,718
	Health champions	£3,351	£3,351	£3,351	£10,053				
	ACAS	£5,585	£5,585	£5,585	£16,754				
	Weight management	£6,460	£6,460	£6,460	£19,381				
	Total cost	£20,221	£20,221	£20,221	£60,663				
Cambridgeshire Community Services	Mental Health First Aid Lite	£2,346	£2,346	£2,346	£7,038	£23,665	£166,227	£166,227	£356,119
	Health champions	£1,629	£1,629	£1,629	£4,888				
	ACAS	£2,715	£2,715	£2,715	£8,146				
	Weight management	£2,890	£2,890	£2,890	£8,670				
	Total cost	£9,581	£9,581	£9,581	£28,742				
Papworth	Mental Health First Aid Lite	£2,279	£2,279	£2,279	£6,836	£22,987	£161,465	£161,465	£345,918
	Health champions	£1,583	£1,583	£1,583	£4,748				
	ACAS	£2,638	£2,638	£2,638	£7,913				
	Weight management	£2,807	£2,807	£2,807	£8,422				
	Total cost	£9,306	£9,306	£9,306	£27,918				
Total	Mental Health First Aid Lite	£27,286	£27,286	£27,286	£81,857	£163,500	£1,887,070	£1,887,070	£3,937,640
	Health champions	£18,948	£18,948	£18,948	£56,845				
	ACAS	£31,581	£31,581	£31,581	£94,742				
	Weight management	£33,766	£33,766	£33,766	£101,298				
	Total cost	£111,580	£111,580	£111,580	£334,741				

Work already planned

The Cambridgeshire and Peterborough Public Health Reference Group has already identified workplace interventions as a priority area, with a number of projects and programmes outlined in the group's action plan for the next six months, which is currently being refined.

The plan includes the offer of a package of interventions as part of a Workplace Programme for Local Authorities over two years. It will include policy development, leadership and capacity development, direct provision, and network facilitation. Although the programme will promote diet and physical activity it will also offer obesity, mental health, smoking and alcohol related initiatives as part of an holistic workplace programme. It will also include the development of individual workplace champions and a peer support network. This is also the type of model which is we have used to estimate costs here.

The package of interventions suggested by the Public Health Reference Group is broadly in line with those outlined in the NHS England workplace programme.

Where should the strategic focus be?

The evidence and modelling is clear that investing in workforce health will generate short term productivity savings to the NHS. These are estimated, with the package modelled here to be approximately £3.9m over three years.

Recommendations

- NHS employers should see considerable productivity savings from investing in workplace health. In particular this needs to focus on improve management and awareness of mental health and illness.

8. Smoking

Headlines

- There are an estimated 105,548 people across Cambridgeshire and Peterborough who smoke. There is a high quality, high ranking evidence that stop smoking services are cost effective, are good value for money and provide a good return on investment.
- Sub-national programme work, such as tobacco control, is critical to ensuring savings to the NHS. Nationally and locally we should continue to invest in this.
- We should maximise our prevention opportunities and increase the number of people setting a quit date through stop smoking services (adults, older people and pregnant women) in Cambridgeshire by 5%, and in Peterborough to the Cambridgeshire average.
- An additional investment of £346k, only £175k of which is new investment, is needed to generate a saving over £356k over the next two years.
- There are additional savings to the NHS to be made from stopping people smoking before operations, and this group should be a target population.

Background

Smoking is still one of the most important causes of preventable ill health and early death in the UK. A recent study found that in the UK out of 40% of the potentially preventable NHS workload, 10% was attributable to smoking. This was the highest contributing factor along with sub-optimal diet[39].Additionally we know that high numbers of hospital admissions are caused by smoking related conditions.

Local context

In Cambridgeshire, around 16% of adults are estimated to smoke. Although this is below the national average of 18%, it represents around 79,000 smokers across the county. There are approximately 27,000 smokers in Peterborough.

The prevalence of smoking in Cambridgeshire has fallen, as it has nationally. Rates are consistently higher though in Fenland, compared to the other districts, and up until 2012 were increasing, although more recent data suggests a fall in 2013 and 2014.

Smoking is more common among people working in routine or manual professions. 27% of these workers are estimated to smoke in the county, similar to the national average of 29%.

[39] PHE Lancet Changes in health in England, with analysis by English regions and areas of deprivation, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013. September 15, 2015 http://dx.doi.org/10.1016/S0140-6736(15)00195-6

Data suggests smoking rates have been higher in this group in Fenland and East Cambridgeshire. In Peterborough, 35% of routine and manual workers smoke.

Data from GP practices across the county also show us that smoking prevalence is strongly linked to levels of deprivation. Practices serving more deprived areas, regardless of district, tend to have higher rates of smoking. There is also a strong relationship between smoking and people living with mental health problems. People with mental health conditions are twice as likely to be smokers.

Smoking is a major risk factor for many diseases, such as lung cancer and many other cancers, chronic obstructive pulmonary disease and heart disease. Over 200 people in Peterborough die due to smoking every year, including 45 people from lung cancer.

Current position

What is the scale of the problem?

The data in table 17 shows the estimated prevalence of smoking amongst adults (aged 18 years and above) in Cambridgeshire and Peterborough between 2010 and 2014, compared to the average for England.

The red, amber and green status indicates whether local prevalence is statistically significantly higher, similar or lower than the average for England.

Table 17 – Estimated smoking prevalence in Cambridgeshire and Peterborough

Year	ENGLAND	CAMBRIDGESHIRE		PETERBOROUGH	
	Estimated prevalence	Estimated prevalence	95% CI	Estimated prevalence	95% CI
2010	20.8	19.0	17.4 to 20.6	25.2	23.0 to 27.4
2011	20.2	19.2	17.3 to 21.0	24.3	22.0 to 26.7
2012	19.5	17.9	15.8 to 19.9	21.1	18.7 to 23.4
2013	18.4	13.5	11.7 to 15.3	20.8	18.6 to 23.1
2014	18.0	15.5	13.5 to 17.4	18.6	16.4 to 20.8

Source: Public Health England Public Health Outcomes Framework (using data from the Integrated Household Survey)

Statistical significance compared with the England average:

Lower

Similar

Higher

CI = confidence interval: a range of values so defined that there is a specified probability that the value of a parameter lies within it.

For 2014, these prevalence rates equate to the following estimated numbers of smokers of:

- Cambridgeshire - 78,791
- Peterborough - 26,757

There are high smoking in pregnancy rates in Peterborough. In 2014, the most recent data showed that 18% of mothers were smokers at the time of delivery in Peterborough compared to 13% in Cambridgeshire and in England as a whole[40].

A local survey undertaken by over 8,500 Year 8 and Year 10 pupils in Cambridgeshire every two years found that in 2014, 1% of Year 8 and 7% of Year 10 pupils reported that they smoked regularly, with around half wishing to give up. Prevalence is higher in girls than boys, in children in care and in children in single parent families. One out of ten young people in Peterborough are regular smokers by the age of 15, and two out of three smokers began smoking before they were 18.

The proportion of Year 10 children in Cambridgeshire who reported never having smoked, however, has increased from 54% in 2008 to 65% in 2014 and positive trends are seen across the districts.

Future smoking prevalence

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. GP practices and community pharmacies report continued difficulty with recruiting smokers to make quit attempts.

We have seen a fall, which is reflected nationally, in the number of people setting a four week quit date, and the number of four week quitters. There were 1,805 less four week quitters in 2014/15 compared to 2012/13 across Cambridgeshire and Peterborough. The number setting a quit date in 2014/15 is projected to be lower than the previous two years. This is particularly the case in Peterborough, where the number setting a quit date is projected to be 850 by the end of 2015/16 compared to 1,213 in 2014/15. This is in part due to a reduction in specialist stop smoking provision, as well as the impact of e-cigarettes.

Current public health spend

In Cambridgeshire, annual public health spend on smoking and tobacco control is £1,167,000. In Peterborough, spend per head on smoking and tobacco control is £1.84 per head, compared with a national average of £3.36 and an average for Peterborough's deprivation decile of £3.38. Despite this the number of people who set a quit date and go on to quit in Peterborough is above the Cambridgeshire rate.

[40]Public Health Outcomes Framework, available at http://www.phoutcomes.info. Accessed 10/04/15

Interventions and cost savings to the NHS

There is a high quality, high ranking evidence that stop smoking services are cost effective, and provide a good return on investment. As well as savings to the NHS, there are also wider savings to social care through reduced disability resulting in lower social care need in later life. These are outlined in multiple NICE guidance documents.

We have used the NICE smoking return on investment tool to estimate the savings to the NHS from the current programme, and to estimate what an increase in activity would generate in savings.

Cambridgeshire

For Cambridgeshire we have modelled the impact of increasing local stop smoking service uptake up 5% from 2014/15, as well as continuing to invest in the sub-national programme which focuses on tobacco control and other prevention initiatives.

The figure and table below show that an investment of £157k a year generates a net saving (above this cost) of £161k. It is important to note that £136k of this investment is already invested, and remains part of the local authority budget, and therefore the actual new investment needed is approximately £22k. The mix of sub-national programme work as well as specialist stop smoking work is critical to generate savings for the NHS. The impact of specialist stop smoking work is not estimated by the tool to generate savings until year 5, but the investment in the sub-national programme generates the early savings. It is therefore critical that local authority investment levels in sub-national work remain at this level to generate NHS savings. We have only modelled two year savings as there is a fast changing smoking pattern and the tool allows for a calculation of two years of isolated NHS savings.

To increase smoking uptake we plan to focus on groups within the population with higher prevalence levels, such as those with serious mental illness and also those people about to have an operation. There is high quality, high ranking evidence that stopping smoking prior to an operation can reduce the risks associated with surgery. There is also evidence that short term costs, such as length of stay can be reduced.

Some studies have found that stopping smoking before an operation can reduce operative and post-operative hospital costs. Extrapolating one such study on hip and knee replacement surgery we found a short-term cost-benefit per patient can be estimated as £65 per patient undergoing intervention (not per patient quitting) in Cambridgeshire and Peterborough. This would be in addition to any savings estimate through the NICE ROI tool modelling below.

There is also evidence from the trials of pre-operative smoking cessation interventions,2,4 that the quit rate at 12 months follow up was 30% versus 10% in the intervention and

control groups respectively, showing that some difference in long-term quit rates is likely to be maintained.

Using the rewards intervention for pregnant women, which gave quit rates of 9% versus 3% for intervention versus control at 1 year, as a conservative proxy for pre-operative quits, the cost-benefit to women (excluding child cost-benefit and excluding the cost of the intervention) was £144 per patient undergoing the intervention. A conservative estimate of the total cost benefit of pre-operative smoking cessation intervention is £209 per patient undergoing the intervention.

Figure 11 – expected impact of increasing local stop smoking service uptake in Cambridgeshire by 5% and investing £136,000 in the sub-national programme

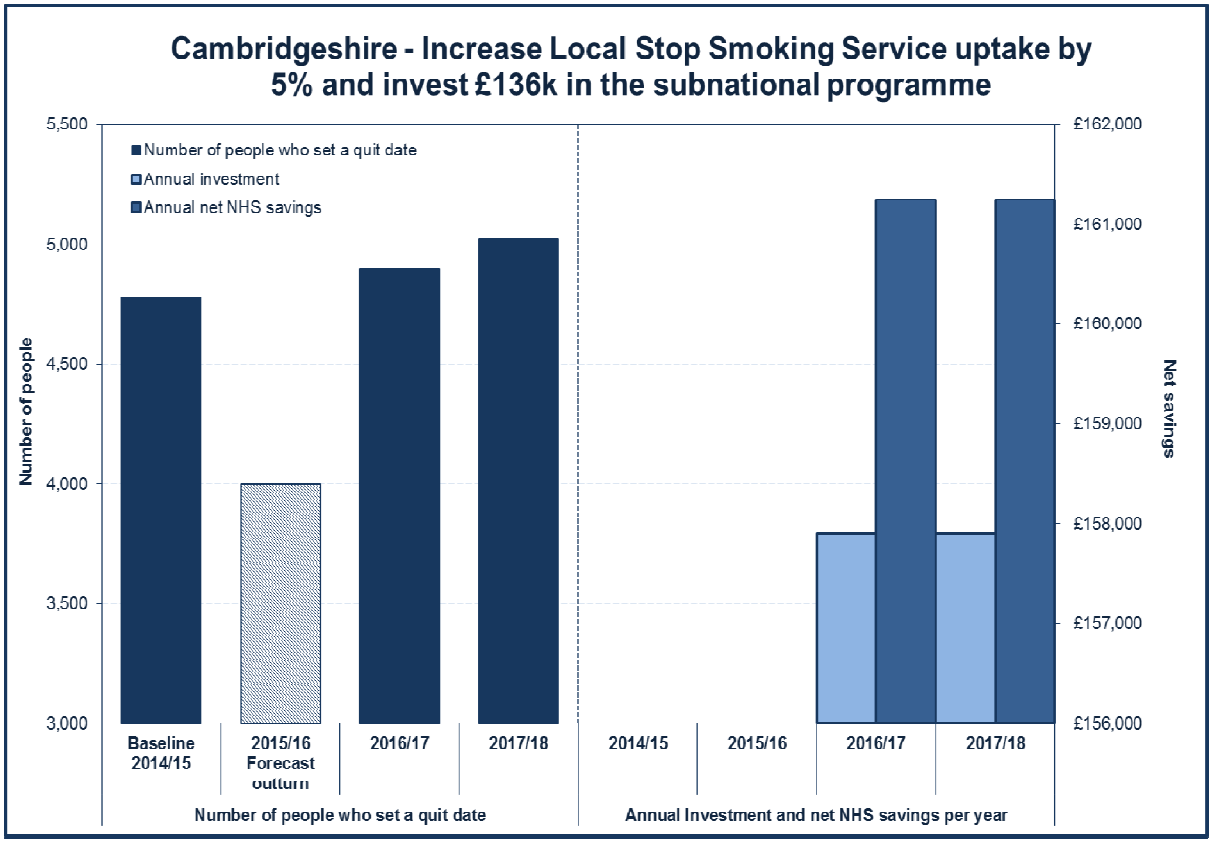


Table 18 – quit date information for Cambridgeshire

	Baseline 2014/15	2015/16 Forecast outturn	2016/17	2017/18
Number of people who set a quit date	4,777	*4,000*	4,900	5,022
Annual investment			£157,904	£157,904
(Annual new investment)			£21,904	£21,904
Annual net NHS savings			£161,250	£161,250

Smoking rates are much higher in Peterborough than in Cambridgeshire and so the model proposed here is to increase the number of people setting a quit date in Peterborough to

the same as the Cambridgeshire average. The table and figure below show how new investment of £65,589 a year, will lead to a saving of £16,307.

Peterborough

Figure 12 – expected impact of increasing local stop smoking service uptake the current Cambridgeshire levels and investing £35,000 in the sub-national programme

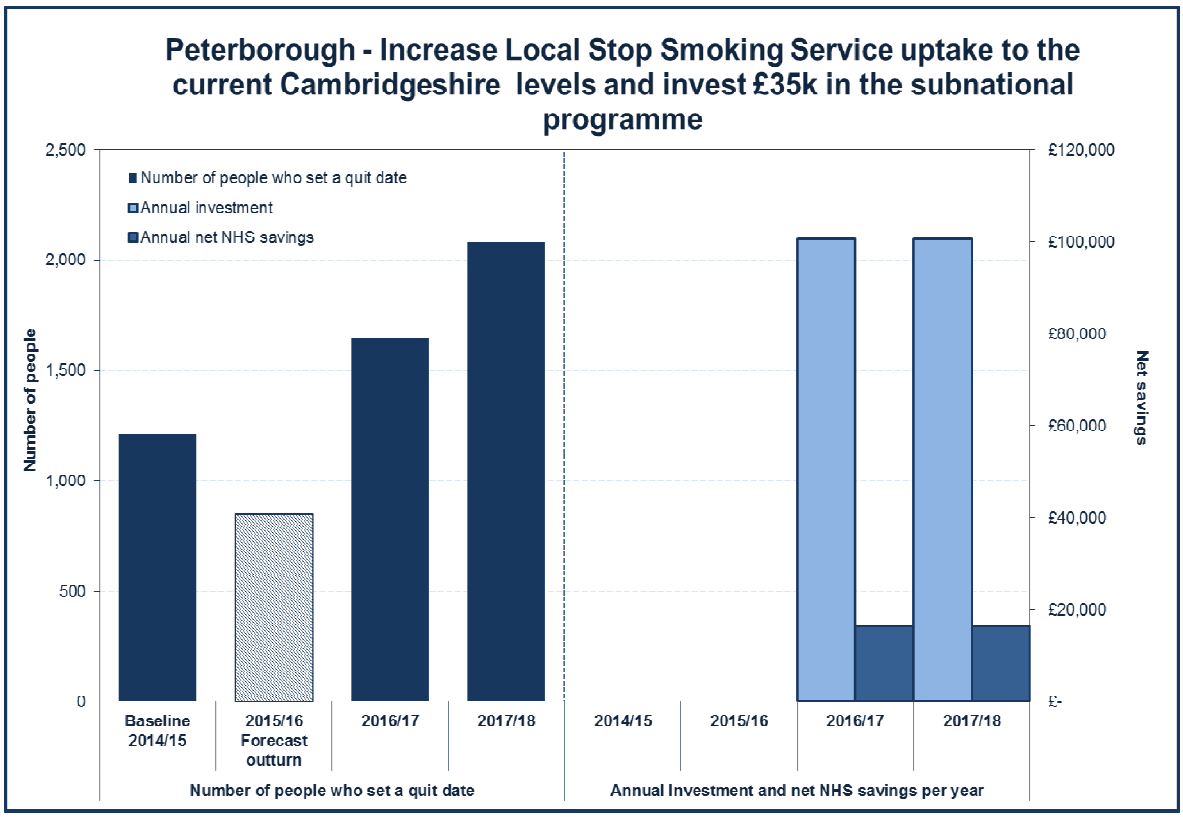


Table 19 – quit date information for Peterborough

	Baseline 2014/15	2015/16 Forecast outturn	2016/17	2017/18
Number of people who set a quit date	1,213	*850*	1,648	2,082
Annual investment			£100,589	£100,589
(Annual new investment)			£65,589	£65,589
Annual net NHS savings			£16,307	£16,307

It is important to note that our projections suggest that the number of people setting a quit date in Cambridgeshire and Peterborough will fall considerably from 2014/15, which is used as the baseline in these projections in terms of activity and investment. Given the scale of the projected fall in numbers in Peterborough the increase needed to reach the Cambridgeshire average requires the service to more than double its activity. The overall drop in activity, and associated investment, in 2015/16 is a risk to achieving targets for 2016/17 and 2017/18.

Work already planned

There is an ongoing programme to improve performance that includes targeting routine and manual workers and the Fenland area. CamQuit, the core Stop Smoking service in Cambridgeshire, is providing increasingly higher levels of support to the other providers along with promotional activities. Practices and community pharmacies are regularly visited with poor performers being targeted. During 2014/15 social marketing research was undertaken which is informing activities to promote Stop Smoking Services. Other activities introduced recently include a mobile workplace service, a migrant worker Health Trainer post that will target these communities where smoking rates are high, a wide ranging promotional campaign and the recruitment of an additional Stop Smoking Advisor to focus upon Fenland.

Going forward, Cambridgeshire and Peterborough will be working with neighbouring local authorities on tobacco related campaigns and engagement work, including a focus on illicit tobacco sales.

Where should the strategic focus be?

There are an estimated 105,548 people across Cambridgeshire and Peterborough who smoke. There is a high quality, high ranking evidence that stop smoking services are cost effective, are good value for money and provide a good return on investment.

Recommendations

- Sub-national programme work, such as tobacco control, is critical to ensuring savings to the NHS. Nationally and locally we should continue to invest in this.
- There are additional savings to the NHS to be made from stopping people smoking before operations, and this along with sub-groups in the population with high prevalence levels should be a focus for the additional numbers setting a quit date.
- An additional investment of £346k, only £175k of which is new investment, is needed to generate a saving over £356k over the next two years.

9. Alcohol

Headlines

- Maximise opportunities to provide brief advice on alcohol to more GP practice patients, at new registrations and/or next appointment. If 10,000 more patients were to receive this advice, it is estimated this would save the NHS £217k (above the cost of the intervention) over seven years with the vast majority of the savings in years 2-5. **[PH: further work is needed to define local stretch targets, including A&E as well as GP practices, and to model the cost savings]**

Background

The consumption of alcohol contributes to a range of health conditions and admissions to hospital. Alcohol-related conditions include liver disease, hypertension, oesophageal and other cancers and mental and behavioural disorders. Drinking alcohol is also linked to hospital admissions due to accidents and injuries and toxic effects of consumption, and causes considerable costs to the NHS.

It is estimated that 6.6m adults in England currently consume alcohol at hazardous levels and 2.3m at harmful levels. The total costs of alcohol misuse in England are estimated to be around £23.1bn of which £0.3m is NHS costs. Overall average annual costs of a harmful drinker are around 3.4 times that of a hazardous drinker.

Current position

Cambridgeshire context

In 2012/13, alcohol-related hospital admissions for men were lower than the national average across Cambridgeshire but highest in Cambridge and Fenland. In 2012/13, alcohol-related hospital admissions for women were higher than the England average in Cambridge and Huntingdonshire.

In Cambridgeshire it is estimated that there are 114,000 hazardous drinkers and 40,000 harmful drinkers.

