CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD

Cambridgeshire County Council

Date:Thursday, 19 January 2017

Democratic and Members' Services
Quentin Baker
LGSS Director: Lawand Governance

10:00hr

Shire Hall
Castle Hill
Cambridge
CB3 0AP

Kreis Viersen Room
Shire Hall, Castle Hill, Cambridge, CB3 0AP

AGENDA

Open to Public and Press

15 Appointments to External Bodies

To appoint a representative of the Health and Wellbeing Board to sit on the Primary Care Co-Commissioning Joint Committee. Information about the Committee is available at:

http://www.cambridgeshireandpeterboroughccg.nhs.uk/primary-care-co-commissioning-joint-committee.htm

16 Date of Next Meeting

The Health and Wellbeing Board will meet next on Thursday 30 March 2017 at 10.00am in the Council Chamber, South Cambridgeshire Hall, Cambourne, Cambridge CB23 6EA.

The Cambridgeshire Health and Wellbeing Board comprises the following members:

Councillor Tony Orgee (Chairman) Tracy Dowling (Vice-Chairwoman)

Councillor Margery Abbott Dr Catherine Bennett Councillor Mike Cornwell Councillor Sue Ellington Kate Lancaster Chris Malyon Lance McCarthy Val Moore Wendi Ogle-Welbourn Dr Sripat Pai Councillor John Michael Palmer Liz Robin Councillor Joshua Schumann Vivienne Stimpson Aidan Thomas and Matthew Winn Councillor Paul Clapp Councillor David Jenkins Councillor Peter Topping and Councillor Joan Whitehead

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

Clerk Name: Richenda Greenhill

Clerk Telephone: 01223 699171

Clerk Email: Richenda.Greenhill@cambridgeshire.gov.uk

The County Council is committed to open government and members of the public are welcome to attend Committee meetings. It supports the principle of transparency and encourages filming, recording and taking photographs at meetings that are open to the public. It also welcomes the use of social networking and micro-blogging websites (such as Twitter and Facebook) to communicate with people about what is happening, as it happens. These arrangements operate in accordance with a protocol agreed by the Chairman of the Council and political Group Leaders which can be accessed via the following link or made available on request: http://tinyurl.com/ccc-film-record.

Public speaking on the agenda items above is encouraged. Speakers must register their intention to speak by contacting the Democratic Services Officer no later than 12.00 noon three working days before the meeting. Full details of arrangements for public speaking are set out in Part 4, Part 4.4 of the Council's Constitution http://tinyurl.com/cambs-constitution.

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Agenda Item No: 2

CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD: MINUTES

Date: 17 November 2016

Time: 9.30am to 10.15am

Venue: The Civic Suite, Pathfinder House, Huntingdon

Present: Cambridgeshire County Council (CCC)
Councillor D Jenkins
Dr Liz Robin, Director of Public Health (PH)
Charlotte Black, Service Director – Older People's Services and Mental Health (substituting for Wendi Ogle-Welbourn, Interim Executive Director for Children, Families and Adults).

City and District Councils
Councillors M Abbott (Cambridge City), M Cornwell (Fenland) and S Ellington (South Cambridgeshire) and J Schuman (East Cambridgeshire).

Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)
Dr Cathy Bennett, Tracy Dowling, Chief Officer – Cambridgeshire and Pterborough Clinical Commissioning Group (Vice-Chairwoman) and Dr Sripat Pai.

Healthwatch
Val Moore.

NHS Providers
Cara Charles-Barks (Hinchingbrooke Health Care NHS Trust (substituting for Lance McCarthy), John Syson (Papworth Hospital NHS Foundation Trust – substituting for Claire Tripp), Aidan Thomas (Cambridgeshire and Peterborough NHS Foundation Trust) and Matthew Winn (Cambridgeshire Community Services NHS Trust).

Voluntary and Community Sector (co-opted)
Julie Farrow, Chief Executive Officer, Hunts Forum of Voluntary Organisations.

Also in attendance:
Jessica Bawden, Director of Corporate Affairs, Cambridgeshire and Peterborough Clinical Commissioning Group
Kate Parker, Head of Public Health Programmes, CCC.

Apologies: Councillor Paul Clapp (CCC), Kate Lancaster (Cambridge University Hospitals NHS Foundation Trust), Lance McCarthy (Hinchingbrooke Healthcare NHS Trust), Chis Malyon (Section 151 Officer, CCC), Wendi Ogle-Welbourn (Interim Executive Director, Children, Families and Adult Services, CCC), Councillor Tony Orgee (CCC and Chairman of the Cambridgeshire Health and Wellbeing Board), Councillor John Palmer (Huntingdonshire District Council), Vivienne Stimpson (NHS England), Councillor Peter Topping (CCC), Claire Tripp (Papworth Hospital NHS Foundation Trust) and Councillor Joan Whitehead (CCC).

241. APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST

Apologies were noted as recorded above. In the absence of the Chairman the meeting was chaired by Tracy Dowling, Vice Chairwoman. There were no declarations of interest.

242. MINUTES OF THE MEETING ON 15 SEPTEMBER 2016

The minutes of the meeting on 15 September 2016 were agreed as an accurate record and signed by the Vice Chairwoman.

243. ACTION LOG

The Director of Public Health reported that the Action Log had been revised to include the date of the meeting at which each action had arisen and that a strengthened process had been put in place via the Health and Wellbeing Board Support Group to monitor progress on each action.

- **Minute 181 & 223: Older People's and Adult Community Services (OPACS) Contract:** The Director of Corporate Affairs, Cambridgeshire and Peterborough Clinical Commissioning Group reported that as of 18 November 2016 all beds at Doddington Court would be back in use. Action complete;
- **Minute 214: Quality Premium 2016/17: Clinical Commissioning Group Choice of Local Indicators:** The Vice Chairwoman asked that a brief report be submitted to the Board's January meeting and commented that it was important to see where progress was and was not being made;
  (Action: Sue Last)
- **Minute 235: Safeguarding Adults Board Annual Report 2015/16:** Julie Farrow said that she had attended a meeting of the Transforming Lives Board the previous day. Action complete.

It was resolved to:

1. Note the Action Log and verbal updates provided.

244. HEALTH AND CARE SYSTEM SUSTAINABILITY AND TRANSPORMATION PROGRAMME – MEMORANDUM OF UNDERSTANDING

The Director of Public Health explained that all NHS organisations within the Cambridgeshire and Peterborough area had been asked to take part in preparing a five year strategic plan, known as the Sustainability and Transformation Plan (STP). Due to the interdependence of local authority social care and public health services with local NHS services, Cambridgeshire County Council and Peterborough City Council had been asked to plan jointly with NHS providers and to align services with the STP where appropriate. As part of the STP process local NHS organisations were being asked to sign up to a memorandum of understanding (MOU) which included a commitment to working towards greater collaboration including the sharing of financial risk. It was not deemed feasible for local authorities to sign up to the full MOU due to the different democratic processes and financial and governance structures in local government. However, a separate local authority appendix to the MOU had been produced which set out key behaviours and principles and which was designed to promote integrated working across local authorities and the NHS. This recognised the role of District Councils as well as county and city councils.

Given the significant and wide-ranging scope of the MOU the Monitoring Officer had agreed to the local authority appendix being submitted to both the Cambridgeshire County Council (CCC) Adults Committee on 3 November 2016 and the CCC Health Committee on 10 November 2016 for consideration and comment prior to submission to the Health and Wellbeing Board and CCC Chief Executive for final approval and sign-off. With the Vice-Chairwoman's agreement, a revised version of the draft local authority appendix to the MOU was tabled which showed the amendments requested by the CCC Adults and Health Committees when they had considered the draft text as tracked changes (copy attached at Appendix A).

The following points were raised in discussion:

- District Councillors indicated that they were minded to support the inclusion of the Local Authority Appendix, but felt that they would need the approval of their own District Councils before they could formally sign up;
- Some NHS provider representatives felt that the Local Authority Appendix focused too closely on what could not be done and felt that it could have been given a more positive tone by referencing more areas of common interest between the health service, local authorities and city and district councils;
- Noting the difficulty caused to local authorities in signing up to shared financial risk it was suggested that a form of words might be included which made clear that there was no reluctance to look at this in relation to specific projects as part of the existing democratic process, but without implying any wider acceptance of shared financial risk. The Director of Public Health said that it might be possible to include an enabling sentence to this effect, but that this would need to be cleared with lawyers;
- The Voluntary and Community Sector representative said that there had been a lack of engagement nationally with the voluntary sector in production of the STPs;
- The Chief Executive of the Cambridgeshire and Peterborough NHS Foundation Trust said that it was intended to work more closely with voluntary sector organisations on primary care and integrated neighbourhood workstreams;
- The Director of Corporate Affairs, Cambridgeshire and Peterborough Clinical Commissioning Group said that it was hoped that the STP would be published the following week and that there would be a period of further engagement after publication (Secretary's Note: The Cambridgeshire and Peterborough STP was published on 21 November 2016).