Peterborough context

1 in 5 people in Peterborough (23,000 people) drink above the recommended levels.7,500 people in Peterborough drink heavily at levels which have, or risk, damaging their health.

There were 1,171 alcohol-related hospital admissions in Peterborough in 2012-13, which is the highest in the East of England. The cost to the local NHS system is £1.8 million a year or £244 per person for the 7,500 people in Peterborough who drink heavily.

Interventions and cost savings to NHS

Current public health spend and activity

In Cambridgeshire, annual Public Health spend on drug and alcohol services is £5,964,000. This breaks down for specific spend on alcohol as:

- Adult alcohol treatment - £961,000
- Young people's drug and alcohol service - £315,000
- Inpatient beds, recovery hub, service users' network, controlled drinkers project

Alcohol screening takes place through NHS Health Checks, and for all new adult patients of GP practices through a national DES.

[PH: Need to add Cambridgeshire activity]

In Peterborough, combined spend on substance misuse (drug, alcohol and young people) is £16.73 per head, compared with a national average of £17.36 and a deprivation decile average of £21.25.

Peterborough commission Drink Sense as an alcohol interventions service, which inevitably includes brief and extended interventions. In 2014/15 190 people were referred for Brief Advice and a further 152 received Brief interventions.

The Hospital Alcohol Liaison Project (HALP) also commissioned through CCG, set a target for 480 Brief Advice interventions at PCH , and in fact 2014/15 made 746 interventions. This service then follows up relevant patients with further brief interventions.

DrinkSense adult service is commissioned primarily to deliver alcohol treatment interventions, of which Brief Advice and Brief Interventions form only a part. Activity in Q1 shows 160 people receiving brief interventions.

Work already planned

HALP target for Brief Advice increased to 720, with Brief Interventions increased to 1200.

Work is currently underway on a Drugs and Alcohol JSNA in Cambridgeshire. This detailed analysis is due to be completed in July 2015.

Cost saving prevention initiatives – possible areas of focus

There are a number of national initiatives such as minimum unit pricing that have been shown to be potentially cost saving to a range of organisations, and would reduce alcohol consumption. A recent NICE evidence update (PH24) on Alcohol-use disorders highlighted evidence that affordability, minimum pricing, taxation and location of outlets can all influence drinking levels.

Minimum Unit Pricing has been recommended in Scotland as a way of increasing the price of drinks such as own-brand spirits and white cider, which have high alcohol content but are

usually very cheap. Minimum unit pricing would set a floor price for a unit of alcohol, meaning it cannot be sold for lower than that. The more alcohol a drink contains, the stronger it is and therefore the more expensive it would be.

The Alcohol (Minimum Pricing) (Scotland) Act 2012 was passed in June 2012. It has not yet been implemented due to a legal challenge led by the Scotch Whisky Association.

Scotland's Chief Medical Officer concluded that - like the smoking ban - minimum unit pricing would save lives within a year. Research by the University of Sheffield estimated that the proposed minimum price of 50p per unit would result in the following benefits:

- Alcohol related deaths would fall by about 60 in the first year and 318 by year ten of the policy
- A fall in hospital admission of 1,600 in year 1, and 6,500 per year by year ten of the policy
- A fall in crime volumes by around 3,500 offences per year
- A financial saving from harm reduction (health, employment, crime etc) of £942m over ten years

In terms of local initiatives we have focused here on the cost effectiveness of screening and brief advice for alcohol.

The costs and benefits of GPs using the Alcohol use disorders identification test (AUDIT) have been modelled using a representative sample of 1,000 adults attending their next GP consultation, followed by 5 minutes of advice for those identified as hazardous or harmful drinkers (£17.41 cost per person screened). The model assumes that 20% of relevant individuals are missed in the screening, and the effectiveness of the intervention is assumed to decline to zero in seven years.

Table 20: Costs/pay off per head for screening and brief advice based on a representative sample of 1000 adults attending their next GP consultation (2009/10 prices)

Table 5: Costs/pay-offs per head for screening and brief advice based on a representative sample of 1,000 adults attending their next GP consultation (2009/10 prices)

	Year 1 (£)	Years 2–5 (£)	Years 6–7 (£)	Total (£)
NHS	-10.55	-24.61	-3.91	-39.07
Crime	-28.49	-66.02	-10.49	-105.00
Productivity losses	-16.20	-38.24	-6.05	-60.48
Total	-55.23	-128.87	-20.45	-204.55

Source: Mental health promotion and prevention: the economic case. 2011. Knapp & Parsonage.

Taking these figures, if 10,000 more people in Cambridgeshire and Peterborough were screened and received brief advice, it is estimated that there would be net savings at over seven years of £216,600 with the vast majority of these in years 2-5. The overall cost of the programme would be £174k and the total return £390,700.

The existing activity and capacity within the health system to take on this additional work (roughly 2 additional patients per week for 50 weeks of the year per practice), would need to be considered in any model. This model also assumes this activity is undertaken by GPs, not practice nurses, and it is also not clear if the costs include any initial training costs.

More recent modelling work[41] continues to find that screening and brief interventions at registration are potentially cost saving to the NHS and social services, with the majority of savings in the NHS.

Where should the strategic focus be?

There is good evidence that brief interventions for alcohol are cost saving to the NHS in the short term. The focus should be on maximising opportunities to ensure this screening takes place with as big a proportion of the population as possible.

Recommendation

- Maximise opportunities to provide brief advice on alcohol to more GP practice patients, at new registrations and/or next appointment. If 10,000 more patients were to receive this advice, it is estimated this would save the NHS £217k (above the cost of the intervention) over seven years with the vast majority of the savings in years 2-5.

[PH: further work is needed to define local stretch targets, including A&E as well as GP practices, and to model the cost savings]

[41]Modelling the Cost-Effectiveness of Alcohol Screening and Brief Interventions in Primary Care in England. Purshouse, R et al (2012) Alcohol and Alcoholism Vol.48, no 2 pp 180-188.

10. Falls

Headlines

- Injurious falls in older people have a high cost impact for health and social care services, estimated at £83 million for 2016, with increasing costs forecast for the ageing population locally.
- There is important and robust evidence indicating net savings for falls interventions targeted at community dwelling older adults across a range of UK and international settings.
- In particular three areas of intervention for preventing falls in community-living older people have been trialled and indicated cost savings: home-based exercise (the Otago Exercise Programme) in over 80-year-olds, home safety assessment and modification in those with a previous fall, and specific multi-factorial programmes.
- Further development of models to estimate the cost savings to the NHS of local multi-component falls interventions accurately is in progress.
- Potential savings may require delivery of preventative approaches at a much wider scale than current provision.

Background

A fall is defined as an unplanned descent to the floor with or without injury to the patient[42]. Falls are the commonest cause of accidental injury in older people and the commonest cause of accidental death in the population aged 75 and over in the UK. The majority of fractures in older people occur as a result of a fall from standing height. These are low trauma fragility fractures commonly affecting the pelvis, wrist, upper arm or hip.

Falls in older people can be predicted by assessing a number of risk factors including conditions that affect balance, chronic health conditions, physical and cognitive impairments, and multiple medications[434445]. Multi-faceted interventions can prevent falls in the general community, in those at greater risk of falls, and in residential care facilities[46]. Well organised services, based on national standards and evidence-based guidelines can prevent future falls, and reduce death and disability from fractures[47].

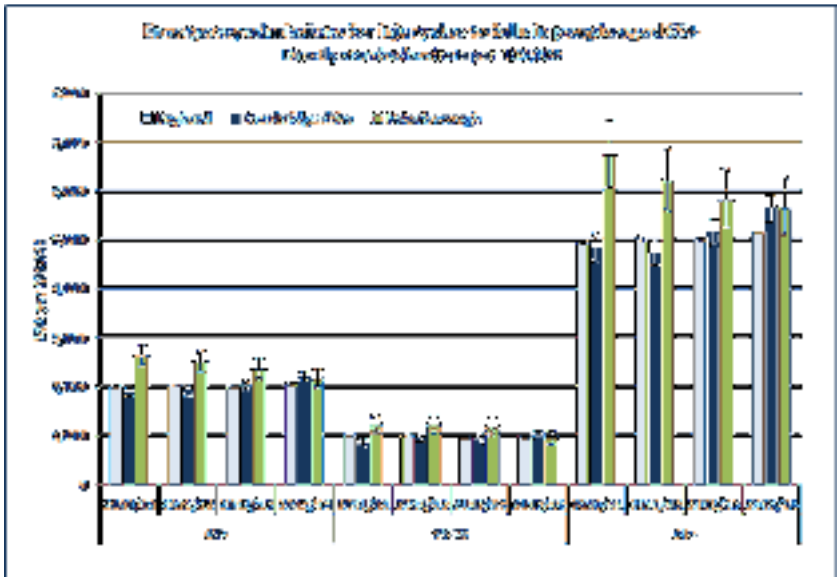
[42]National Database of Nursing Quality Indicators (2011).
[43]Gillespie LD, Gillespie WJ, Robertson MC et al. Interventions for preventing falls in elderly people. Cochrane Database Syst Rev 2003;Issue 4.
[44]Ganz DA, Bao Y, Shekelle PG et al. Will my patient fall? JAMA 2007;297:77–86.
[45]Clinical Guideline 21. Falls: The Assessment and Prevention of Falls in Older People. London, UK: National Institute for Clinical Excellence, 2004.
[46]Gillespie LD, Gillespie WJ, Robertson MC et al. Interventions for preventing falls in elderly people. Cochrane Database Syst Rev 2003;Issue 4.
[47]Royal College of Physicians. Falling standards, broken promises. Report of the national audit of falls and bone health in older people 2010. Available at: http://www.rcplondon.ac.uk/sites/default/files/national_report.pdf

Current position

What is the scale of the problem?

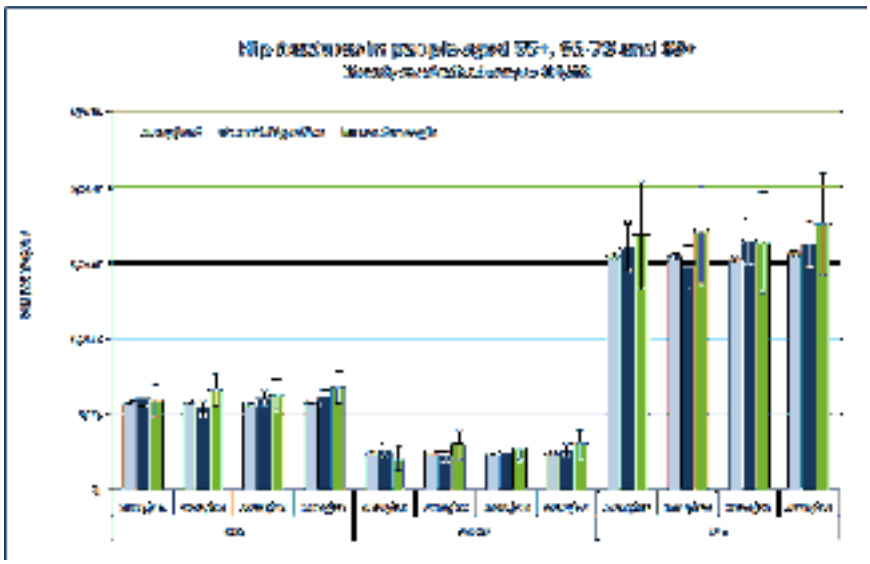
Figures 13 and 14, show rates of emergency admission for injuries due to falls, and for fracture of the hip between 2010/11 and 2013/14. Rates are generally higher in women than in men (data not shown) and increase substantially with age. Rates for emergency admissions in Cambridgeshire as a whole are similar to the national average whilst rates in Peterborough have been higher than the national average.

Figure 13: Emergency admissions for injury due to falls in people aged 65+



Source: Public Health England (PHE) Fingertips http://www.phoutcomes.info/
Primary diagnosis code for Injury (ICD 10 S00-T19) with falls code (WOO-W19) anywhere in diagnostic string.

Figure 14: Hip fractures in people aged 65+, 65-79 and 80+



Source: Public Health England (PHE) Fingertips http://www.phoutcomes.info/
Primary diagnosis ICD 10 S72.0, S72.1, S72.2.

From the above data it is clear that in Cambridgeshire the impact of falls is disproportionately greater in those aged 80 years and above which accentuates the case for preventive interventions targeted at age-bands preceding the rise in incidence of hip fractures and frailty.

How is this expected to change locally?

The number of older people aged 65 and over is forecast to increase significantly across the CCG population, with an increase of 42% in Peterborough and 48% in Cambridgeshire by 2031. In Cambridgeshire, amongst the oldest, the number of people aged 90 years and over is forecast to nearly double in the next 15 years.

Table 21: number of older people

Peterborough

	2013	2016	2021	2026	2031	Change 2016-31
65-74	14,000	15,300	17,200	18,300	20,700	35%
75-84	9,000	9,200	10,200	12,600	13,900	51%
85+	3,500	3,900	4,800	5,500	6,600	69%
65+	28,513	30,416	34,221	38,426	43,231	42%
All ages	189,300	198,300	220,700	231,000	235,300	19%

Cambridgeshire

	2013	2016	2021	2026	2031	
65-74	59,400	65,400	70,400	72,500	82,700	26%
75-84	34,700	36,600	44,700	56,300	60,400	65%
85+	15,000	17,000	21,000	25,900	33,300	96%
65+	109,100	119,000	136,100	154,700	176,400	48%
All ages	621,200	627,200	653,400	713,800	752,800	20%

Source: CCC R&PT 2013-based population forecasts

The health consequences and costs

[PH: This section replicates previous work for Cambridgeshire using CCG populations. At present it is an under-estimate of total 'health' costs since it does not include the breakdown, post discharge from the acute sector, or costs associated with community health services. These need to be estimated.]

In 2013, results were published from a Scottish study which aimed to estimate the costs for health and social care services in managing older people in the community who fall[48]. The study used predominantly national databases and cost of illness methodologies and the authors noted that costs, while specific to Scotland, were anticipated to generalise to other parts of the UK. The study found that 34% of people aged 65 years and over living in the community fall at least once a year and 20% of these people contacted a medical service for assistance. Applying the results from the Scottish study to local population figures for Cambridgeshire & Peterborough CCG, we can estimate the costs of falls across health and social care.

In the CCG, in 2016 these falls result in over 5,500 GP attendances, over 8,700 ambulance call outs, and more than 6,300 A&E attendances resulting in over 3,000 inpatient admissions annually. The associated costs are high and estimated to be over £78 million. Costs at discharge are predominantly associated with social care but not from the funder perspective.

The table 22 shows the figures from the Scottish study applied to the forecast population of Cambridgeshire and Peterborough Clinical Commissioning Group in 2016.

Table 22: Estimated number and cost of fall related events, Cambridgeshire & Peterborough CCG 2016, based on study estimates applied to local population figures.

Clinical event			Number	Cost per event	Total cost (2016)	Total percentage
Population aged 65+			166,039			
Total people falling	34%	of population	56,453			
Of whom serious	7%	of population	11,623			
GP attendances	51%	of serious falls	5,928	£36	£213,393	0.3
Ambulance callouts	61%	of serious falls	7,090	£257	£1,822,090	2.2
A&E attendances	80%	of serious falls	9,298	£101	£939,114	1.1
Inpatient admissions	35%	of A&E attendances	3,254			
Falls (non hip fractures)	69%	of admissions	2,246	£7,406	£16,630,208	20.1
Hip fracture	31%	of admissions	1,009	£14,528	£14,656,572	17.7
Discharge falls						
Home	64%		1,439	£1,776	£2,556,323	3.1
Residential: short term	21%		480	£8,406	£4,033,619	4.9
Long term	15%		326	£65,942	£21,515,799	25.9
Discharge fractures						
Home	34%		345	£1,776	£612,321	0.7
Residential: short term	47%		470	£8,406	£3,952,282	4.8
Long term	19%		194	£65,942	£12,786,202	15.4
Re-admissions	7%	of admissions	391	£7,406	£2,892,210	2.1
Mortality at one year	12%	of admissions	228	£3,703	£843,561	1.8
Total cost					**£83,453,695**	**100**

[48]Craig J, Murray A, Mitchell S et al. The high cost to health and social care of managing falls in older adults living in the community in Scotland. Scottish Medical Journal 2013;58(4):198-203. Available at: http://scm.sagepub.com/content/58/4/198.

Source: CCC PHI. ONS population projections applied to FHS Registration System (Exeter) April 2015 (Costs and estimates modelled using Craig et al.).

The next table gives an additional breakdown of the NHS costs associated with falls and fractures and shows the financial impact assuming no change in prevention to 2020.

Table 23: Estimated number and NHS costs of fall related events, Cambridgeshire & Peterborough CCG 2016, based on study estimates applied to local population figures.

Breakdown of costs to NHS - Cambridgeshire & Peterborough CCG - no change in prevention

	2016	2020	2016	2017	2018	2019	2020
Population 65+	166,039	181,667					
Estimated falls in the community	56,453	61,767					
of which serious	11,623	12,717					
GP attendances	5,928	6,486	£.2M	£.2M	£.2M	£.2M	£.2M
Ambulance callouts	7,090	7,757	£1.8M	£1.9M	£1.9M	£2.M	£2.M
A&E attendances	9,298	10,173	£.9M	£1.M	£1.M	£1.M	£1.M
Costs GP/Amb/A&E			**£3.M**	**£3.M**	**£3.1M**	**£3.19M**	**£3.25M**
Inpatient admissions	3,254	3,561					
Of which non hip fx	2,246	2,457	£16.6M	£17.M	£17.4M	£17.8M	£18.2M
Of which hip fractures	1,009	1,104	£14.7M	£15.M	£15.4M	£15.7M	£16.04M
Costs of admission			**£31.3M**	**£32.1M**	**£32.8M**	**£33.5M**	**£34.2M**
Readmissions	228	249	**£.8M**	**£.9M**	**£.9M**	**£.9M**	**£.9M**
Total			**£35.1M**	**£36.M**	**£36.8M**	**£37.6M**	**£38.4M**

Source: CCC PHI. ONS population projections applied to FHS Registration System (Exeter) April 2015 (Costs and estimates modelled using Craig et al

Interventions and cost savings to the NHS

The cost implications for the system of falls are evident and a do nothing option incurs increasing costs.

Table X below demonstrates the impact of conservative estimates of reduction on costs by applying a 10% and 15% reduction on the overall costs. Potential cost reductions are substantial as shown in Table 5. Using the 10% reduction results in a reduction of NHS costs of over £3.5 million.

Table 24: Potential cost savings across health from 10% and 15% reduction in falls related events

Clinical event			Total cost (2016)	10% reduction	15% reduction
Population aged 65+					
Total people falling	34%	of population			
Of whom serious	7%	of population			
GP attendances	51%	of serious falls	£213,393	£192,053	£181,384
Ambulance callouts	61%	of serious falls	£1,822,090	£1,639,881	£1,548,776
A&E attendances	80%	of serious falls	£939,114	£845,202	£798,247
Inpatient admissions	35%	of A&E attendances			
Falls (non hip fractures)	69%	of admissions	£16,630,208	£14,967,187	£14,135,677
Hip fracture	31%	of admissions	£14,656,572	£13,190,915	£12,458,086
Re-admissions	7%	of admissions	£2,708,552	£2,892,210	£2,302,270
Total cost			£36,969,929	£33,272,936	£31,424,440

Source: (Costs and estimates modelled using Craig et al

Falls prevention is multi-faceted with phases of need across the population, ranging from older people who are well and mobile, with no risks identified, those complaining of unsteadiness, those who have fallen and injured themselves, and those with significant frailty and multi-morbidities that may have already had interventions related to falls.

Therefore an array of evidence-based interventions is required, as appropriate, to specific population groups, such as:

Effective Interventions[49]	Target Group
Strength and Balance (community)	All population >65
Tai chi (community)	Low/medium risk of falling
Home improvements (hazard assessments)	Medium/high risk of falling
Multi-factorial risk screening and intervention	Medium/high risk of falling
Medication review (withdrawal of psychotropic medication)	Taking multiple medications
Expedited cataract surgery	Patients with cataracts
Vision and eye exam	All population >65
Vitamin D and calcium	All population >65
Cardiac pacing	Patients with carotid hypersensitivity

'Gold standard' falls preventions interventions/packages typically include strong pathways between the relevant services. The Greater Glasgow and Clyde model[50],which has evidence of actual realised savings, includes the following key components[51]:

[49]Interventions drawn from Day et al., (2009) Modelling the impact, costs and benefits of falls prevention measures to support policy-makers and program planners. MONASH University Accident Reduction Centre; Church J, Goodall S. Norman R. Haas M. An economic evaluation of community and residential aged care falls prevention strategies in NSW. Sydney. NSW Ministry of Health 2011.

- A single point of referral in each locality for triage and onward referral
- Multi-factorial falls assessments (all assessment in the home)
- Data recording of patients using the service
- A programme of exercise classes run in community centres by trained specialist therapists (held immediately after rehabilitation classes)
- Integration: there is close partnership between the NHS and local council
- The service is widely promoted in GP practices, libraries, and other public settings

It is not yet clear from the evidence which, and at what scale, of the interventions and components, are required to achieve the 10% or 15% reduction in the costs of falls related injuries.

Current public health spend and activity

The majority of interventions to reduce falls in older people are not funded directly by Public Health. Detailed mapping of stakeholder activity is underway, so descriptions of current provision must be considered estimates; falls are events rather than conditions or diseases so health data coding is problematic.