In light of the discussion, it was resolved that:

1. Officers would explore the inclusion of an enabling clause regarding shared risk and gain in the Local Authority Appendix to the MOU. If it was not possible to include such a clause an explanation of why this was not possible would be provided;
   (Action: Director of Public Health)
2. The Chief Executive of Cambridgeshire County Council and Peterborough City Council would be invited to sign off the Local Authority Appendix on behalf of both authorities;
   (Action: Director of Public Health)

3. District and City Councillors would each take the STP MOU Local Authority Appendix through their own democratic processes (for example, Cabinet) before final sign-off by the Chairman of the Health and Wellbeing Board at the Board's next meeting on 19 January 2017;
   (Action: District and City Council representatives)
4. The Voluntary and Community Sector representative would provide feedback on where she felt the voluntary sector could contribute in discussion with the Chief Executive of the Cambridgeshire and Peterborough NHS Foundation Trust.
   (Action: The Voluntary and Community Sector representative)

245. FORWARD AGENDA PLAN

The Board considered the Forward Agenda Plan and it was resolved to:

1. Amend the Plan to show that reports on the Cambridgeshire and Peterborough Health and Care System Sustainability and Transformation Programme would be made by the Chief Officer, Cambridgeshire and Peterborough Clinical Commissioning Group. It was agreed that the January report would include an update on organisational planning;
   (Action: Chief Officer, Cambridgeshire and Peterborough Clinical Commissioning Group)
2. Add an item on dual diagnosis of mental health and substance misuse issues to the agenda for January;
   (Democratic Services Officer)
3. Reflect on whether any information items on the March agenda might be circulated outside of the meeting;
   (Director of Public Health)
4. Consider the inclusion of a development session on understanding county council, district and city council and NHS budgets and budget processes;
   (Director of Public Health/ Head of Public Health Programmes)
5. Add an item on Primary Care Strategy to the January agenda;
   (Democratic Services Officer)
6. Add a development session on the future development of primary care in Cambridgeshire, including the location of services, integrated use of the estate and estate development;
   (Head of Public Health Programmes)
7. Add a report on the output from the November development session to the agenda for the January meeting.
   (Democratic Services Officer)

246. DATE OF NEXT MEETING

The Board will meet next on Thursday 19 January 2017 at 10.00am in the Kreis Viersen Room, Shire Hall, Cambridge.

Chairman

Appendix A

CAMBRIDGESHIRE AND PETERBOROUGH
SUSTAINABILITY AND TRANSFORMATION PROGRAMME
MEMORANDUM OF UNDERSTANDING

Tracked changes to the text requested by Cambridgeshire County Council Adults Committee on 3 November 2016 are shown in red and changes requested by Cambridgeshire County Council Health Committee on 10 November 2016 are shown in blue.

Appendix 1: Local Authorities and the C&P Sustainability and Transformation Plan

Introduction

- The local health economy within the Cambridgeshire & Peterborough Clinical Commissioning Group area has agreed a single Sustainability and Transformation Plan (STP) for 2016 – 2021, which has been approved by NHS England and NHS Improvement.

- All partners share an ambition to return the health and care system in Cambridgeshire and Peterborough to financial, clinical and operational sustainability, coordinating System improvements for the benefits of local residents and healthcare users by:
  - Supporting local people to take an active and full role in their own health
  - Promoting health, preventing health deterioration and promoting independence
  - Using the best, evidence-based, means to deliver on outcomes that matter
  - Focussing on what adds value (and stopping what doesn't)

  Cambridgeshire County Council (CCC) and Peterborough City Council (PCC) are key stakeholders in the development and delivery of the STP and will act as partners in the STP by working together to find solutions to ensure that healthcare, public health and social care services are aligned. ~~aligning their public health and social care services to support its delivery.~~ However the Councils will only be able to do this in line with their statutory responsibilities, democratic and constitutional duties in the local authorities' governance arrangements

- The Cambridgeshire District and City Councils, which are members of the Cambridgeshire Health and Wellbeing Board, exercise a number of relevant functions including housing, land use planning, leisure services etc, which may also align to the wider STP Programme, and which are subject to their own democratic and constitutional arrangements.