Community exercise provision (strength and balance and tai chi) across the county (not all funded by PH) may currently reach about 500 people aged 50 and over across the county. Adaptations to reduce hazards in the home environment are delivered through handyperson schemes, or funded by disability facilities grants, and other local provision. GPs provide an important coordination role in primary care, ensuring medication reviews, hearing and sight checks, foot health and other key risk factors. Secondary preventative work with fallers (falls prevention services/intervention) is held within Older People health services (CPFT/UCP) neighbourhood teams.

Work already planned

The business case for Cambridgeshire County Council April 2015 – March 2017 (£300,000 per annum) includes:

- Increasing provision of evidence-based community exercise to increase reach and uptake in the over 65 population, particularly targeted at those aged 75 and over.

[50]This programme is the only UK model to have evidence of realised savings, finding over a 10 year period the service has achieved a reduction in falls in the home of 32%, a reduction of falls in residential institutions of 27% and a reduction of falls in the street of almost 40%. However there may be some concerns about the analysis, and the ability to extrapolate for local models.

[51]Greater Glasgow and Clyde Falls Prevention and Osteoporosis Services. Available at: http://www.nhsggc.org.uk/CONTENT/default.asp?page=s1361

- Primary preventative awareness raising (campaigns, information) to reach those 75 years and over, and their family and carers
- Training and awareness raising of actions to reduce falls for the health, social care, VCO and wider workforces
- Building system level partnership to reduce falls

UnitingCare are currently considering pathways and approaches for the provision of multi-factorial assessments and interventions.

Cost saving prevention initiatives – possible areas of focus

A Cochrane review in 2012[52] on interventions for preventing falls in community-living older people identified thirteen trials providing a comprehensive economic evaluation. Three of these indicated cost savings for their interventions during the trial period: home-based exercise (the Otago Exercise Programme) in over 80-year-olds, home safety assessment and modification in those with a previous fall, and one multifactorial programme targeting eight specific risk factors. In the multi-factorial programme, total average costs were approximately US$2000 [~GBP £1310] less per subject in the intervention group than the usual care group, largely reflecting lower hospitalisation costs in those who received the intervention[53].

A prior review in New Zealand identified the same three cost-saving approaches as Cochrane, and found that best value for money came from effective single factor interventions such as the Otago Exercise Programme in adults 80 years and older[54]. A cost-benefit analysis in 2014 of three specific exercise interventions demonstrated positive net benefits for each programme[55]. The Otago Exercise Programme provided a return on investment of 36% for each dollar invested when delivered to persons aged 65 and over, and an ROI of 127% when delivered to 80 year olds and over (comprising a net benefit of $429.15). The highest ROI was found for Tai Chi at 509%. The ROI for the Australian Stepping On programme (21 hours of occupational therapist-led group exercises, and falls prevention advice) was 64%.

[52]Gillespie LD, Robertson MC, Gillespie WJ, Sherrington C, Gates S, Clemson LM, Lamb SE. Interventions for preventing falls in older people living in the community. Cochrane Database of Systematic Reviews 2012, Issue 9. Art. No.: CD007146. doi: 10.1002/14651858

[53]Rizzo JA, Baker DI, McAvay G, Tinetti ME. The cost effectiveness of a multi-factorial targeted prevention program for falls among community elderly persons. Medical Care 1996;34(9):954–69.

[54]Davis JC, Robertson MC, Ashe MC, Liu-Ambrose T, Khan KM, Marra CA. Does a home-based strength and balance programme in people aged > or =80 years provide the best value for money to prevent falls? A systematic review of economic evaluations of falls prevention interventions. Br J Sports Med 2010; 44: 80–9.

[55]Carande-Kulis V, Stevens JA, Florence CS, Beattie BL, Arias I. 2015 A cost-benefit analysis of three older adult fall prevention interventions.J Safety Res. 2015 Feb;52:65-70. doi: 10.1016/j.jsr.2014.12.007.

Alongside the evidence for single factor interventions, modelling by the Center for Disease Control has identified that community-based multi-disciplinary programmes are well tolerated and their potential offer in terms of health economics is great[56].

Cost savings associated with the implementation of interventions have been reported at population scale; a multi-disciplinary programme in a population of 400,000 in New South Wales, Australia showed a benefit to cost ratio of 20.6:1[57]. Over a 4-year period, the programme generated savings of up to A$16.9 million [~GBP £7.91million].

In the US, a cohort study demonstrated savings of US$938 [~GBP £615] per person at 1 year among older people participating in the 'Matter of Balance' intervention which addresses fear of falling and activity limitation[58]. The majority of the savings (US$517) amount from reduced unplanned hospitalisations. The programme is currently delivered in 38 of the 50 United States. A study modelling the potential for savings from Matter of Balance for Massachusetts calculated a return on investment of 144%. As there is no current uptake data available, savings were calculated for three participation levels: 25%, 50% and 75%, and found to range from US$2.79million to $8.37million.

Further detail from economic modelling for a population health falls prevention programme[59] shows a high incremental cost-effectiveness ratio (ICER) of $A28,631 [GBP£13577] per QALY gained. Sensitivity analyses indicated that the public health outcomes were greater and less costly than no programme, when programme costs were $A500 or lower and risk ratio for falls was 0.70 or lower, indicating that a population-wide approach will be most appropriate, and cost-saving, with effective and relatively low cost interventions.

Where should the strategic focus be?

There is clear evidence that falls prevention interventions are cost effective when modelled across the population. Any cost saving benefits may be realised only by working at population scale, however, concerted action will be required to avoid increases in service utilisation. Specific components of falls prevention e.g. medication reviews are likely to also be cost saving but our current models are not sufficiently sophisticated to identify this. Further detail will need to be added to inform the development local work.

[56]Hanley, A., Silke, C., & Murphy, J. (2011). Community-based health efforts for the prevention of falls in the elderly. Clinical Interventions in Aging, 6, 19–25. doi.org/10.2147/CIA.S9489

[57]Hanley, A., Silke, C., & Murphy, J. (2011). Community-based health efforts for the prevention of falls in the elderly. Clinical Interventions in Aging, 6, 19–25. doi.org/10.2147/CIA.S9489

[58]Ghimire E, Colligan EM, Howell B, Perlroth D, Marrufo G, Rusev E, Packard M. (2015) Effects of a Community-Based Fall Management Program on Medicare Cost Savings. Am J Prev Med. 2015 Sep 15. doi: 10.1016/j.amepre.2015.07.004.

[59]Farag I., Howard K., Ferreira ML., Sherrington C. (2015) Economic modelling of a public health programme for fall prevention. Age and Ageing 2015; 44: 409–414. doi: 10.1093/ageing/afu195

Recommendation

- Further development of models to estimate the cost savings to the NHS of local multi-component falls interventions accurately is in progress.
- Potential savings may require delivery of preventative approaches at much wider scale than current provision.

11. Malnutrition in older people

Headlines

- An estimated 13,000 to 18,300 older people are malnourished in the Cambridgeshire & Peterborough population, and more are at risk
- Potential cost savings may be achieved by increasing proportion screened for malnutrition among inpatients, outpatients and new GP registrations to 90% and appropriate treatment; with investment of £524k and savings in the order of £543k primarily from reducing length of stay in acute care. At worst this intervention should not cost the NHS additional funding, and will improve quality of life for older people.

Background

Malnutrition is measured as a Body Mass Index (BMI) lower than 18.5kg/m2 or unintentional 10% weight loss. The annual health care costs associated with malnutrition are primarily due to more frequent and expensive hospital in-patient admissions, more primary care consultations and the greater long-term care needs of malnourished individuals. About two thirds of cases of malnutrition are not recognised.

Current position

What is the scale of the problem?

It is estimated that there are around one million older people in the UK who are malnourished or at risk of malnutrition. The vast majority (93%) of people who are malnourished or at risk of malnutrition are living in the community, with a minority in care homes (5%) or in hospital (2%). It is estimated that 25-28% of admissions to hospital and 30-41% of admissions to care homes are at risk of malnutrition.

There is a paucity of local data about the prevalence or costs of malnutrition, so local estimates are drawn from risk factors, or applying national estimates to the population; it is estimated that 10-14% of the population aged 65 years and over in England are malnourished.

Cambridgeshire

In Cambridgeshire life expectancy at birth is significantly higher for both males and females compared to the national average, so there is potential for high prevalence of malnutrition. Applying national estimates there is an estimated 10,000 to 14,000 older residents of Cambridgeshire, or about one in 50 people in the general population, who are malnourished. In terms of lifestyle and psychosocial risk factors, approximately 29% of older people live alone in Cambridgeshire (29,000 people), and these people may also be at increased risk of malnutrition.

Peterborough

In 2016 in Peterborough 15% of the population will be aged 65 years and over (30,416 people), indicating an estimated 3000 to 4300 older people who are malnourished.

Population changes in older people are described in the section on falls.

The health consequences and costs

Disease-related malnutrition costs in excess of £13 billion per annum based on malnutrition prevalence figures and the associated costs of both health care and social care[60]. The annual health care costs associated with malnutrition are primarily due to more frequent and expensive hospital in-patient admissions, more primary care consultations and the greater long-term care needs of malnourished individuals[61].

Interventions and cost savings to the NHS

On a national level in 2013 NICE identified malnutrition as the sixth largest source for potential NHS savings[62]. Early identification and treatment of malnutrition in adults could save the NHS £45.5 million a year even after costs of training and screening[63].

The interventions centre on screening eligible population groups, and for those identified, dietetic assessments and interventions. The cost impact of modelling for increasing the proportion of the local population screened is shown in table 25.

[60]Brotherton A, Simmonds N & Stroud M. Malnutrition Matters. Meeting Quality Standards in Nutritional Care. BAPEN. 2012.
[61]Brotherton A, Simmonds N & Stroud M. Malnutrition Matters. Meeting Quality Standards in Nutritional Care. BAPEN. 2012.
[62]Benefits of Implementation: Cost saving guidance, NICE, (updated) 2013
[63]National cost impact report to accompany CG32, NICE, 2006

Table 25:Cost impact of increasing proportion screened to 90% from current (national) estimates of 65% of inpatients 15% of outpatients and 10% of GP new registrations. National estimates based on expert opinion (NICE)

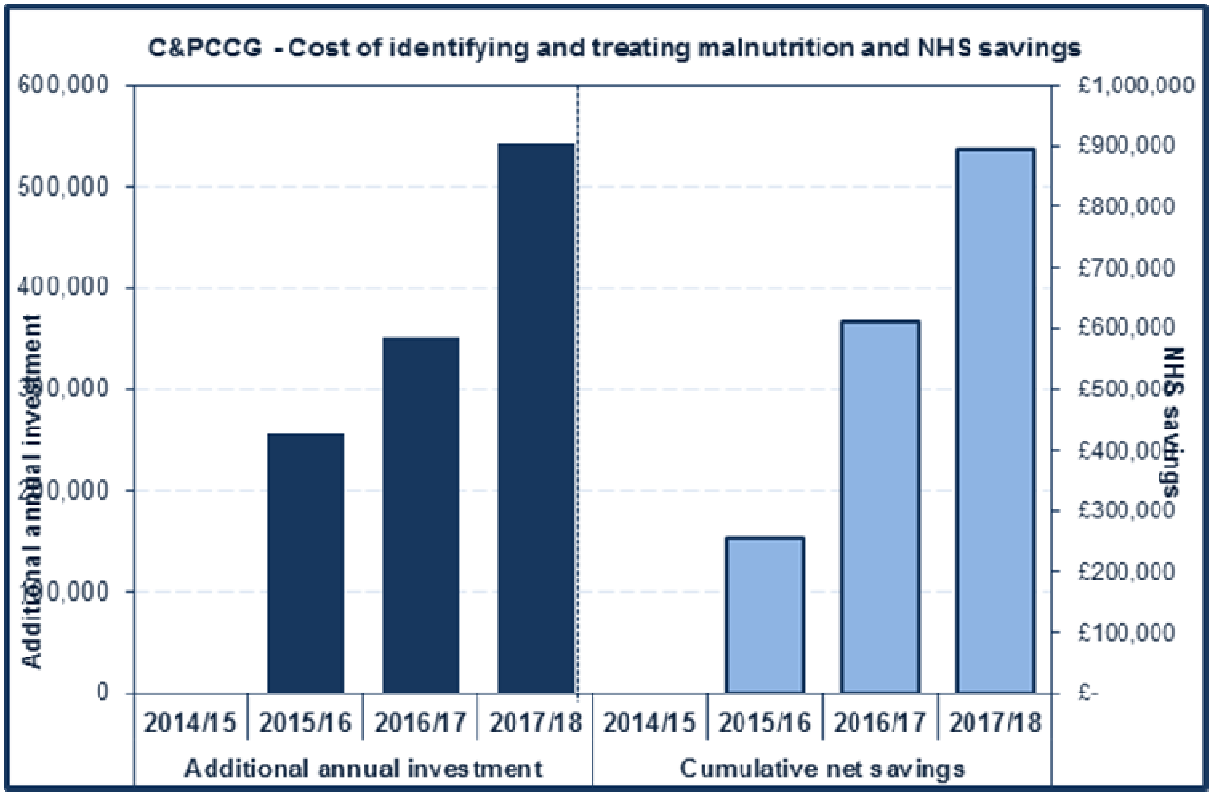
	Cost impact (£000s)	Cost impact C&P CCG (£)
Increase in screenings - direct costs 5-minute 'MUST' screening by a nurse in various settings	£38.9	£294,528
Increase in nutritional assessments - direct costs 45 minute assessment by a dietician, in the community or secondary care	£10.8	£81,771
Increase in nutritional interventions Includes net ingredient costs and costs associated with administration of oral supplements, enteral and parenteral nutrition	£22.0	£166,571
Additional annual investment cost		£542,870
Decrease in secondary care activity Primarily from decreased length of stays	£143.6	£1,087,254
Net cost	**£71.8**	**£543,627**

Source: Implementation Programme: NICE support for commissioners using the quality standard on nutrition support in adults November 2012. Applied to CCG Population April 2015 (FHS Registration System (Exeter)

There are important limitations in the model. As noted, the baseline screening proportions are based on national expert opinion; it is not known how well these align with local practice. The cost savings are realised through improved secondary care outcomes i.e. a reduction of the level of malnutrition in the population. The NICE template does not detail the inter-relationship of the elements e.g. proportion screened and proportion referred for a nutritional assessment, to allow more precise adjustments in line with local activity. The costing model does also not take into account specific interdependencies, such as the fact that those who are malnourished are less likely to respond well to treatment for other conditions, and therefore are likely to cost the NHS and social care more.

An indicative trajectory may be described as:

Figure 15: Cost of identifying and treating malnutrition and NHS savings



Work already planned

Current activity to identify malnutrition and improve nutritional status in older people is not known in detail. Good practice in acute settings was highlighted in the work on malnutrition for the Cambridgeshire JSNA Primary Prevention of Ill health in older people 2014. The training of care staff and the provision of general services in the community by VCOs such as transport schemes, hot meal delivery schemes, and lunch clubs, are significant local assets.

Cost saving prevention initiatives – possible areas of focus

As suggested by the model, focus is required on screening at key junctures, referral for assessment, and the appropriate interventions.

Recommendations

- Potential cost savings may be achieved by increasing proportion screened for malnutrition among inpatients, outpatients and new GP registrations to 90% and appropriate treatment; investment of £524k and savings in the order of £543k primarily from reducing length of stay in acute care. At worst this intervention should not cost the NHS additional funding, and will improve quality of life for older people.

12. Sexual health

Headlines

- For every £1 invested in contraception services, there is a £11.09 saving to the NHS, rising to £13.42 for LARCs.
- It is proposed that we increase the number of women with long-acting reversible contraceptives (LARCs) by approximately 859 a year in Cambridgeshire & Peterborough. This should generate savings of £935k in 2016/17, £1.15m in 2017/18 and £1.26m in 2018/19.
- This would require an additional investment of £115k. However, the additional investment needed for Cambridgeshire, is already within the Council budget proposals for 2016/17.

Background

Long-acting reversible contraception (LARC) is a method of contraception that requires administering less than once per cycle or month. Included in the category of LARC are the copper intrauterine devices (non-hormonal) and three progestogen-only methods of contraception (intrauterine system, injectables and the implants).

It is clear that investment in contraception services not only helps to avoid the personal and social costs of unintended pregnancies, but is also economically effective. According to the Government, the prevention of unintended pregnancy by NHS contraception services probably saves the NHS over £2.5 billion a year, and research has shown that every £1 spent on contraception services saves the NHS £117.

There is widespread agreement that increasing use of long-acting reversible contraception (LARC) in women at all stages of their reproductive lives is a vital component of the strategy to reduce unwanted fertility. Improving both access to and provision of LARC methods was recommended by the 2005 NICE guideline on LARC,1 which was updated in 2014. It highlighted that these contraceptive methods were both more effective and cost efficient when compared with the most popular user-dependent methods. Long-acting reversible contraceptive methods consistently achieve superior efficacy by reducing user error.

Current position

In 2015/16 we have seen a considerable drop in LARC activity in Cambridgeshire. This is largely due to a gap in trained GPs retiring and a new cohort of GPs being trained. This has brought the rate of LARCs down in Cambridgeshire to 68 per 1000 population, or 8,168 LARCs, compared to 82 per 1000 population, or 3,101 LARCs in Peterborough.

Interventions and cost savings to the NHS

For every £1 invested in contraception services there is a £11.09 saving, rising to £13.42 for LARCs[64]. NICE estimated in 2005 that 8% shift to the use of LARCs from other types of contraception would result in £102 million savings nationally (more if those not using any contraception were factored in) e.g. population of 40,000 15-49 year old females could produce £300,000 savings at one year.

There are also costs saved to social care and longer term educational and employment outcomes.

Work already planned

The shortfall in the sexual health budget related to the decrease in LARC activity in Cambridgeshire has been identified by the Health Committee as an area of focus, where they would like to see increased activity. The saving from this drop in activity is not anticipated for 2016/17.

Cost saving prevention initiatives – possible areas of focus

The following two graphs and tables set out the planned future activity for LARC, the additional investment and the NHS savings per year. We have used conservative estimates of the impact of costs saved to the NHS.

For Cambridgeshire where activity levels have fallen, the ambition is to increase the number of LARCs by approximately 747 a year by 2018/19. The additional investment needed for Cambridgeshire has already been identified within the 2016/17 Public Health budget, and the savings to the NHS are estimated to be £1.1m by 2018/19.

Cost saving prevention initiatives – possible areas of focus

The following two graphs and tables set out the planned future activity for LARC, the additional investment and the NHS savings per year. We have used conservative estimates of the impact of costs saved to the NHS.

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[64]The Cost Effectiveness of family planning service provision. D Hughes and A McGuire. Journal of Public Health medicine vol 18 No 2, pp189-196 (1996).

Figure 16: Cambridgeshire planned number of LARCs, investment and NHS savings

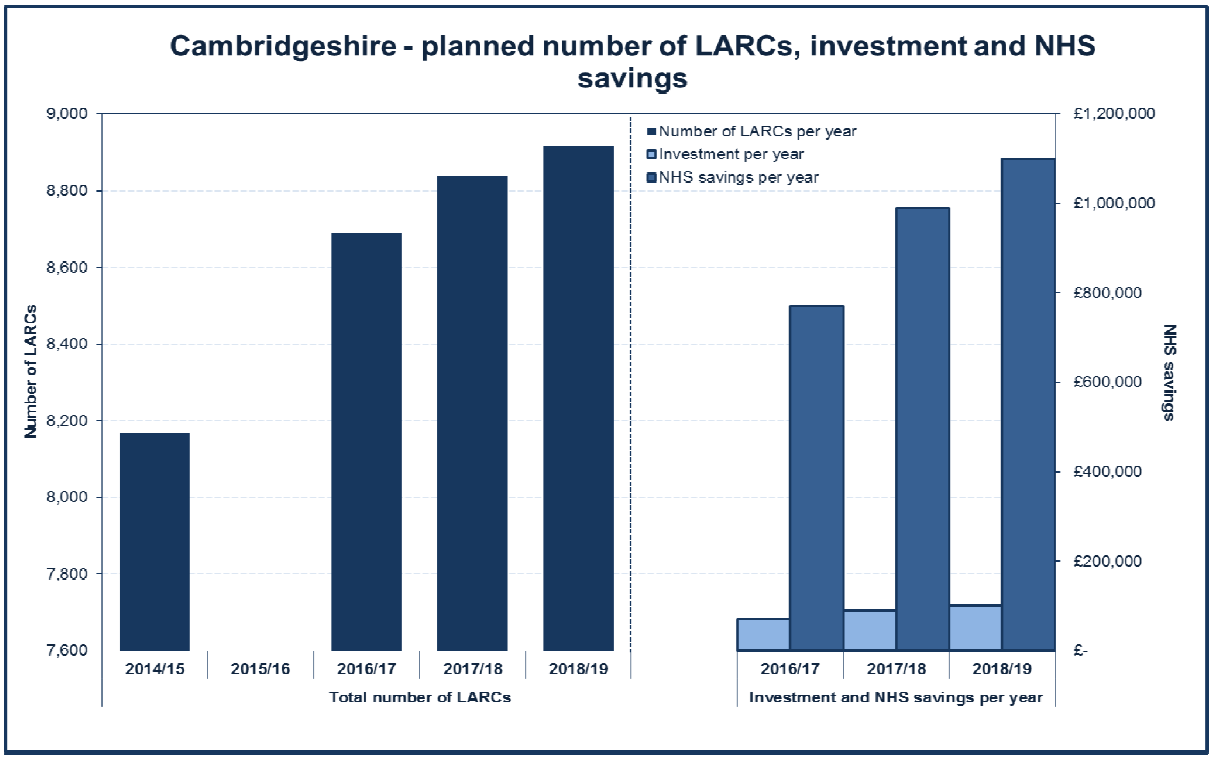

Table 26: Cambridgeshire planned number of LARCs, investment and NHS savings

Cambridgeshire	2014/15	2015/16	2016/17	2017/18	2018/19
		Projections suggest that this years activity will be broadly in line with 2014/15 or marginally lower.			
Current activity	8,168				
Current investment	£1,094,125				
Additional number of LARCs	-		523	672	747
Additional investment	-		£70,000	£90,000	£100,000
Savings	-		£770,000	£990,000	£1,100,000
Number of LARCs per year	-		8,691	8,840	8,915

Peterborough activity on LARCs is already fairly high and so this additional activity is based on a small increase in LARC activity of 112 LARCs a year, and additional investment of £15,000 a year. The net savings (savings after the investment costs) are £165m by 2018/19.

Figure 17: Peterborough planned number of LARCs, investment and NHS savings

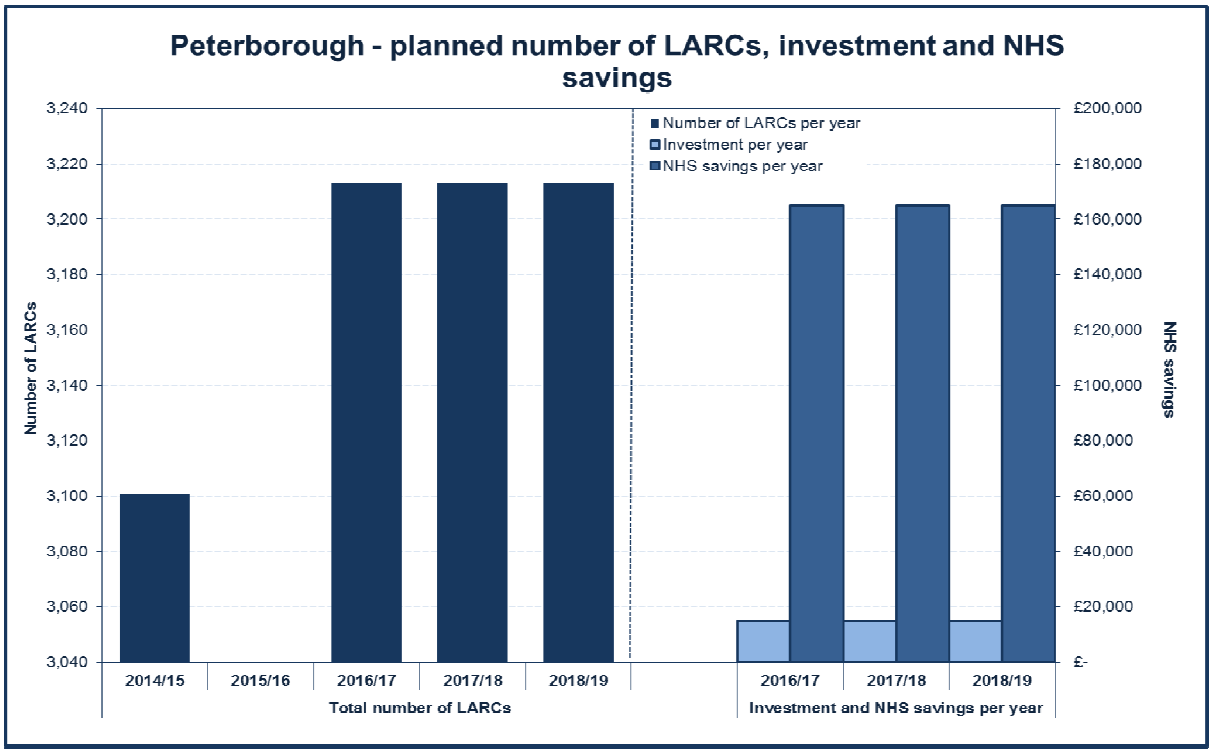

Table 27: Peterborough planned number of LARCs, investment and NHS savings

Peterborough	2014/15	2015/16	2016/17	2017/18	2018/19
		Projections suggest that this years activity will be broadly in line with 2014/15.			
Current activity	3,101				
Current investment	£415,387				
Additional number of LARCs	-		112	112	112
Additional investment	-		£15,000	£15,000	£15,000
Savings	-		£165,000	£165,000	£165,000
Number of LARCs per year	-		3,213	3,213	3,213

It is important to note that the estimated number of additional LARCS is based on an average cost for the device and fitting and therefore the final number will vary depending on the type of LARC chosen.

Recommendations

LARCs are highly cost saving to the NHS. An additional investment of £115k will generate savings of £935k in 2016/17, £1.15m in 2017/18 and £1.26m in 2018/19.

13. Breastfeeding

Headlines

- Low breastfeeding rates in the UK lead to an increased incidence of illness that has a significant cost to the health service. Investment in evidence-based multi-faceted interventions has been shown to generate savings to the health economy, in the short term, by reducing hospital admissions for four acute childhood illnesses[65].
- There is evidence to suggest that breastfeeding can contribute to longer term savings through its impact on key health outcomes, including childhood obesity, but this is difficult to quantify.
- The focus should be on joint commissioning with local authorities to improve breastfeeding support, and implementing or piloting interventions in both acute and community settings. These interventions should include strengthening breastfeeding support and advice in acute settings, and easily accessible breastfeeding peer support programmes focused on the most deprived areas of the CCG.

Background

Breast milk is the best form of nutrition for infants, and exclusive breastfeeding is recommended for the first six months (26 weeks) of an infant's life[66].

Breastfeeding contributes to various important public health outcomes including[67]:

- reduction of the infant mortality rate;
- reduction of preventable infections and unnecessary paediatric admissions in infancy;
- the halting of the rise in obesity in under 11s;
- improving children's life outcomes and general wellbeing; and
- breaking the cycle of deprivation and reducing the impact of health inequalities.

Despite the overwhelming health benefits and cost savings of breastfeeding, initiation rates in the UK are around the lowest in Europe, and worldwide, with rapid discontinuation rates for those who do start[68].

[65]Renfrew MJ, et al. ''Preventing disease and saving resources: the potential contribution of increasing breastfeeding rates in the UK' (2012) UNICEF. Available at: http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&ved=0CCcQFjABahUKEwjxtcW__PHIAhXLtxQKHRZqBNk

[66]http://www.nhs.uk/conditions/pregnancy-and-baby/pages/why-breastfeed.aspx

[67] NICE. Dyson, L. et al. 'Promotion of breastfeeding initiation and duration Evidence into practice Briefing' (2006). Available at: https://www.nice.org.uk/proxy/?sourceUrl=http%3a%2f%2fwww.nice.org.uk%2fnicemedia%2fpdf%2fEAB_Breastfeeding_final_version.pdf

Young mothers with a lower level of education and low income are the least likely to breastfeed their baby. Across the UK, at three months, the number of mothers breastfeeding exclusively was 17% (up from 13% in 2005) and at four months, it was 12% (up from 7% in 2005). Breastfeeding initiation and prevalence of breastfeeding at 6-8 weeks is a key health improvement indicator measured in the Public Health Outcomes framework[69].

Key Facts

- Breastfed babies have a reduced risk of respiratory infections, gastroenteritis, ear infections, allergic disease and Sudden Infant Death Syndrome. Breastfed babies may have better neurological development and be at lower risk of tooth decay and cardiovascular disease in later life.
- There is evidence to suggest that breastfed babies may experience benefits that continue into later life, including being less likely to be overweight or obese.
- Breastfeeding has been shown to have benefits for both mother and baby including promoting emotional attachment between them. Women who breastfeed are at lower risk of breast cancer, ovarian cancer and hip fractures/reduced bone density.

Current position

Breastfeeding rates at 6-8 weeks after birth are monitored through the Health Visiting contract and reported nationally to Public Health England.

Figures for quarter 1 of 2015-2016 show that; 55.4% of mothers in Cambridgeshire, and 44% in Peterborough, report that they are breastfeeding at 6-8 weeks compared to 43.4% in England. Breastfeeding levels remain lowest in areas of highest deprivation. Therefore, although rates in Cambridgeshire are better than the England average, there remains significant room for improvement.

Interventions and cost savings to the NHS

NICE Public Health Guidance 11 on maternal and infant nutrition[70] identifies key interventions to improve breastfeeding initiation and duration as a priority and recommends the following. These include adopting a multi-faceted approach or a co-ordinated programme of interventions across different settings to increase breastfeeding rates.

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[68]DH/DCSF. (2009) 'Commissioning local breastfeeding support services'. Available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_106497.pdf

[69]Public Health Outcomes Framework web tool: 2.02 Breastfeeding. Available at: http://www.phoutcomes.info/public-health-outcomes-framework#page/7/gid/1000042/pat/6/par/E12000006/ati/102/are/E10000003/iid/20202/age/170/sex/4

[70]NICE Guidance PH11: Maternal and child nutrition (2008). Available at: http://www.nice.org.uk/guidance/ph11/chapter/1-Key-priorities#breastfeeding

A systematic review published by UNICEF in 2012 identified economic savings from a multi-faceted intervention based on evidence-based guidelines including this NICE guidance. The study made a conservative estimate that assuming a moderate increase in breastfeeding rates, if 45% of women exclusively breastfed for four months, and if 75% of babies in neonatal units were breastfed at discharge, every year there could be an estimated £17 million gained nationally by avoiding the costs of treating four acute diseases:

- 3,285 fewer gastrointestinal infection-related hospital admissions and 10,637 fewer GP consultations, with over £3.6 million saved in treatment costs annually;
- 5,916 fewer lower respiratory tract infection related hospital admissions and 22,248 fewer GP consultations, with around £6.7 million saved in treatment costs annually;
- 21,045 fewer acute otitis media (AOM) related GP consultations, with over £750,000 saved in treatment costs annually;
- 361 fewer cases of NEC, with over £6 million saved in treatment costs annually.

There were also found to be cost savings to the NHS of over £21 million nationally, due to fewer cases of breast cancer, if half of those mothers who currently do not breastfeed were to do so for up to 18 months of their lifetime. This was based on an estimated 865 fewer cases of breast cancer nationally.

Further evidence suggests that savings could be made in relation to reducing obesity, although insufficient data was available for sophisticated economic modelling. It was estimated that increasing breastfeeding rates could lead to around a 5% reduction in childhood obesity, which would save around £1.6million each year across the UK.

Very crude modelling using these conservative national figures can be used to extrapolate possible cost savings per head of the UK population to our local population. In total the savings from the UNICEF report for the UK is £17.1 million if 45% of mothers were to exclusively breastfeed at 4 months. If this is divided by the number of UK births (45% of 776,352) you could estimate £48.80 would be saved for every baby exclusively breastfed to 4 months. If we assume an average breastfeeding rate of 15% at 4 months at present (based on the UNICEF report), it could be extrapolated that £155k might therefore be saved across Cambridgeshire and Peterborough by increasing this rate to 45%. It should be emphasised that this is a very crude calculation and estimate, and also that the economic modelling on which it is based was very conservative.

A case study in the UNICEF report of multi-faceted interventions in Lancashire (population 1.5 million, 13,000 births, deprivation, breastfeeding initiation rates 66-68%, and rates 32-39% at 6 weeks) found there was an annual cost saving of between £82-553K depending on the range of improvement in breastfeeding rates, assuming approximately £446K was spent on interventions.

Work already planned

Promotion and support for breastfeeding is one of six key high impact priorities for health visitors and is specified in the Health Visiting Contract for Cambridgeshire and Peterborough services[71].

Currently in Peterborough, the NCT are commissioned to co-ordinate the provision of 4 Baby Cafés across Peterborough and to train and manage peer supporters, working in partnership with midwifery and health visitors. In Cambridgeshire, peer support groups are largely volunteer run and led, with focus on Cambridge city and there is limited support in areas of deprivation.

However, key opportunities exist to build on the support from health visitors and provide community support and actions across health and other agencies to achieve maximum impact, and a multi-agency forum in Cambridgeshire has been working on a draft Breastfeeding strategy for Cambridgeshire.

With significant budget cuts to local authority funding, there are important opportunities for the Clinical Commissioning Group (CCG), to jointly commission relatively low cost interventions to invest in training and workforce development in acute trusts, to build community resilience and support and to focus on areas of high deprivation.

Where should the strategic focus be?

Strategic focus should be on the core objectives outlined in NICE to achieve a multi-faceted intervention programme, which also focuses resources on parents in the most deprived areas.

Recommendations

The focus should be on joint commissioning with local authorities to improve breastfeeding support and, implementing or piloting interventions in both acute and community settings. These interventions should include strengthening breastfeeding support and advice in acute settings, and easily accessible breastfeeding peer support programmes focused on the most deprived areas of the CCG.

[71]NHS England. '2015 – 16 National Heath Visiting Core Service Specification ' (2014) Available at: https://www.england.nhs.uk/wp-content/uploads/2014/12/hv-serv-spec-dec14-fin.pdf

14. Appendices

Appendix A: What is included and what is not in this strategy

Areas of focus and rationale

Area in scope	Intervention in scope	Rationale
Obesity, weight management, diet and physical activity (adults and older people)	Adult weight management services (non-surgical) tiers 2 and 3	• Evidence strength – High • Cost saving to NHS • Can calculate short term effectiveness
	Breastfeeding support	• Evidence strength – High • Can calculate global savings only.
	Physical activity and brief advice	• Evidence strength – High • Cost saving to NHS • Savings long term to NHS, majority of savings in increased productivity.
	Physical activity and walking interventions	• Evidence strength – Medium • Cost saving to NHS • Savings long term to NHS, majority of savings in increased productivity
Diabetes prevention	Management of hyperglycaemia	• Management once diagnosed not addressed here. However, high level evidence supports impact of lifestyle interventions.
	Focused screening/lifestyle interventions with South Asian population.	• High level evidence from NICE guidance economic modelling and subsequent modelling that this is cost saving in the long term.
Cardiovascular disease	Cardiac rehabilitation	• High level evidence can reduces readmissions by 30%. Can model potential savings.
	Atrial fibrillation (AF) management	• High level evidence can reduce stroke risk. Can model potential savings.
	Hypertension management	• High level evidence can manage risk through lifestyle management. Can model potential savings.
Supported self-care for long term conditions (LTCs)	Mental health screening and treatment for comorbid LTCs	• Currently insufficient evidence to support the implementation of routine screening for depression/anxiety. • Medium level evidence from outside of the UK that psychological interventions for those with LTCs may be cost saving, or at least cost neutral.
	Other LTC self-management programmes – diabetes, asthma management / chronic obstructive	• Evidence strength – full range from low to high. • High level evidence COPD and cardiac

	pulmonary disease (COPD), cardiac best evidence	rehab can reduce healthcare costs. • Possible to model potential COPD savings.
Workplace health for NHS as an employer	Mental health interventions	• Evidence strength – High • Potential saving to NHS • Can calculate NHS productivity savings
	Stop smoking interventions	• Evidence strength – High • Cost saving to NHS • Savings in line with smoking section
	Physical activity interventions in the workplace	• Cost saving to NHS as an employer • Can calculate productivity savings
Smoking and tobacco control	Specialist smoking cessation services	• Evidence strength – High • Savings to NHS • Can calculate savings
	Stop before the op	• Evidence strength – High • Likely to be cost saving above standard smoking cessation
	Smoking cessation in pregnancy	• Evidence strength – High • Savings to NHS • Can calculate savings
Alcohol	Screening for the identification of people at risk of or misusing alcohol and brief interventions and extended brief interventions.	• Evidence strength – High • Potentially cost saving to NHS • Can calculate savings
Falls in older people	Falls in older people	• Evidence strength – High • Cost saving to NHS • Can model potential savings
Malnutrition in older people	Malnutrition in older people	• Evidence strength – Medium • Can model potential savings using NICE tool.
Sexual health	Contraception – Long-acting reversible contraception (LARC)	• Cost saving to NHS • Can calculate savings

Areas and interventions out of scope

There are also a number of areas and interventions that have been considered, but are not within the scope of this plan. These areas and interventions are generally where the evidence base is not so strong, where there is less potential financial impact (or savings are not to the NHS), and/or the information is not available to model reasonable estimates of NHS savings, within the timescales of this work.

Area out of scope	Intervention out of scope	Rationale
Mental health	Preventing postpartum depression through psychosocial and psychological interventions	• Evidence strength – High • Limited cost effectiveness evidence. • Savings wider than NHS.
	Physical health interventions for those with severe mental illness e.g. smoking cessation/diet/physical activity	• Evidence strength – Medium • No specific additional NHS savings above general lifestyle management interventions.
	Tier 2 & 3 mental health services for children and young people.	• Evidence strength – High • Possibly cost saving (early intervention) but levels of unmet need high • Not possible to model NHS cost reduction as a result of intervention. Early intervention in psychosis an exception to this.
	Suicide prevention – GP Suicide Prevention Training	• No cost saving to NHS • Vast majority of savings to wider economy.
Obesity and weight management	Oral health	• NICE didn't find initiatives cost saving.
	Children's weight management programmes	• Evidence strength – Medium • Potentially cost saving to NHS, but no long term evidence to base this on. • Can calculate intervention effectiveness but not long term savings.
	Physical activity and school playgrounds	• Evidence strength – Medium • Evidence of cost savings to NHS inconclusive.
Physical activity	Brief intervention and referral in primary care	• Evidence strength – High • Cost saving • Cost saving in v long term potentially. Can't quantify currently.
Other Older people	Reablement	• Lack of robust evidence of NHS savings.
	Flu uptake in workforce	• Lack of robust evidence of NHS savings
Children	Early years centres' nutrition policy	• Evidence strength – High • Probable cost savings to NHS, but no evidence • No economic modelling
	Parenting programmes	• Cost savings but mainly to criminal justice,

		education and social services
Other parenting support in early years – intensive home visiting/FNP	Family Nurse partnership	• Recent evidence finds FNP not cost effective.
Diet	Domestic violence interventions (IDVAs)	• Evidence strength – medium. • Small cost savings to the NHS, majority to CJS.
	Chronically excluded adults	• Evidence strength – Medium Possible savings to NHS but very small. Majority savings to criminal justice system.
Social prevention	Debt advice	• Evidence strength – Medium (Low for primary care) • Small savings to NHS but majority to wider economy.
	Warm homes / reduction in fuel poverty	• Evidence strength – high. • NHS savings difficult to calculate (are some related to COPD). Majority wider savings, and difficulties with varying intervention definitions.
	Local Sugar Tax	• Issues with local implementation
	Local alcohol licensing approaches	• Issues with local implementation, particularly costs of legal challenge.
	Reducing social isolation	• Medium level evidence. • Likely to be some NHS savings, but evidence not strong enough to model these. Community navigator type programmes promising.

Appendix B: Public Health Reference Group evidence review - matrix indicating Agency Involvement and quality of evidence (Nesta Scale)

Note: Lower quality of evidence may be due to the nature of the intervention and how easy it is to research, rather than its overall effectiveness and impact.

Key: Quality of Evidence
High Ranking **H** Middle Ranking –**M** Lower Ranking - **L**

No.	Intervention	CCG/NHS	CCC Public Health	CCC Children's Services	CCC Adult Services	CCC Environ-Ment/ Planning	District Councils	Voluntary Sector	Police
1	**Diet**								
1.1	Breastfeeding peer support	**H**	**H**	**H**				**H**	
1.2	Early years centres nutrition policy		**H**	**H**				**H**	
1.3	*Reducing socio-economic inequalities in obesity in children and adults*								
1.3.1	Targeted school based approaches		**M**	**M**					
1.3.2	Workplace health (as employer)	**M**	**M**	**M**	**M**	**M**	**M**	**M**	**M**
1.3.3	Workplace health as commissioner for private sector workplaces	**M**	**M**				**M**		
1.4	Targeted primary care-delivered weight loss programmes	**M**	**M**						
1.5	Group based counselling and community engagement approaches	**L**	**L**				**L**	**L**	
2	**Weight Management**								

	Interventions								
2.1	Weight Management during and after pregnancy	**M**	**M**						
2.2	Children's Weight Management Services	**M**	**M**						
2.3	Adult Weight Management Services (non-surgical)	**H**	**H**						

	Intervention	**CCG/NHS**	**CCC Public Health**	**CCC Children's Services**	**CCC Adult Services**	**CCC Environ-ment & Planning**	**District Councils**	**Voluntary Sector**	**Police**
3	**Physical Activity programmes**								
3.1	Physical Activity and Young Children		**M**	**M**		**M**	**M**		
3.2	*Physical Activity and Workplaces*								
3.2.1	Workplace health (as employer)	**M**	**M**	**M**	**M**	**M**	**M**	**M**	**M**
3.2.2	Workplace health as commissioner for private sector workplaces	**M**	**M**				**M**		
3.3	Physical activity in the community Increasing accessibility/community engagement	**L**	**L**				**L**	**L**	
3.4	Exercise Referral	**L**	**L**				**L**		
3.5	Physical Activity and Brief Advice	**H**	**H**				**H**		
3.6	Physical activity and technology	**L**					**L**		
3.7	Physical activity and	**M**	**M**				**M**	**M**	

	walkinginterventions								
4	**Physical Activity and the Physical Environment**								
4.1	Physical Activity and Planning		**L**	**L**		**L**	**L**		
4.2	Physical Activity and Transport		L			**L**	**L**		
	Intervention	**CCG/NHS**	**CCC Public Health**	**CCC Children's Services**	**CCC Adult Services**	**CCC Environ-ment & Planning**	**District Councils**	**Voluntary Sector**	**Police**
4.3	Physical Activity and Cycling					**L**	**L**		
4.4	Physical Activity and Walking (infrastructure)		**L**			**L**	**L**		
4.5	Physical Activity and Public Open Spaces		**L**			**L**	**L**		
4.6	Public Open Spaces and Public Paths					**L**	**L**		
4.7	Physical Activity and Workplaces								
4.7.1	Workplace health (as employer)	**M**	**M**	**M**	**M**	**M**	**M**	**M**	**M**
4.7.2	Workplace health as commissioner for private sector workplaces	**M**	**M**				**M**		
4.8	Physical Activity and School Playgrounds		**M**	**M**			**M**		
5.	**Older People – prevention**								
5.1	Older People and Malnutrition	**M**			**M**				
5.2	Older People and Physical Activity interventions	**H**					**H**		

Agenda Item No: 8

PLANNING INTENTIONS FOR CAMBRIDGESHIRE AND PETERBOROUGH 2016/17

To: Health and Wellbeing Board

Date: 19 November 2015

From: Sarah Shuttlewood, Director of Contracts, Performance and Delivery, NHS Cambridgeshire and Peterborough Clinical Commissioning Group

1.0 PURPOSE

1.1 The purpose of this report is to brief the Board on the work undertaken to date in identifying the 2016/17 planning intentions for the Cambridgeshire and Peterborough System. The Board is invited to comment.

2.0 BACKGROUND

2.1 At the end of September each year, Commissioners set out for their providers their commissioning intentions and priorities for the next financial year. This signals the start of the next financial year's planning and commissioning cycle.

2.2 As a result of the substantial work to date of the System Transformation Programme in Cambridgeshire and Peterborough, we have adopted a different approach for 2016/17 planning. Ultimately, our aim is to move towards a system-wide approach to planning through working collaboratively with providers and Local Authority colleagues to identify jointly our priorities. However, this will take several years to achieve in full.

2.3 Consequently, for 2016/17 planning, we have taken a first step in that direction by framing the operational priorities for 2016/17 within the context of the strategic direction for the System. This report highlights some of the key priorities and strategic developments for 2016/17. A copy of the full planning intentions paper can be accessed through the CCG website (see Section 7).

3.0 OVERVIEW OF THE PLANNING INTENTIONS FOR 2016/17

3.1 Strategic Planning Intentions

Two significant strategic transformational initiatives are planned and have been summarised below.

3.1.1 Creating Hospital Alliances and Accountable Clinical Networks

a) We will develop plans to enable hospitals to work more closely with increased sharing of medical expertise across sites through the establishment of accountable clinical networks. Initially, this work will focus on four clinical specialties comprising Orthopaedics, Ear Nose and Throat, Ophthalmology and Cardio-vascular Disease. Research and teaching opportunities for tomorrow's patients and clinicians will be created as a result of this work.

b) 2016/17 will be a year of preparation. New clinical pathways for the four specialties will be implemented in 2017/18 at the latest, with work planned to be underway during 2016/17. Additional networks in other areas will be developed thereafter, for example, Medicine for the Elderly, Cancer, Diabetes, Paediatrics and Gastro-enterology.

3.1.2 Significant Transformation of Urgent and Emergency Care

a) Our intention is to radically transform Urgent and Emergency Care through the creation of an overarching, clinically-led Strategic System Resilience Group, who will accelerate the pace of improvement which the three System Resilience Groups[1] in the County have started to deliver.

b) The Strategic System Resilience Group will be part of the East of England Urgent and Emergency Care Network and it will act as the governance vehicle for delivery as part of the System Transformation Programme (supported by the System Transformation Board). There is good alignment with the work being undertaken through the Better Care Fund initiative and the Uniting Care contract.

c) This initiative has a wide range of objectives, several of which are listed below:

- Re-aligning the way in which services are made available in emergency departments and urgent care centres with a focus on developing a network of community-based urgent care centres around primary care hubs, out of hours bases and Minor Injury Units
- Ensuring that access to emergency care is primarily phone first via 111 or 999, with sign posting to services supported by multidisciplinary clinical hubs, seven days a week
- Expanding GP services to cover 8am to 8pm midweek and 9am to 9pm weekends with GP services supporting the 'front door' of Emergency Departments
- Reducing the admission rates of older people in line with plans for UnitingCare outcomes and a focus on prevention through a new third sector driven Well-Being Service
- Reducing significantly crisis mental health presentations to A&E, by improving early community based intervention models for all ages
- Making significant progress in implementing 7 day working across all services with no deterioration in outcomes for patients admitted at weekends
- Aligning and commissioning voluntary sector services to support early intervention and post discharge pathways

3.2 Operational Planning Intentions

This section of the report summarises a selection of the intentions identified for 2016/17.

3.2.1 Planned Care, Long Term Conditions and Prevention

a) We wish to ensure that care is provided in line with agreed clinical policies and that care pathways are as efficient as possible and available in the most appropriate clinical setting. In addition, we wish to explore opportunities to encourage prevention of disease.

[1] Comprising Cambridge and Isle of Ely, Huntingdonshire, Borderline and Peterborough

b) Several objectives have been identified, including:

- Adopting a collaborative approach to managing demand for elective services across the System and identifying opportunities where care could be delivered safely, more efficiently and cost effectively
- Conducting a 'deep dive' into the impacts of obesity on health services and prepare plans for implementation in 2017/18 and beyond to address the key issues identified
- Designing and implementing robust commissioning arrangements for Tuberculosis Services
- Promoting the benefits of self-care for long term conditions
- Implementing the new contract for the Non-Emergency Patient Transport Service from September 2016

3.2.2 Maternity Children and Young People

a) We wish to consolidate the joint commissioning arrangements agreed in 2015/16 and build on the benefits of joint working to ensure that services are available to meet the health needs of the population. Services should be integrated where this is sensible with clear benefits to the care of children and young people.

b) Several objectives have been identified, including:

- Implementing the service transformation priorities to take forward the re-design of Children and Maternity services, including all elements of the healthy child programme
- Taking forward with service providers new specifications for Children Looked After Health services
- Completing the re-commissioning of rapid response services
- Improving further the paediatric care pathway, linking into the current transformation work

3.2.3 Primary Care

a) Ensuring that we will have sustainable primary care organisations for the future is one of our key aims. To achieve this, we will need to develop high quality, integrated out-of-hospital services, organised around the patient, closer to home. Key outcomes will be improved patient experience, access to primary care, equity of access and reduced inequalities.

b) Objectives for 2016/17 include:

- Agreeing the vision for the range of services which could be commissioned from organisations offering primary care at scale
- Building on the co-commissioning of primary care arrangements in place
- Continuing to address the primary care workforce gaps and priorities to secure longer term sustainability
- Working with System Resilience Groups to implement improved patient triage / treatment processes in Emergency Departments

3.2.4 Mental Health Services

a) 2016/17 will be a year of consolidation of the service re-design initiatives started in 2015/16, in order to create a more resilient local mental health system. Together with local stakeholders, we will revise the Adult Mental Health Commissioning Strategy for 2016/19 and ensure that the key priorities are reflected in planning intentions for 2016/17.

b) Objectives for 2016/17 include:

- Implementing improvements to the Advice and Referral Centre through the development of local single-points-of-access, closer links between clinicians and making more use of local community-based resources
- Rolling-out the innovative model of “Recovery Coaches” and peer support workers
- Piloting “Phase 1” of an Enhanced Primary Care Service to provide better support to stable psychosis patients who no longer need to remain in secondary mental health services but have needs beyond what primary care is currently contracted to provide
- Continuing to support local implementation of the Crisis Care Concordat
- Fully implementing self-referral to Improving Access to Psychological Therapies services
- Re-designing pathways for services where waiting-times have become unacceptable

3.2.5 Learning Disability

a) We wish to continue the excellent joint working in place between Health and Local Authorities with the patient foremost in mind. Services should be accessible and available in the community supported by information which is easy to read and understand.

b) Objectives for 2016/17 comprise:

- Supporting local implementation of the Assuring Transformation / Winterbourne View Plans for Cambridgeshire and Peterborough
- Reviewing local in-patient requirements in the light of the requirement that, post-Winterbourne View, all people with learning disability should be supported to live within local communities
- Supporting the uptake and delivery of primary care Learning Disability health checks and other primary care agreements (e.g. by offering practice-based training, promoting health check awareness etc.)
- Supporting the achievement of the new national accessible information standards by all commissioned providers (e.g. by the provision of easy read materials)

3.2.6 Health & Wellbeing, Integration and the Better Care Fund

a) Our aim is to move towards an operating model for the health and social care system that helps people to help themselves, where the majority of people’s needs are met appropriately through family and community support.

b) Objectives for 2016/17 include:

- Together with Uniting Care, continuing to develop services for older people aged 65 years and over and adults who need community services
- Continuing the close partnership working already in place to ensure that services are aligned and duplication avoided
- Working with the county-wide Urgent and Emergency Care System Resilience Group to ensure that plans for optimising urgent care pathways and introducing seven day services are aligned
- Continuing to implement the five projects agreed for Cambridgeshire and Peterborough as a result of aligning the Better Care Funds, i.e. person-centred system, data sharing, seven day working, information and communication and healthy ageing.

4.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

4.1 There is good alignment with the following priorities as set out in the Cambridgeshire Health and Wellbeing Strategy:

Priority 1	Ensure a positive start to life for children, young people and their families
Priority 2	Support older people to be independent, safe and well
Priority 3	Encourage healthy lifestyles and behaviours in all actions and activities while respecting people's personal choices
Priority 4	Create a safe environment and help to build strong communities, wellbeing and mental health
Priority 6	Work effectively together

5.0 IMPLICATIONS

5.1 There are no known implications arising from this report.

6.0 RECOMMENDATION/DECISION REQUIRED

6.1 Cambridgeshire Health and Wellbeing Board are requested to **note** the content of this report and to **comment** where relevant.

Source Documents	Location
Cambridgeshire and Peterborough Planning Intentions 2016/17	http://www.cambridgeshireandpeterboroughccg.nhs.uk/commissioning-and-contracts.htm
Cambridgeshire and Peterborough System Change Document	http://www.cambridgeshireandpeterboroughccg.nhs.uk/five-year-plan.htm

Agenda Item No. 9

UPDATE ON HEALTH AND WELBEING BOARD DEVELOPMENT DAY

To: Health and Wellbeing Board

Date: 19 November 2015

From: Dr Liz Robin, Director of Public Health

1.0 PURPOSE

1.1 To outline the topics of discussion at the Cambridgeshire Health and Wellbeing Board (HWB) development session on 29 October 2015 and the next steps.

2.0 BACKGROUND

2.1 The development session was based around the recent Local Government Association (LGA) report, 'Making it better together: A call to action on the future of health and wellbeing boards'. The full LGA report is available online (see source documents at section five of this paper).

2.2 The session was facilitated by David White, former chief executive of Norfolk County Council and adviser to Cambridgeshire's Better Care Fund plans.

2.3 Cambridgeshire Health and Wellbeing Board members were asked to reflect on the board's current position and ideal future position in relation to the following suggestions and recommendations in the LGA report:

What makes a good Health and Wellbeing Board?

- Shared leadership
- A strategic approach
- Engaging with communities
- Collaborative ways of working

Stepping up to the challenge – local leaders

- Parity, trust and confidence between board members
- Ensuring a focus on outcomes
- Improving local capacity and understanding
- Establishing the right footprint for commissioning
- Working with providers
- Measuring progress towards outcomes

3.0 KEY POINTS

3.1 Most of the discussion focused on the topics in the report relating to shared leadership, parity and trust between board members.

3.2 Discussion at the development session drew out a number of ideas and suggestions for potential future ways of working as a health and wellbeing board. It was agreed that further work is required to explore some of these suggestions in more detail.

3.3 It was proposed that a small working group consisting of Health and Wellbeing Board members is established and tasked with progressing these ideas for future ways of working.

3.4 A more detailed progress update will be provided at the next meeting of the Cambridgeshire Health and Wellbeing Board.

4.0 RECOMMENDATION

4.1 The Health and Wellbeing Board is asked to:

- Note this report and comment on the development session held on 29 October 2015.
- Agree to explore and further develop the ideas and suggestions for future ways of working as a health and wellbeing board.
- Volunteer, or nominate members of the HWB, to join the proposed working group tasked with exploring and developing the detail around future ways of working.

Source Documents	Location
Local Government Association (LGA), 'Making it better together: A call to action on the future of health and wellbeing boards'.	http://www.local.gov.uk/documents/10180/6869714/L15-254+Making+it+better+together+-+A+call+to+action+on+the+future+of+health+and+wellbeing+boards/311885a4-5597-4007-8069-46bc2732d6a2

Agenda Item No: 10

BETTER CARE FUND – QUARTERLY REPORT AND PLANNING FOR 2016-17

To: Health and Wellbeing Board

Date: 19th November 2015

From: Adrian Loades, Executive Director – Children, Families and Adults Services
Andy Vowles, Chief Strategy Officer – Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)

1.0 PURPOSE

1.1 The purpose of this report is to provide a brief update on the quarterly reporting process on the Better Care Fund (BCF); and inform Board Members of the continuation of the Better Care Fund into 2016-17. A further verbal update will be provided at the meeting.

2.0 BACKGROUND

2.1 As previously reported, The Better Care Fund (BCF) has created a joint budget to help health and social care services to work more closely together in each Health and Wellbeing Board area. The BCF came into effect in April 2015 and in Cambridgeshire the BCF is £37.7 million for 2015/16. This is not new money, but a reorganisation of existing funding already used to provide health, social care and housing services across the county. It is designed to be used to support better integration of health and social care to improve services for the most vulnerable people in the community; provide better support for carers; and create efficiencies. In the first year of BCF most funding remains in community health and social care budgets, particularly supporting the Clinical Commissioning Group (CCG)'s Older People and Adult Community Services Contract; and a smaller amount of spending is focused on medium term projects that will begin to support those outcomes. The expectation is that in future years there will be more funding available to support different services as our work begins to have an impact.

3.0 BETTER CARE FUND DEVELOPMENT

3.1 On 27 November, a report on progress against the Better Care Fund will be submitted to NHS England. A verbal summary of the return will be provided at the meeting; the draft return will then be shared with Board Members by email for any comments before submission.

3.2 Full performance data for non-elective admissions is not available at the time of writing, and so it is not possible to offer a complete commentary on non-elective admissions at this stage. However, data available at this stage indicates that in the second quarter, the number of non-elected admissions has continued to rise, meaning that BCF targets for reducing non-elective admissions will not have been met. A verbal update on the figures for the full quarter will be provided at the meeting.

3.3 The BCF transformation projects are continuing to develop across Cambridgeshire and Peterborough:

- The **Data Sharing** project has developed a dataset of social care data to be made available to health partners with appropriate consent in place in order to improve decision making about people's health and care; this data will then be included within 'OneView', the single view of the patient record being developed by UnitingCare.
- For **Seven Day Working**, recent workshops have been held in the Cambridge and Ely system; and the Huntingdonshire system; with representation from across health, social care and the voluntary sector to agree principles and priorities for each local area. These are being developed into plans for implementation by each area's System Resilience Group (SRG)
- The **Person Centred System** project has been working across the system to agree how elements of the UnitingCare service model being implemented by CPFT will link to the rest of the system – including how social care will participate in the recently established neighbourhood teams; and how reablement should work with health services in future. A strand of work has been established to explore the use of a shared tool across the system to help to develop a shared language about people's level of risk
- The **Healthy Ageing and Prevention** project has now held its first steering group meeting. It agreed that priorities for the project will be:
    - A coordinated approach to falls prevention across Cambridgeshire and Peterborough
    - Overseeing the development of UnitingCare's Wellbeing Service
    - Continence and Urinary Tract Infections (UTIs)
    - How organisations coordinate action on early warning signals that an individual may be developing greater levels of risk.

3.4 In a joint letter from the Department of Health and Department for Communities and Local Government on 16th October 2015, it was confirmed that the Better Care Fund will continue into the 2016-17 financial year. However, details about the minimum size of the Fund will not be confirmed until after the Spending Review reports on 25 November. It is reported that full guidance on the process will be published shortly after the Spending Review, with updated BCF plans expected to be submitted in early February 2016. Local areas are asked to begin planning for 2016-17 based on an evaluation of implementation to date; officers are beginning this process and an update will be provided at the meeting.

4.0 RECOMMENDATIONS

4.1 The Cambridgeshire Health and Wellbeing Board is invited to:

- comment on the update above and the verbal update provided at the meeting; and
- comment on the Quarterly Report to be circulated in draft following the meeting.

Source Documents	Location
None	

HEALTH AND WELLBEING BOARD FORWARD AGENDA PLAN

MEETING DATE	ITEM	REPORT AUTHOR	TO DEMOCRATIC SERVICES RUTH YULE BY
14 Jan 2016	***Priority 3 – Encourage healthy lifestyles and behaviours in all actions and activities while respecting people's personal choices***		
	Person's story	TBC	**Wednesday 30 December**
	Priority 3 update	Val Thomas	
	Public Health Reference Group update	Liz Robin	
	Prevention workstream	Liz Robin / Emma de Zoete	
	Community resilience strategy (TBC – may form part of Priority 3 update)	Sarah Ferguson / Lisa Faulkner	
	General business		
	CCG's Operational Plan	Jessica Bawden	
	CCG's planning intentions	Jessica Bawden	
	Better Care Fund Update [standing item]	Adrian Loades / Andy Vowles/ Geoff Hinkins	
	Cambridgeshire and Peterborough Health and Care System Transformation Programme [standing item]	Andy Vowles / Dr Modha	
	Update on Cambridge University Hospitals NHS Foundation Trust – strategic impact and direction	Jess Bawden to advise	
17 March 2016	***Priority 5 – Create a sustainable environment in which communities can flourish***		
	Person's story	TBC	**Thursday 3 March 2016**
	New Communities JSNA? (TBC)	TBC	
	Priority 5 update	Iain Green	

MEETING DATE	ITEM	REPORT AUTHOR	TO DEMOCRATIC SERVICES RUTH YULE BY
	General business		
	Better Care Fund Update [standing item]	Adrian Loades / Andy Vowles/ Geoff Hinkins	
	Cambridgeshire and Peterborough Health and Care System Transformation Programme [standing item]	Andy Vowles / Dr Modha	
26 May 2016	***No theme: first meeting of municipal year***		
	Person's story	TBC	**Thursday 12 May**
	Election of Vice-Chairman/woman	Oral	
	Alcohol and Drugs JSNA report	Val Thomas	
	CCG's Choice of Local Quality Premium Indicators	Jessica Bawden	
	Cambridgeshire and Peterborough Health and Care System Transformation Programme [standing item]	Andy Vowles / Dr Modha	
	Better Care Fund Update [standing item]	Adrian Loades / Andy Vowles/ Geoff Hinkins	
	The Handyperson Scheme	Iain Green	

To be scheduled:

- Actions arising from the JSNA on Long-Term Conditions
- Report from the Service Director, Adult Social Care on work in relation to safeguarding being undertaken with the universities

Update: RY 9 November 2015

CAMBRIDGESHIRE AND PETERBOROUGH HEALTH AND CARE SYSTEM TRANSFORMATION PROGRAMME

To: Health and Wellbeing Board

Date: 19 November 2015

From: Dr Neil Modha, Chief Clinical Officer (AccountableOfficer)
Cambridgeshire and Peterborough Clinical Commissioning Group

1.0 PURPOSE

1.1 Cambridgeshire and Peterborough Health and Care System Transformation Programme last presented information to the Health and Wellbeing Board on 17 September 2015. This paper updates the Health and Wellbeing Board on this planning process.

2.0 BACKGROUND

2.1 Strategic aims and values

The strategic aims and values of the programme remain:

- People at the centre of all that we do
- Empowering people to stay healthy
- Developing a sustainable health and care system
- Improving quality, improving outcomes.

2.2 Update

Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) is leading a process to plan changes to the health system that will improve outcomes for people and enable financial sustainability. This process involves providers, partners and patients and has four phases.

The programme continues to work on the following areas:

- Detailed analysis of the issues facing the health system, working with key stakeholders about areas of challenge. The Change Document for the programme has been updated
- Engagement with the public around the key challenges facing the health system now and into the future
- Getting feedback from the public about current services and how they think things could change.

2.3. Changes since the last update to the Health and Wellbeing Board on 17 September

2.3 a Progress of the engagement work

- Pre-engagement work with the public in the challenges facing the health system continues.
- “Fact pacts” for each locality have been produced to support this. These are shown in the appendix.
- Formal engagement with the public on the key changes facing the health system is expected to take place early in 2016.

2.3 b Public Involvement Assembly

The second round of Public Involvement Assembly sessions takes place in October and November. Everyone is welcome to the sessions, which are being held in eight locations.

All workshops take place between 6.30pm and 8.30pm as follows:

- Wednesday 21 October – Wisbech – Wisbech Library, Ely Place, PE131EU
- Thursday 22 October – Peterborough – The Fleet, Fleet Way, PE28DL
- Tuesday 03 November – Ely – The Cathedral Centre, Palace Green, CB74EW
- Wednesday 04 November – Huntingdon – Huntingdon Town Hall, Market Hill, PE293PJ
- Tuesday 10 November – Cambridge – Central Library, Lion Yard, CB23QD
- Thursday 12 November – St Neots - St Neots Library, Priory Lane, St NeotsPE19 2BH
- Tuesday 17 November – Chatteris – The King Edward Community Centre, King Edwards Road, Chatteris, Cambs PE166NG
- Tuesday 24 November - Little Shelford Memorial Hall, Church Street, Little Shelford, Cambridge, CB225HG – 6.30pm to 8.30pm.

The workshops are a continuation of the Cambridgeshire and Peterborough Fit for the Future NHS Saturday Cafés and Public Involvement Assembly sessions that were held this summer.

As a direct result of feedback from the last round of the Public Involvement Assembly a leaflet is being prepared to explain how people can return unwanted equipment.

Residents who attended the first sessions have been invited and the sessions have been advertised via the local media and social media, and an email via the CCG Stakeholder database, to encourage more people to join the sessions. Posters and flyers will be displayed in venues in advance of each event.The workshops will cover:

- feedback received during the events over the summer and how that is being used
- localised fact packs to allow an informed debate on shaping health services in the future.

The Programme will plan separate events to engage with people, such as those with caring responsibilities for young children, who are unable to attend early evening meetings.

2.3.c Development of the Urgent and Emergency Care Vanguard

In July Cambridgeshire and Peterborough CCG was successful in being awarded Vanguard status for the Urgent and Emergency Care element of the NHS New Care Models (NCM) programme, bringing the 'Five Year Forward View' into action.

The CCG was one of eight sites selected nationally, tasked with implementing the recommendations set out in Sir Bruce Keogh's review of Urgent and Emergency Care (UEC). The Keogh review recommended that there be ***no consultation in isolation.*** What this means in practice is that patients accessing the urgent and emergency care system, whether by phone via 999 or 111,or digitally, should be provided with the necessary advice regarding how to manage their own condition (self-care) or be provided with seamless access to UEC services via direct booking. This could be directly into a GP/dental appointment or to a designated urgent care centre. An overview of the model is presented in appendix 2.

The CCG is in the process of setting up the Vanguard programme which is underpinned by fiveworkstreams, see appendix 3. The Vanguard Programme has established a Strategic SRG (SSRG) to act as the Programme Board to oversee the delivery of each of the workstreams. The board meets monthly and is comprised of clinicians, managers and subject matter experts representing each area of work.

The programme is in the 'set up' phase and will be accountable via the SSRG to the System Transformation Programme (STP) board. Further updates will be provided in due course that describes the aims and objectives of each workstream.

2.3.d Scoping of the prevention work that is needed to maximise wellbeing and reduce demand for services

Activity modelling undertaken as part of the programme has shown that conditions such as obesity are likely to be a cause of half of the increase in demand on health services.

The Director of Public Health is scoping a prevention workstream which aims to promote wellbeing and reduce the need for health and care services. This will be presented to the System Transformation Programme Board on 16 November.

3 NEXT STEPS

The System Transformation Programme Board will meet on 16 November 2015. It is expected to agree recommendations to put forward to Cambridgeshire and Peterborough Clinical Commissioning Group's Governing Body for engagement on potential ideas for change. We will update the Health and Wellbeing Board on the outcomes from that meeting.

4 RECOMMENDATIONS

Health and Wellbeing Board members are asked to note this update.

SOURCE DOCUMENTS

Source Documents	Location
• Cambridgeshire and Peterborough health system Change Document/15 to 2018/19: Main text	http://www.cambridgeshireandpeterboroughccg.nhs.uk/five-year-plan.htm
• Cambridgeshire and Peterborough health system Blueprint 2014/15 to 2018/19: Appendices	http://www.cambridgeshireandpeterboroughccg.nhs.uk/five-year-plan.htm
• Cambridgeshire and Peterborough System Transformation Programme Frequently asked Questions	http://www.cambridgeshireandpeterboroughccg.nhs.uk/STP_FAQS_Feb_2015docx.pdf
• NHS England " Five Year Forward View"	http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
• NHS England " Urgent and Emergency Care Vanguard" site	http://www.england.nhs.uk/ourwork/futurenhs/5yfv-ch3/new-care-models/uec/

Author
Dr Fiona Head
Programme Director
Cambridgeshire and Peterborough System Transformation Programme
29 October2015

Appendix 1

FACT PACKS BY LOCALITY

Appendix 2

OVERVIEW OF THE VANGUARD MODEL

Appendix 3

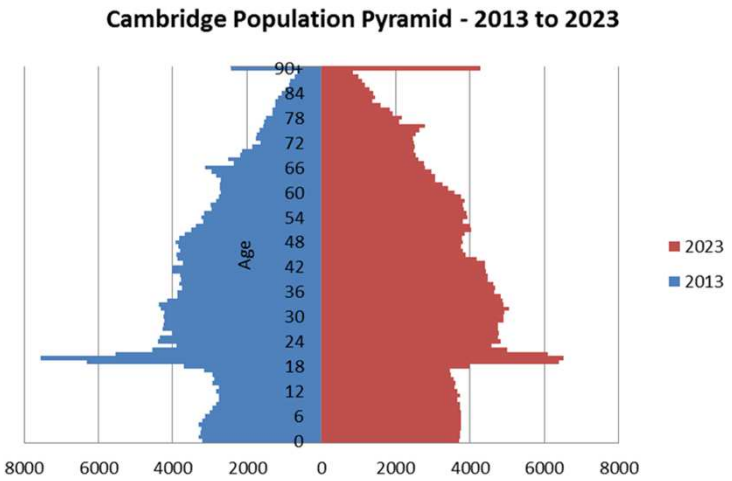
OVERVIEW OF THE VANGUARD PROGRAMME OF WORK

System Transformation Programme Engagement Fact Pack: Cambridge System

September 2015

This pack contains data published for different geographical areas. The closest match to the area served by the CATCH and Cam Health Local Commissioning Groups has been used throughout. Depending on the data source, this may be the locality, the local authorities of Cambridge City and South Cambridgeshire, the county of Cambridgeshire or the CCG catchment area.

Population



- The total resident population of Cambridge City and South Cambridgeshire was 278,200 in 2013 and is forecast to rise by 17% to 2023, reaching a total of 326,700.
- The population aged 65 and over is forecast to rise by 30% by 2023. The number of people aged 90 or over will rise by three quarters in this time.
- The number of children and young people aged 18 and under is forecast to rise by 21% to 2023.

Source: Cambridgeshire County Council Research Group 2013-based population forecasts

Primary Care

Local context

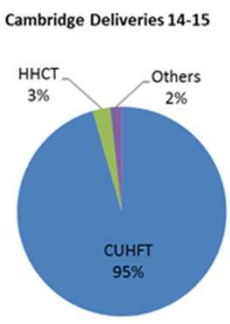
- There are 37 GP practices in CATCH and Cam Health Local Commissioning Groups, which make up the Cambridge System locality. Together these serve a registered population of 323,000. List sizes vary from 2,700 to 18,000, with an average list size of 8,700 (the same as the CCG average).
- If practice populations increase in line with expected population growth, average list size will rise to 10,200 in 2023 (an increase of 17%).

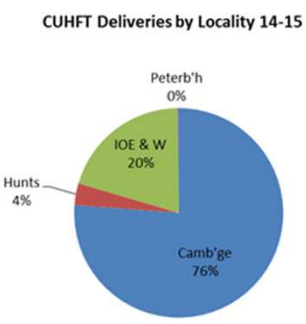
National GP pressures (source: Nuffield Trust Election Briefing 2015 - http://www.nuffieldtrust.org.uk/blog/facts-figures-and-views-health-and-social-care-resource-reporters-2015-general-election)

- 90% of NHS contacts take place in primary care (HSCIC survey 2012/13)
- Spending on core GP services fell by over 2% in real terms during the 2010-2015 parliament
- The number of people saying they had failed to get an appointment rose from 9% to 11% from 2011/12 to 2013/14
- Consultations at GP surgeries rose by 11% from 2010 to 2014, though most of the increase was in nurse consultations and consultations with 'others' (e.g. pharmacists) (based on a sample of 337 practices)
- Nationally, FTE GP numbers rose by 4.8% from 2010 to 2014, compared to 7% in hospital doctors
- 12% of GPs now work part-time; more than 10% of slots for new GP trainees in practices were left empty in 2014.

Births and deliveries

- There were 3,200 births to women living in Cambridge City and South Cambs in 2013. This is forecast to rise to 3,700 in 2023.
- 95% of women registered with Cambridge System GPs deliver at CUHFT. Very small proportions deliver at HHCT and other Trusts.
- Of CCG births at CUHFT, three quarters were from the locality. 61% of deliveries at the Trust were 'normal', 13% were assisted and 26% were caesarean sections.



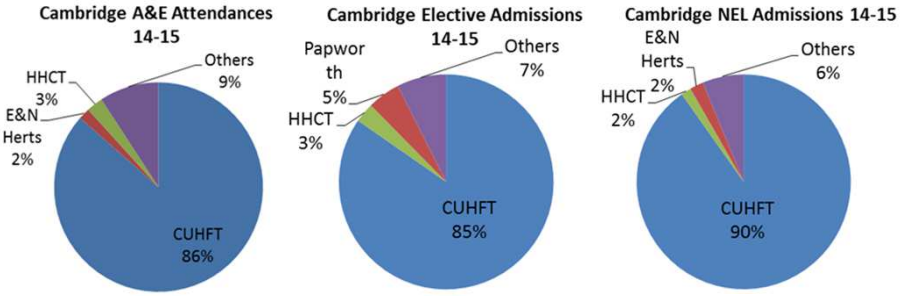


Engagement Fact Pack: Cambridge System

Secondary care use by patients registered with Cambridge System GP practices

Attendance patterns

- 86% of people registered with locality GPs who attend A&E do so at CUHFT. 3% attend HHCT.
- For elective inpatient care 85% of admissions are at CUHFT, with 3% at HHCT and 5% at Papworth. For non-elective care 90% of admissions are at CUHFT.



Current and projected secondary care activity

	A&E attendances	Outpatients	Elective Admissions	Non-elective Admissions	Procedures
2013/14	66,434	297,885	35,244	22,126	54,068
2018/19	79,527	356,499	42,400	27,337	66,238
% change	19.7%	19.7%	20.3%	23.6%	22.5%

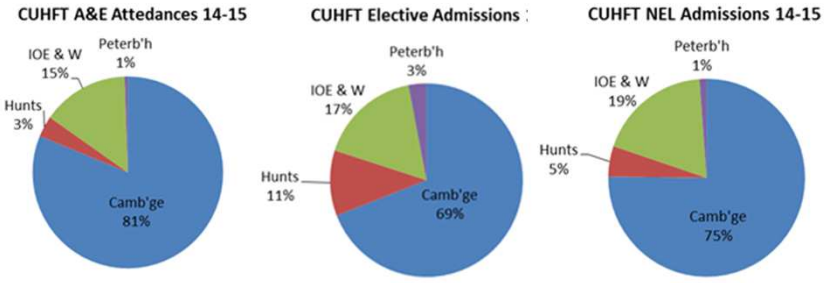
Demand for secondary care across the local population is projected to rise by around 20% over the next five years (24% for non-elective admissions). This takes into account the effect of population change and rising obesity. Types of activity with an older population profile show the greatest increase.

CCG secondary care activity at Cambridge University Hospitals Foundation Trust (CUHFT)

- The most recent monthly monitoring report (June 2015) recorded 9,126 attendances, just a little higher than the England average of 8,923.
- In 2014-15 the Trust saw around 105,500 A&E attendances compared to 93,000 at PSHFT (including minor injuries unit) and 43,000 at HHCT. The Trust is designated as the major trauma centre for the East of England and is also a hyper-acute stroke centre. Ambulance protocols divert patients requiring this level of care to CUHFT from the surrounding area.

Patient composition

- 81% of the CCG's A&E attendances at the Trust were from people registered with CATCH and Cam Health GPs. The proportion for elective admissions was 69% and the proportion for non-elective admissions was 75%. The largest flow from elsewhere in the CCG was from the Isle of Ely and Wisbech locality.



Current and projected CCG secondary care activity at CUHFT

	A&E attendances	Outpatients	Elective admissions	Non-elective Admissions	Procedures
2013/14	74,995	394,001	47,288	27,500	84,823
2018/19	89,731	469,045	56,441	33,908	104,331
% change	19.6%	19.0%	19.4%	23.3%	23.0%

Activity at CUHFT is projected to rise by around 20% over the next five years. This takes into account the effect of population change and rising obesity. Types of activity with an older population show the greatest increase.

Data source: 13/14 data taken from SUS; projections are from the System Transformation Programme's Acute Activity Model and include the impact of planned population growth, ageing and rising obesity.

Engagement Fact Pack: Cambridge System

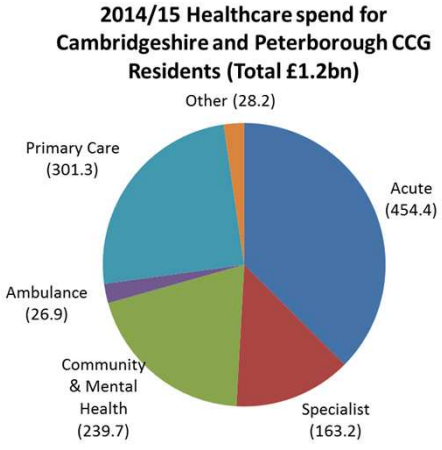
Local Trust Performance in 2014-15 (see glossary on final page for abbreviations)

Organisation	A&E 4hr waits	Referral to Treatment			Elective cancelled operations treated within 28 days	General & Acute Bed Occupancy	Non Elective Average Length of Stay (days)
		Admitted Pathways	Non-admitted pathways	Incomplete pathways			
Target	95.0%	90.0%	95.0%	92.0%	n/a	n/a	n/a
CUHFT	**83.9%**	**86.3%**	**95.1%**	**91.5%**	**88.6%**	**92.8%**	**4.6**
HHC	92.7%	94.7%	99.2%	96.6%	95.9%	86.3%	5.0
PSHFT	85.6%	89.6%	96.0%	96.6%	88.8%	93.2%	4.7
East Anglia Area Team	92.0%	88.2%	96.1%	93.9%	87.4%	n/a	n/a
National	93.6%	87.6%	95.3%	93.1%	93.7%	89.0%	n/a

4-hour waits	• 84% of A&E attendances at CUHFT in 2014/15 were seen within 4 hours. This was below the national target of 95%, the national average of 93.6%, the East Anglia Area Team average of 92%, and was the lowest of the Trusts in the patch.
Referral to treatment	• CUHFT performed below the national target and national and local comparators on admitted pathways. Performance on non-admitted pathways was close to the target but below the other Trusts in the patch.
Cancelled operations	• 89% of cancelled elective operations at PSHFT were subsequently treated within 28 days. There is no national target for this but the Trust performed above the regional but below the national average.
Bed occupancy	• In 2014/15 CUHFT ran at an average bed occupancy rate of 93%, compared to a national average of 89%.
Av. length of stay	• Average length of stay for non-elective admissions at CUHFT was 4.6 days, which was the lowest of the Trusts in the patch.

Local NHS finances

- Total healthcare spend on Cambridgeshire and Peterborough patients was £1.2 billion in 2014/15. Of this, around a half was spent on acute and specialist care and a quarter on primary care (including prescribing).
- If we do not change our health system substantially then we face a deficit of at least £250 million by 2018/19. This will make it harder to deliver good quality care. At the moment our hospitals have significant deficits.
- This deficit figure assumes good performance against local improvement plans.



Engagement Fact Pack: Cambridge System

Health determinants and health outcomes Cambridge System residents

Unless otherwise stated, these are from the Public Health England Health Profiles: http://fingertips.phe.org.uk/profile/health-profiles

Life expectancy

- In Cambridge City, life expectancy at birth is 80 for men and 84.4 for women. In South Cambridgeshire, life expectancy is 83 for men and 89 for women. These figures are all above the national averages of 74.4 for men and 83.1 for women.
- Within Cambridge, there is a life expectancy gap of around 8 years between those living in the most and least deprived areas.

Potential years of life lost

- In 2014, 1,700 potential years of life were lost across the CCG's catchment area from causes amenable to healthcare (PYLL) per 100,000 population. Cambridgeshire is among the 20% best performing local authorities on this measure, while Peterborough is among the worst performing 20%.
- Source: Public Health Information Team, Cambridgeshire County Council

Emergency admissions

CCG PERFORMANCE QUINTILE	Cambs	P'borough
Unplanned admission for chronic ambulatory care conditions	2nd best	2nd worst
Unplanned admissions for epilepsy, asthma, diabetes in under 19s	2nd best	Worst
Emergency admissions for conditions not normally requiring admission	2nd best	Middle
Emergency admissions for children with URTI	2nd best	Middle

Source: http://ccgtools.england.nhs.uk/loa/flash/atlas.html

Disease and poor health

- In Cambridge City, health is generally better than average. Emergency admission rates for hip fracture in people aged over 65 are significantly higher than nationally, as are rates of hospital stays for alcohol-related harm and self-harm.
- In South Cambridgeshire, health is generally better than average. The rate of malignant melanoma in people under 75 is significantly higher than nationally, as are hospital stays for self-harm. The rate of people reported killed or seriously injured on South Cambs' roads is 52.5 per 100,000, which is significantly higher than the national figure of 39.7.

Wider determinants

- At 2.5% in Cambridge City and 1.5% in South Cambs, long-term unemployment is well below the regional and national averages of 5% and 7.1%.
- GCSE results in both local authorities are significantly above the England average. Against this affluent picture, small areas of the City are among the most deprived in England and around 5,000 children across the locality live in poverty.

Lifestyles

- Smoking prevalence is 9.5% in Cambridge City and 11.4% in South Cambs, which is significantly below the regional and national averages of 17.5% and 18.4%.
- Local rates of obesity are significantly below the national average in both Year 6 children (aged 10-11) and adults. 67% of adults in Cambridge City and 62% in South Cambridgeshire are physically active, which is well above the national average of 57%.

Dementia

- Prevalence estimates suggest there are around 3,260 Cambridge System residents with dementia. This is forecast to rise by 23% to 4,010 in 2023.
- Source: MRC CFAS Prevalence estimates applied to local population

Diabetes

- There are 9,400 people with diabetes in Cambridge City & South Cambs (Source: QOF 2013-14)
- Across the CCG's catchment area, just 56% of people with diabetes have good blood glucose control. The CCG is among the worst performing nationally on this measure and performs similarly poorly on measures of diabetic complications.

Mental health

- Mental health represents 23% of the national burden of disease but just 13% of NHS spend. Source: www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf
- Over 44,000 adults registered with CCG GPs had depression in 2013/14. (Source: QOF)

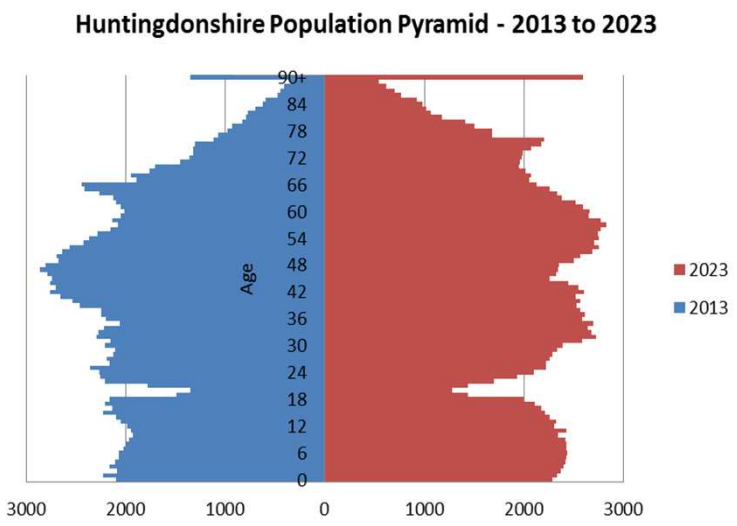
Abbreviations:
CCS: Cambridgeshire Community Services; CUHFT: Cambridge University Hospitals NHS Foundation Trust; HHCT: Hinchingbrooke Health Care NHS Trust; PSHFT: Peterborough & Stamford NHS Foundation Trust; CCG: Clinical Commissioning Group (in this case Cambridgeshire & Peterborough CCG).

System Transformation Programme
Engagement Fact Pack: Huntingdonshire locality

September 2015

This pack contains data published for different geographical areas. The closest match to the area served by the Hunts Care Partners and Hunts Health Local Commissioning Groups has been used throughout. Depending on the data source, this may be the locality, the local authority of Huntingdonshire, the county of Cambridgeshire or the CCG catchment area.

Population



- The total resident population of Huntingdonshire was 175,700 in 2013 and is forecast to rise by 12% to 2023, reaching a total of 196,900.
- The population aged 65 and over is forecast to rise by 37% by 2023. The number of people aged 90 or over will almost double in this time.
- The number of children and young people aged 18 and under is forecast to rise by 11% to 2023.

Source: Cambridgeshire County Council Research Group 2013-based population forecasts

Primary Care

Local context

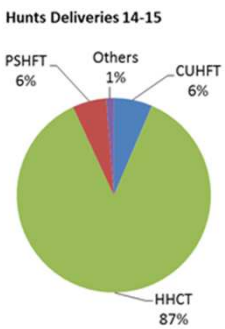
- There are 26 GP practices across Hunts Care Partners and Hunts Health Local Commissioning Groups, which make up the locality. Together these serve a registered population of 194,000. List sizes vary from 2,200 to 14,100, with an average list size of 7,500 compared to a CCG average of 8,700.
- If practice populations increase in line with expected population growth, average list size will rise to 8,400 in 2023 (an increase of 12%).

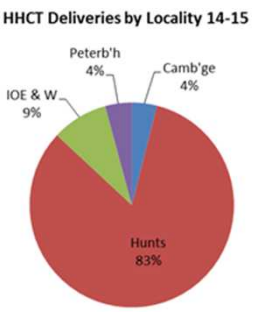
National GP pressures (source: Nuffield Trust Election Briefing 2015 - http://www.nuffieldtrust.org.uk/blog/facts-figures-and-views-health-and-social-care-resource-reporters-2015-general-election)

- 90% of NHS contacts take place in primary care (HSCIC survey 2012/13)
- Spending on core GP services fell by over 2% in real terms during the 2010-2015 parliament
- The number of people saying they had failed to get an appointment rose from 9% to 11% from 2011/12 to 2013/14
- Consultations at GP surgeries rose by 11% from 2010 to 2014, though most of the increase was in nurse consultations and consultations with 'others' (e.g. pharmacists) (based on a sample of 337 practices)
- Nationally, FTE GP numbers rose by 4.8% from 2010 to 2014, compared to 7% in hospital doctors
- 12% of GPs now work part-time; more than 10% of slots for new GP trainees in practices were left empty in 2014.

Births and deliveries

- There were 2,050 births to women living in Huntingdonshire in 2013. This is forecast to rise to 2,250 in 2023.
- 87% of women registered with Hunts locality GPs deliver at Hinchingbrooke.
- Of CCG births at HHCT, the majority (83%) were from the Hunts locality. 62% of deliveries at the Trust were 'normal', 15% were assisted and 24% were caesarean sections.





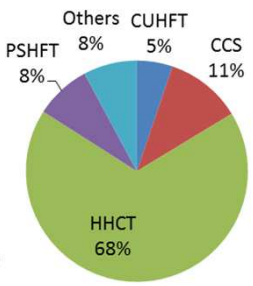
Engagement Fact Pack: Huntingdonshire locality

Secondary care use by people registered with Huntingdonshire locality GP practices

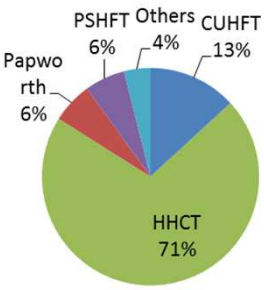
Attendance patterns

- 68% of people registered with Hunts GPs who access A&E do so at Hinchingbrooke Hospital.
- For elective inpatient care this proportion is 71% and for non-elective it is 58%.

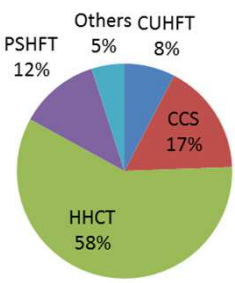
A&E Attendances 14-15



Elective Admissions 14-15



NEL Admissions 14-15



Current and projected secondary care activity

	A&E attendances	Outpatients	Elective Admissions	Non-elective Admissions	Procedures
2013/14	40,353	223,194	30,371	17,615	43,482
2018/19	47,011	263,635	36,484	21,325	53,227
% change	16.5%	18.1%	20.1%	21.1%	22.4%

Demand for secondary care across the local population is projected to rise by 6% (A&E) to 11% (procedures) over the next five years. This takes into account the effect of population change and rising obesity. Types of activity with an older population profile show the greatest increase.

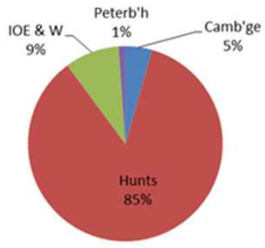
CCG secondary care activity at Hinchingbrooke Healthcare Trust (HHCT)

- HHCT A&E is one of the smallest in the country. The most recent monthly monitoring report (June 2015) recorded 3,826 attendances, the fourth lowest of the 140 Type 1 A&Es in England. The England average is 8,923.
- Each year the Trust sees in the region of 43,000 attendances compared to 93,000 at PSHFT (including minor injuries unit) and 105,000 at CUHFT. Ambulance protocols convey patients needing care for hyper acute stroke, primary angioplasty and poly trauma directly to PSHFT or CUHFT. Patients accessing HHCT via ambulance therefore have predominantly medical elderly conditions.

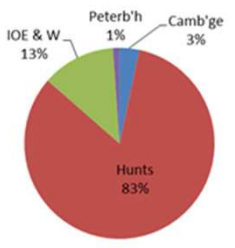
Patient composition

- 85% of the CCG's A&E attendances at the Trust are from people registered with Hunts locality GPs. The proportions for elective and non-elective inpatient admissions are similar.

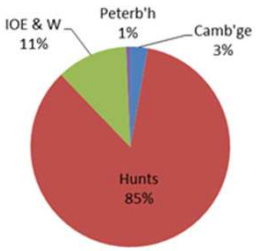
HHCT A&E Attedances 14-15



HHCT Elective Admissions 14-15



HHCT NEL Admissions 14-15



Current and projected CCG secondary care activity at HHCT

	A&E attendances	Outpatients	Elective admissions	Non-elective Admissions	Procedures
2013/14	36,239	141,215	22,585	10,796	25,227
2018/19	42,096	168,311	27,392	13,755	30,688
% change	16.2%	19.2%	21.3%	27.4%	21.6%

Activity at HHCT is projected to rise by 6% (A&E) to 14% (NE admissions) over the next five years. This takes into account the effect of population change and rising obesity. Types of activity with an older population show the greatest increase.

Data source: 13/14 data taken from SUS; projections are from the System Transformation Programme's Acute Activity Model and include the impact of planned population growth, ageing and rising obesity.

Engagement Fact Pack: Huntingdonshire locality

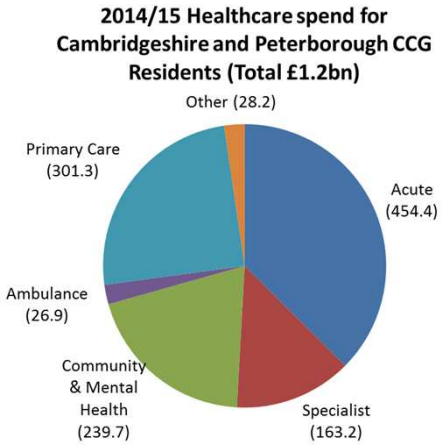
Local Trust Performance in 2014-15 (see glossary on final page for abbreviations)

Organisation	A&E 4hr waits	Referral to Treatment			Elective cancelled operations treated within 28 days	General & Acute Bed Occupancy	Non Elective Average Length of Stay (days)
		Admitted Pathways	Non-admitted pathways	Incomplete pathways			
Target	95.0%	90.0%	95.0%	92.0%	n/a	n/a	n/a
CUHFT	83.9%	86.3%	95.1%	91.5%	88.6%	92.8%	4.6
HHC	**92.7%**	**94.7%**	**99.2%**	**96.6%**	**95.9%**	**86.3%**	**5.0**
PSHFT	85.6%	89.6%	96.0%	96.6%	88.8%	93.2%	4.7
East Anglia Area Team	92.0%	88.2%	96.1%	93.9%	87.4%	n/a	n/a
National	93.6%	87.6%	95.3%	93.1%	93.7%	89.0%	n/a

4-hour waits	• 92.7% of A&E attendances at HHCT in 2014/15 were seen within 4 hours. This was below the national target of 95% and the national average of 93.6% but above the East Anglia Area Team average.
Referral to treatment	• HHCT performed above the national target, national average and regional average on all pathways.
Cancelled operations	• 96% of cancelled elective operations at HHCT were subsequently treated within 28 days. There is no national target for this but the Trust performed above the regional and national average.
Bed occupancy	• HHCT ran at an average bed occupancy rate of 86%, compared to a national average of 89%. They had the lowest bed occupancy of any Trust in the patch.
Av. length of stay	• Average length of stay for non-elective admissions at HHCT was 5 days, which was a little longer than the average of 4.6 and 4.7 and CUHFT and PSHFT respectively.

Local NHS finances

- Total healthcare spend on Cambridgeshire and Peterborough patients was £1.2 billion in 2014/15. Of this, around a half was spent on acute and specialist care and a quarter on primary care (including prescribing).
- If we do not change our health system substantially then we face a deficit of at least £250 million by 2018/19. This will make it harder to deliver good quality care. At the moment our hospitals have significant deficits.
- This deficit figure assumes good performance against local improvement plans.



Engagement Fact Pack: Huntingdonshire locality

Health determinants and health outcomes for Huntingdonshire residents

Unless otherwise stated, these are from the Public Health England Health Profiles: http://fingertips.phe.org.uk/profile/health-profiles

Life expectancy

- Life expectancy at birth is 81.0 for Huntingdonshire men and 84.3 for women. This is significantly higher than the national averages of 79.4 and 83.1 and higher than the East of England average.

Potential years of life lost

- In 2014, 1,700 potential years of life were lost across the CCG's catchment area from causes amenable to healthcare (PYLL) per 100,000 population. Cambridgeshire is among the 20% best performing local authorities on this measure, while Peterborough is among the worst performing 20%.
- Source: Public Health Information Team, Cambridgeshire County Council

Emergency admissions

CCG PERFORMANCE QUINTILE	Cambs	P'borough
Unplanned admission for chronic ambulatory care conditions	2nd best	2nd worst
Unplanned admissions for epilepsy, asthma, diabetes in under 19s	2nd best	Worst
Emergency admissions for conditions not normally requiring admission	2nd best	Middle
Emergency admissions for children with URTI	2nd best	Middle

Source: http://ccgtools.england.nhs.uk/loa/flash/atlas.html

Disease and poor health

- The health of people in Huntingdonshire is generally better than the England average.
- The rate of people reported killed or seriously injured on Huntingdonshire's roads is 48.1 per 100,000, which is significantly higher than the national figure of 39.7.

Wider determinants

- Overall, levels of deprivation in Huntingdonshire are very low. At 2.1%, long-term unemployment is well below the regional and national averages of 5% and 7.1%.
- Against this affluent picture, GCSE results are below average, and there are small areas of relatively concentrated deprivation.

Lifestyles

- Smoking prevalence is 11.6%, which is significantly lower than the regional and national averages of 17.5% and 18.4%.
- The prevalence of obesity in Year 6 children (age 10-11) is significantly lower than national and regional averages.
- Adult obesity is higher than average at 26% compared to 23% nationally.
- 63% of adults are physically active, which is higher than nationally (57%).

Dementia

- Prevalence estimates suggest there are around 2,050 Huntingdonshire residents with dementia. This is forecast to rise by 56% to 3,200 in 2023.
- Source: MRC CFAS Prevalence estimates applied to local population

Diabetes

- There are 8,400 people with diabetes in Huntingdonshire. (Source: QOF 2013/14)
- Across the CCG's catchment area, just 56% of people with diabetes have good blood glucose control. The CCG is among the worst performing nationally on this measure and performs similarly poorly on measures of diabetic complications.

Mental health

- Mental health represents 23% of the national burden of disease but just 13% of NHS spend. Source: www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf
- Over 44,000 adults registered with Cambridgeshire & Peterborough GPs had depression in 2013/14. (Source: QOF)

Abbreviations:

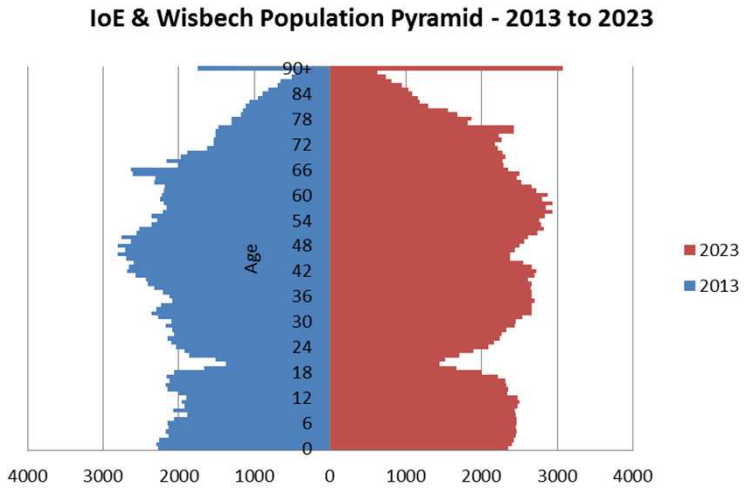
CCS: Cambridgeshire Community Services; CUHFT: Cambridge University Hospitals NHS Foundation Trust; HHCT: Hinchingbrooke Health Care NHS Trust; PSHFT: Peterborough & Stamford NHS Foundation Trust; CCG: Clinical Commissioning Group (in this case Cambridgeshire & Peterborough CCG)

System Transformation Programme
Engagement Fact Pack: Isle of Ely and Wisbech

September 2015

This pack contains data published for different geographical areas. The closest match to the area served by the Isle of Ely and Wisbech Local Commissioning Groups has been used throughout. Depending on the data source, this may be the locality, the local authorities of East Cambridgeshire and Fenland, the county of Cambridgeshire or the CCG catchment area.

Population



- The total resident population of East Cambridgeshire and Fenland was 181,100 in 2013 and is forecast to rise by 14% to 2023, reaching a total of 206,800.
- The population aged 65 and over is forecast to rise by 28% by 2023. The number of people aged 90 or over will almost double in this time.
- The number of children and young people aged 18 and under is forecast to rise by 14% to 2023.

Source: Cambridgeshire County Council Research Group 2013-based population forecasts

Primary Care

Local context

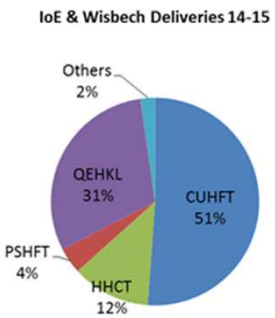
- There are 14 GP practices Isle of Ely and Wisbech Local Commissioning Groups, which make up the locality. Together these serve a registered population of 145,000. List sizes vary from 2,100 to 20,200, with an average list size of 10,400 compared to a CCG average of 8,700.
- If practice populations increase in line with expected population growth, average list size will rise to 11,900 in 2023 (an increase of 14%).

National GP pressures (source: Nuffield Trust Election Briefing 2015 - http://www.nuffieldtrust.org.uk/blog/facts-figures-and-views-health-and-social-care-resource-reporters-2015-general-election)

- 90% of NHS contacts take place in primary care (HSCIC survey 2012/13)
- Spending on core GP services fell by over 2% in real terms during the 2010-2015 parliament
- The number of people saying they had failed to get an appointment rose from 9% to 11% from 2011/12 to 2013/14
- Consultations at GP surgeries rose by 11% from 2010 to 2014, though most of the increase was in nurse consultations and consultations with 'others' (e.g. pharmacists) (based on a sample of 337 practices)
- Nationally, FTE GP numbers rose by 4.8% from 2010 to 2014, compared to 7% in hospital doctors
- 12% of GPs now work part-time; more than 10% of slots for new GP trainees in practices were left empty in 2014.

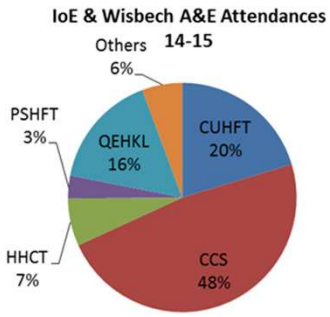
Births and deliveries

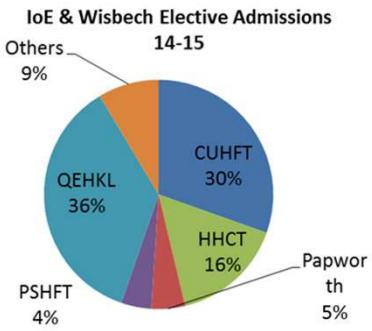
- There were 2,260 births to women living in East Cambridgeshire and Fenland in 2013. This is forecast to rise to 2,330 in 2023.
- 51% of women registered with Isle of Ely and Wisbech locality GPs deliver at CUHFT and 31% deliver at QEH in King's Lynn.

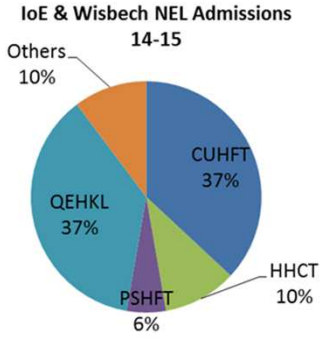


Engagement Fact Pack: Isle of Ely & Wisbech

Secondary care use by people registered with Isle of Ely & Wisbech GP practices







Attendance patterns

- Nearly half of people registered with Isle of Ely and Wisbech GPs who accessed emergency care in 2014-15 did so at minor injuries units provided by Cambridgeshire Community Services. These units were located in Peterborough, North Cambs hospital in Wisbech and the Princess of Wales hospital in Ely (note that commissioning arrangements have changed for 2015/16). Other significant attendance locations were CUHFT and QEHKL, both of which provide full ('Type 1') A&E facilities.
- For elective inpatient care, 36% of people registered with Isle of Ely and Wisbech GPs attended QEH in King's Lynn and 30% attended CUHFT in Cambridge.
- For non-elective inpatient care, both QEHKL and CUHFT took over a third of admissions, with lower proportions of admissions at HHCT and PSHFT.

Current and projected secondary care activity

	A&E attendances	Outpatients	Elective Admissions	Non-elective Admissions	Procedures
2013/14	25,021	157,574	21,857	12,719	31,325
2018/19	29,483	184,533	25,896	15,351	38,050
% change	17.8%	17.1%	18.5%	20.7%	21.5%

Demand for secondary care across the local population is projected to rise by around 20% over the next five years. This takes into account the effect of population change and rising obesity. Types of activity with an older population profile show the greatest increase.

CCG secondary care activity from a Trust perspective

- At CUHFT, 15% of A&E attendances from the CCG's registered population were from Isle of Ely and Wisbech locality. In terms of elective admissions, the proportion is 17% and for non-elective admissions it is 19%.
- At HHCT, 9% of A&E attendances from the CCG's registered population were from Isle of Ely and Wisbech locality. In terms of elective admissions, the proportion is 13% and for non-elective admissions it is 11%.
- At PSHFT, 3% of A&E attendances from the CCG's registered population were from Isle of Ely and Wisbech locality. In terms of elective admissions, the proportion is 4% and for non-elective admissions it is 3%.
- Activity at Trusts in the patch is projected to rise by around 20%, with the greatest rises in types of activity with an older population. This projection takes into account the effect of population change and rising obesity.

Data source: 13/14 data taken from SUS; projections are from the System Transformation Programme's Acute Activity Model and include the impact of planned population growth, ageing and rising obesity.

Engagement Fact Pack: Isle of Ely & Wisbech

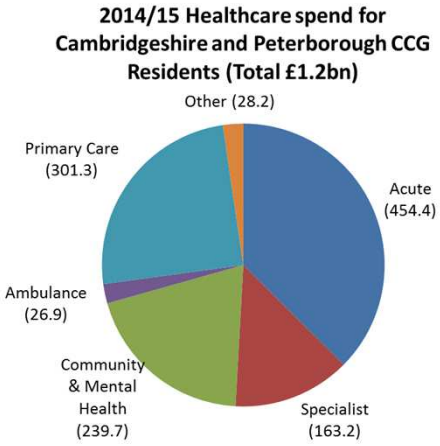
Local Trust Performance in 2014-15 (see glossary on final page for abbreviations)

Organisation	A&E 4hr waits	Referral to Treatment			Elective cancelled operations treated within 28 days	General & Acute Bed Occupancy	Non Elective Average Length of Stay (days)
		Admitted Pathways	Non-admitted pathways	Incomplete pathways			
Target	95.0%	90.0%	95.0%	92.0%	n/a	n/a	n/a
CUHFT	**83.9%**	**86.3%**	**95.1%**	**91.5%**	**88.6%**	**92.8%**	**4.6**
HHC	92.7%	94.7%	99.2%	96.6%	95.9%	86.3%	5.0
PSHFT	85.6%	89.6%	96.0%	96.6%	88.8%	93.2%	4.7
QEHKL	**90.7%**	**88.1%**	**97.0%**	**94.8%**	**76.0%**	**88.3%**	**4.0**
East Anglia Area Team	92.0%	88.2%	96.1%	93.9%	87.4%	n/a	n/a
National	93.6%	87.6%	95.3%	93.1%	93.7%	89.0%	n/a

4-hour waits	• 90.7% of A&E attendances at QEHKL in 2014/15 were seen within 4 hours, compared to 83.9% at CUHFT. Both were below the national target of 95% and the national average of 93.6%.
Referral to treatment	• Both CUHFT and QEHKL were below target on admitted pathways but similar to or above target on non-admitted and incomplete pathways.
Cancelled operations	• 76% of cancelled elective operations at QEHKL were subsequently treated within 28 days, compared to 88.6% at CUHFT. There is no national target for this but both Trusts performed below the national average.
Bed occupancy	• QEHKL ran at an average bed occupancy rate of 88%, compared to 93% at CUHFT. The national average was 89%. QEHKL had lower bed occupancy than the other local Trusts.
Av. length of stay	• Average length of stay for CCG non-elective admissions at QEHKL was 4 days, which was shorter than the figure of 4.6 at CUHFT.

Local NHS finances

- Total healthcare spend on Cambridgeshire and Peterborough patients was £1.2 billion in 2014/15. Of this, around a half was spent on acute and specialist care and a quarter on primary care (including prescribing).
- If we do not change our health system substantially then we face a deficit of at least £250 million by 2018/19. This will make it harder to deliver good quality care. At the moment our hospitals have significant deficits.
- This deficit figure assumes good performance against local improvement plans.



Engagement Fact Pack: Isle of Ely & Wisbech

Health determinants and health outcomes for Isle of Ely and Wisbech residents

Unless otherwise stated, these are from the Public Health England Health Profiles: http://fingertips.phe.org.uk/profile/health-profiles

Life expectancy

- In East Cambridgeshire, life expectancy at birth is 81.8 for men and 85.6 for women. This is significantly higher than the national average. In Fenland, life expectancy is 79.5 for men and 82.8 for women, which is not significantly different to the national average.
- Within Fenland, there is a gap in male life expectancy of nearly 5 years between those living in the most and least deprived areas.

Potential years of life lost

- In 2014, 1,700 potential years of life were lost across the CCG's catchment area from causes amenable to healthcare (PYLL) per 100,000 population. Cambridgeshire is among the 20% best performing local authorities on this measure, while Peterborough is among the worst performing 20%.
- Source: Public Health Information Team, Cambridgeshire County Council

Emergency admissions

CCG PERFORMANCE QUINTILE	Cambs	P'borough
Unplanned admission for chronic ambulatory care conditions	2nd best	2nd worst
Unplanned admissions for epilepsy, asthma, diabetes in under 19s	2nd best	Worst
Emergency admissions for conditions not normally requiring admission	2nd best	Middle
Emergency admissions for children with URTI	2nd best	Middle

Source: http://ccgtools.england.nhs.uk/loa/flash/atlas.html

Disease and poor health

- Overall, taking account of population age structure, death rates from common causes are lower than nationally in East Cambs and not significantly different to nationally in Fenland
- The rate of people reported killed or seriously injured on our roads is 67.8 per 100,000 in East Cambs and 45.8 per 100,000 in Fenland, both of which are significantly higher than the national figure of 39.7.

Wider determinants

- At 2.4% in East Cambs and 4.3% in Fenland, long-term unemployment is below the regional and national averages of 5% and 7.1%.
- GCSE results in both local authorities are below average. Parts of the locality, particularly to the north, are among the most deprived 20% of areas of the country.

Lifestyles

- Smoking prevalence is 18% in East Cambs and 22% in Fenland, which is not significantly different to the regional and national averages of 17.5% and 18.4%.
- Local rates of obesity are not significantly different to nationally in both Year 6 children (aged 10-11) and as adults.
- 58% of adults in East Cambs are physically active, which is similar to the national average. In Fenland this is just 51%, which is significantly lower than nationally (57%).

Dementia

- Prevalence estimates suggest there are around 2,670 East Cambridgeshire and Fenland residents with dementia. This is forecast to rise by 20% to 3,210 in 2023.
- Source: MRC CFAS Prevalence estimates applied to local population

Diabetes

- There are 11,100 people with diabetes in East Cambs & Fenland. (Source: QOF 2013/14)
- Across the CCG's catchment area, just 56% of people with diabetes have good blood glucose control. The CCG is among the worst performing nationally on this measure and performs similarly poorly on measures of diabetic complications.

Mental health

- Mental health represents 23% of the national burden of disease but just 13% of NHS spend. Source: www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf
- Over 44,000 adults registered with CCG GPs had depression in 2013/14. (Source: QOF)

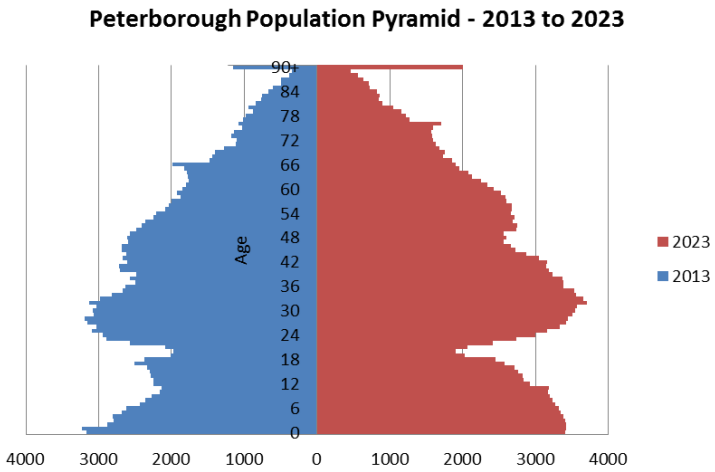
Abbreviations:
CCS: Cambridgeshire Community Services; CUHFT: Cambridge University Hospitals NHS Foundation Trust; HHCT: Hinchingbrooke Health Care NHS Trust; PSHFT: Peterborough & Stamford NHS Foundation Trust; CCG: Clinical Commissioning Group (in this case Cambridgeshire & Peterborough CCG); QEHKL: Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

System Transformation Programme
Engagement Fact Pack: Peterborough & Borderline

September 2015

This pack contains data published for different geographical areas. The closest match to the area served by the Peterborough and Borderline Local Commissioning Groups has been used throughout. Depending on the data source, this may be the locality, the local authority of Peterborough or the CCG catchment area.

Population



- The total resident population of Peterborough was 189,300 in 2013 and is forecast to rise by 19% to 2023, reaching a total of 224,800.
- The population aged 65 and over is forecast to rise by 28% by 2023. The number of people aged 90 or over will almost double in this time.
- The number of children and young people aged 18 and under is forecast to rise by 23% to 2023.

Source: Cambridgeshire County Council Research Group 2013-based population forecasts

Primary Care

Local context

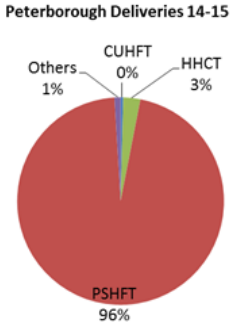
- There are 29 GP practices Peterborough and Borderline Local Commissioning Groups, which make up the locality. Together these serve a registered population of 257,000. List sizes vary from 2,000 to 25,800, with an average list size of 8,900 compared to a CCG average of 8,700.
- If practice populations increase in line with expected population growth, average list size will rise to 10,600 in 2023 (an increase of 19%).

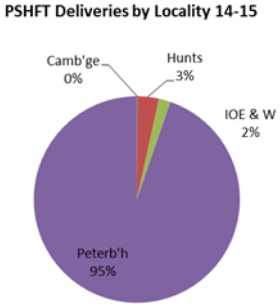
National GP pressures (source: Nuffield Trust Election Briefing 2015 - http://www.nuffieldtrust.org.uk/blog/facts-figures-and-views-health-and-social-care-resource-reporters-2015-general-election)

- 90% of NHS contacts take place in primary care (HSCIC survey 2012/13)
- Spending on core GP services fell by over 2% in real terms during the 2010-2015 parliament
- The number of people saying they had failed to get an appointment rose from 9% to 11% from 2011/12 to 2013/14
- Consultations at GP surgeries rose by 11% from 2010 to 2014, though most of the increase was in nurse consultations and consultations with 'others' (e.g. pharmacists) (based on a sample of 337 practices)
- Nationally, FTE GP numbers rose by 4.8% from 2010 to 2014, compared to 7% in hospital doctors
- 12% of GPs now work part-time; more than 10% of slots for new GP trainees in practices were left empty in 2014.

Births and deliveries

- There were 3,200 births to women living in Peterborough in 2013. This is forecast to rise to 3,440 in 2023.
- 96% of women registered with Peterborough and Borderline locality GPs deliver at PSHFT. Very small proportions deliver at HHCT and other Trusts.
- Of CCG births at PSHFT, almost all were from Peterborough and Borderline locality. 62% of deliveries at the Trust were 'normal', 12% were assisted and 27% were caesarean sections.



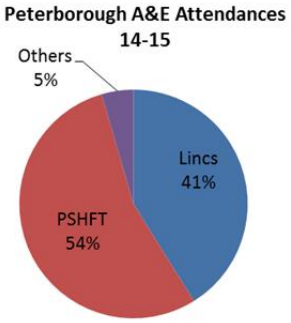


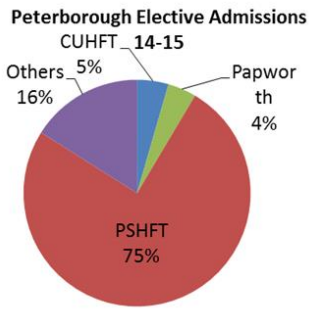
Engagement Fact Pack: Peterborough & Borderline

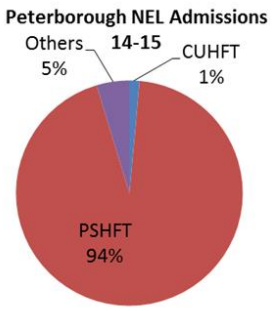
Secondary care use by people registered with Peterborough & Borderline GP practices

Attendance patterns

- 95% of people registered with locality GPs who access emergency care do so in Peterborough, either at the minor injuries unit run by Lincolnshire Community Services or at PSHFT.
- For elective inpatient care 75% of admissions are at PSHFT. For non-elective care 94% of admissions are at PSHFT.







Current and projected secondary care activity

	A&E attendances	Outpatients	Elective Admissions	Non-elective Admissions	Procedures
2013/14	57,774	307,347	28,558	22,982	33,757
2018/19	68,484	361,750	34,094	27,542	40,501
% change	18.5%	17.7%	19.4%	19.8%	20.0%

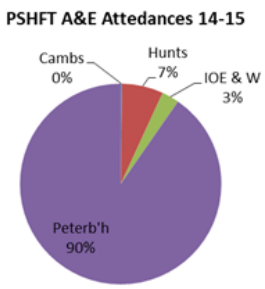
Demand for secondary care across the local population is projected to rise by around 20% over the next five years. This takes into account the effect of population change and rising obesity. Types of activity with an older population profile show the greatest increase.

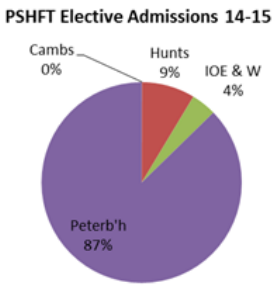
Secondary care activity at Peterborough & Stamford Hospital (PSHFT)

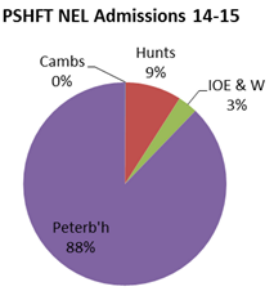
- The most recent monthly monitoring report (June 2015) recorded 7,036 attendances, which was below the England average of 8,923.
- Each year the Trust sees in the region of 93,000 attendances (including minor injuries unit) compared to 105,000 at CUHFT and 43,000 at HHCT.

Patient composition

- 90% of the A&E attendances at the Trust are from people registered with Peterborough and Borderline GPs. The proportions for elective and non-elective inpatient admissions are similar, with 9% of admissions from the Huntingdonshire locality.







Current and projected CCG secondary care activity at PSHFT

	A&E attendances	Outpatients	Elective admissions	Non-elective Admissions	Procedures
2013/14	60,435	299,621	25,737	23,902	30,955
2018/19	71,711	352,269	30,755	28,745	37,253
% change	18.7%	17.6%	19.5%	20.3%	20.3%

Activity at PSHFT is projected to rise by 18% (outpatients) to 20% (NE admissions and procedures) over the next five years. This takes into account the effect of population change and rising obesity. Types of activity with an older population show the greatest increase.

Data source: 13/14 data taken from SUS; projections are from the System Transformation Programme's Acute Activity Model and include the impact of planned population growth, ageing and rising obesity.

Engagement Fact Pack: Peterborough & Borderline

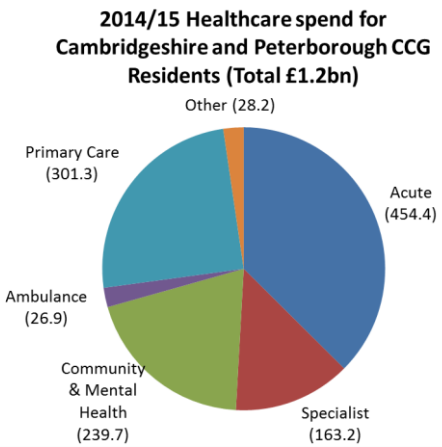
Local Trust Performance in 2014-15 (see glossary on final page for abbreviations)

Organisation	A&E 4hr waits	Referral to Treatment			Elective cancelled operations treated within 28 days	General & Acute Bed Occupancy	Non Elective Average Length of Stay (days)
		Admitted Pathways	Non-admitted pathways	Incomplete pathways			
Target	95.0%	90.0%	95.0%	92.0%	n/a	n/a	n/a
CUHFT	83.9%	86.3%	95.1%	91.5%	88.6%	92.8%	4.6
HHC	92.7%	94.7%	99.2%	96.6%	95.9%	86.3%	5.0
PSHFT	**85.6%**	**89.6%**	**96.0%**	**96.6%**	**88.8%**	**93.2%**	**4.7**
East Anglia Area Team	92.0%	88.2%	96.1%	93.9%	87.4%	n/a	n/a
National	93.6%	87.6%	95.3%	93.1%	93.7%	89.0%	n/a

4-hour waits	• 86% of A&E attendances at PSHFT in 2014/15 were seen within 4 hours. This was below the national target of 95%, the national average of 93.6%, and the East Anglia Area Team average of 92%.
Referral to treatment	• PSHFT performed close to the national target on both admitted and non-admitted pathways and was well above target for incomplete pathways.
Cancelled operations	• 89% of cancelled elective operations at PSHFT were subsequently treated within 28 days. There is no national target for this but the Trust performed above the regional but below the national average.
Bed occupancy	• PSHFT ran at an average bed occupancy rate of 93%, compared to a national average of 89%. They had the highest bed occupancy of any Trust in the patch.
Av. length of stay	• Average length of stay for non-elective admissions at PSHFT was 4.7 days, which was comparable to the figure at CUHFT and a little shorter than the figure at HHCT.

Local NHS finances

- Total healthcare spend on Cambridgeshire and Peterborough patients was £1.2 billion in 2014/15. Of this, around a half was spent on acute and specialist care and a quarter on primary care (including prescribing).
- If we do not change our health system substantially then we face a deficit of at least £250 million by 2018/19. This will make it harder to deliver good quality care. At the moment our hospitals have significant deficits.
- This deficit figure assumes good performance against local improvement plans.



Engagement Fact Pack: Peterborough & Borderline

Health determinants and health outcomes Peterborough & Borderline residents

Unless otherwise stated, these are from the Public Health England Health Profiles: http://fingertips.phe.org.uk/profile/health-profiles

Life expectancy

- In Peterborough, life expectancy at birth is 78.1 for men and 82.6 for women. This is significantly lower than the national average. Within Peterborough, there is a gap in male life expectancy of over 9 years between those living in the most and least deprived areas.

Potential years of life lost

- In 2014, 1,700 potential years of life were lost across the CCG's catchment area from causes amenable to healthcare (PYLL) per 100,000 population. Cambridgeshire is among the 20% best performing local authorities on this measure, while Peterborough is among the worst performing 20%.
- Source: Public Health Information Team, Cambridgeshire County Council

Emergency admissions

CCG PERFORMANCE QUINTILE	Cambs	P'borough
Unplanned admission for chronic ambulatory care conditions	2nd best	2nd worst
Unplanned admissions for epilepsy, asthma, diabetes in under 19s	2nd best	Worst
Emergency admissions for conditions not normally requiring admission	2nd best	Middle
Emergency admissions for children with URTI	2nd best	Middle

Source: http://ccgtools.england.nhs.uk/loa/flash/atlas.html

Disease and poor health

- Rates of hospital stays for alcohol related harm and self-harm are significantly higher than the national average and the prevalence of opiate and/or crack use is also high.
- The incidence of tuberculosis is significantly higher than the national average at 56.7 per 100,000 compared to 30.4 per 100,000.
- Emergency admissions for hip fracture in over 65 year olds are significantly higher than nationally. The death rate from cardiovascular disease in people aged under 75 is significantly higher than nationally. The comparable figure for cancer deaths is similar to the national average.

Wider determinants

- At 7.6%, long-term unemployment is above the national average of 7.1%.
- GCSE results are below average. Parts of the local authority are among the most deprived 20% of areas of the country.

Lifestyles

- Smoking prevalence is 21% in Peterborough, which is significantly above the regional and national averages of 17.5% and 18.4%.
- Local rates of obesity are lower than average in Year 6 children (aged 10-11) but rise to national levels in adults.
- 55% of adults in Peterborough are physically active, which is similar to the national average of 57%.

Dementia

- Prevalence estimates suggest there are around 1,950 Peterborough residents with dementia. This is forecast to rise by 33% to 2,590 in 2023.
- Source: MRC CFAS Prevalence estimates applied to local population

Diabetes

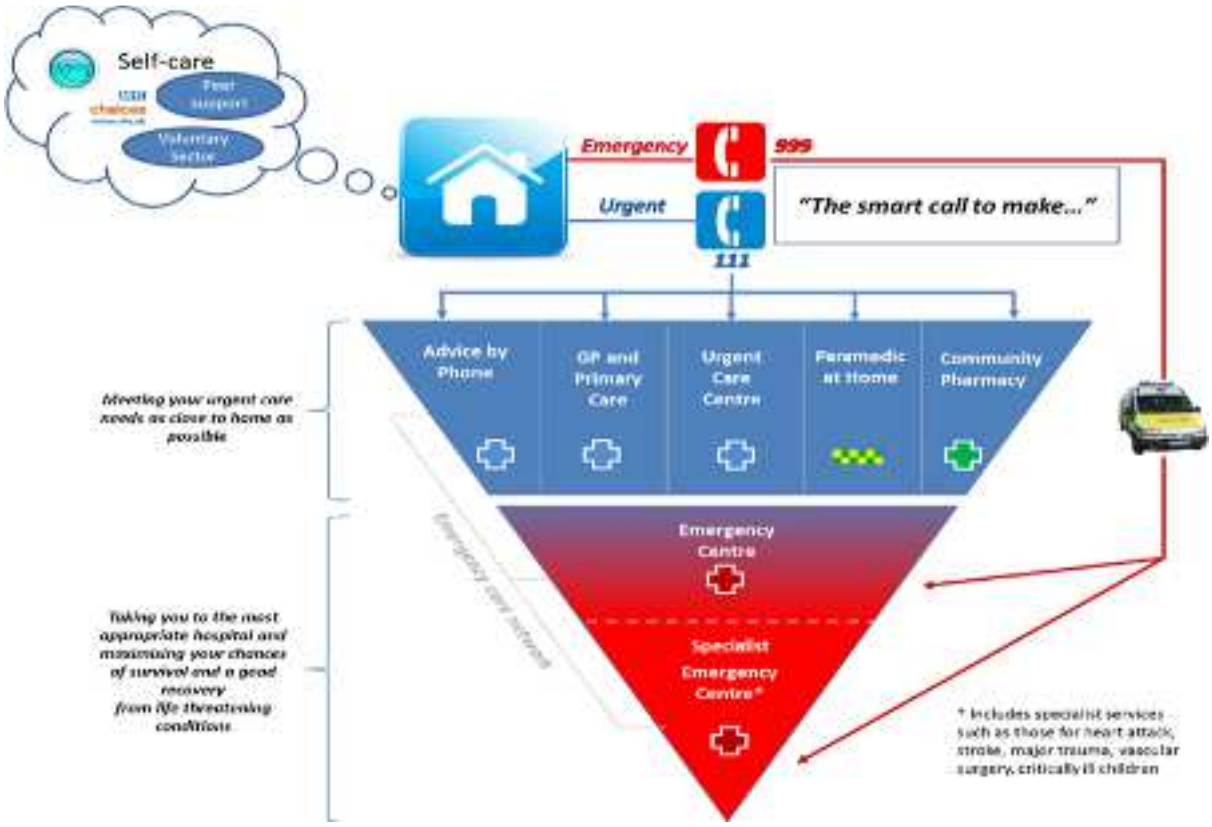
- There are 9,270 people with diabetes in Peterborough. (Source: QOF 2013/14)
- Across the CCG's catchment area, just 56% of people with diabetes have good blood glucose control. The CCG is among the worst performing nationally on this measure and performs similarly poorly on measures of diabetic complications.

Mental health

- Mental health represents 23% of the national burden of disease but just 13% of NHS spend. Source: www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf
- Over 44,000 adults registered with the CCG's GPs had depression in 2013/14. (Source: QOF)

Abbreviations:
CCS: Cambridgeshire Community Services; CUHFT: Cambridge University Hospitals NHS Foundation Trust; HHCT: Hinchingbrooke Health Care NHS Trust; PSHFT: Peterborough & Stamford NHS Foundation Trust; CCG: Clinical Commissioning Group (in this case Cambridgeshire & Peterborough CCG); QEHKL: Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

Appendix 2 OVERVIEW OF THE VANGUARD MODEL



The term 'click, call or come in' highlights the need to manage the majority of urgent care needs in the community. The use of expensive hospital services is deemed to be the last resort and reserved for those patients with life threatening conditions.

Appendix 3 OVERVIEW OF THE VANGUARD PROGRAMME OF WORK