- All partners across local authorities and the NHS are expected to support local Health and Wellbeing Strategies and Better Care Fund Plans. NHS partners will ensure that STP delivery is aligned with these wider partnership strategies and plans.

- An agreed set of behaviours and principles has been developed in order for CCC, PCC and the wider local authority membership of the HWB Board to support (and be supported) in the contribution to and delivery of the STP.

- These behaviours and principles outline how CCC, PCC and the wider local authority HWB Board membership will work together with the Health system, whilst adhering to their statutory duties and democratic and constitutional duties in the local authorities' governance arrangements

Key Behaviours:

CCC, PCC and the wider local authority Health and Wellbeing Board membership recognise the scale of change required to deliver the STP and that cultural change applies from leadership level to front line staff.

CCC, PCC and the wider local authority Health and Wellbeing Board membership will continue to build and promote trusting relationships, mutual understanding and where feasible take decisions together with the health system.

CCC and PCC representatives on the Health and Care Executive (HCE) will take full responsibility for making sure their staff are well briefed on system improvement work, drawing from system messages and materials. The HCE will ensure that relevant system messages and materials are shared with the wider HWB Board membership.

All members of the Health Care Executive and the Health and Wellbeing Boards will support and promote system behaviours for the benefit of local residents and healthcare users including:

- Working together and not undermining each other
- Behaving well, especially when things go wrong
- Engaging in honest and open discussion
- Keeping our promises – small and large
- Seeing success as collective
- Carrying through ~~sticking to~~ decisions once made

Key Principles:

The key principles of local authorities working with partners to deliver the STP plan are:

- Commitment to implementation at pace

- Use collective commissioning and buying opportunities to improve delivery outcomes and/or system savings

- Where appropriate, HCE representatives and other senior local authority officers to act as if part of a single executive leadership team, to coordinate system improvements for the benefits of local residents in line with the STP.

- Influence the view of regulators and external assurance bodies regarding the primacy of System sustainability enshrined in the STP and the joint commitment to it.

- Highlight and work to prevent cost shunting to other partners, subject to statutory requirements on both partners.

- Adopt an invest to save approach

- Share information on new major service developments, savings, closures or relocations, and more generally share information in a timely manner when needed to support development of partnership business cases and savings plans. This should comply with existing information sharing agreements and protocols.

- Align human, financial, estate and digital resources to deliver these changes where this adds value, delivers people-centred outcomes and saves money.

Democratic requirements and local authority governance

- CCC and PCC will participate in the Health and Care Executive (HCE) arrangements through their senior officer representatives acting as non-voting members of the HCE. This arrangement will recognise that local authority policy and financial decisions are subject to the constitutional decision making arrangements within their respective authorities, with are led by elected Councillors.

- CCC, PCC and Cambridgeshire District and City Councils will also participate in and support the STP through their local Health and Wellbeing Boards and shared programme management arrangements. Again, this arrangement will recognise that local authority policy and financial decisions are subject to the constitutional decision making arrangements within their respective authorities, which are led by elected Councillors.

- Local authorities support the commitment to longer-term planning, but the Partners recognise that local authorities are subject to democratic governance. Therefore the LAs must reserve the right to change their priorities in accordance with the priorities of their elected Councils

- CCC, PCC and wider local authority HWB Board membership cannot commit to sharing the opening financial risk in the STP, given that local authorities have a statutory requirement to balance their budgets and cannot operate at a deficit. Likewise, NHS partners are not expected to commit to meeting the financial risk of meeting statutory social care requirements.

- CCC and PCC ~~also~~ have a particular statutory requirement to scrutinise proposals for NHS service changes as elected representatives of their communities, and must ensure the independence and integrity of those arrangements.

- The role of all Councillors to represent the views of their local constituents and speak up on their behalf is recognised. Councillors have a unique responsibility of advocacy with respect to their constituents. Nothing in this memorandum should undermine that.

HEALTH & WELLBEING BOARD ACTION LOG: JANUARY 2017

MINUTE & ITEM TITLE	ACTION REQUIRED / UPDATE	STATUS
Meeting Date: 17.09.15		
149: Progress on HWB Priority 4	Circulate a briefing to HWB members on the work being done on universal credit and provision of support in benefits sanction cases in Children, Families and Adults Services (CFA) and in the District Councils **UPDATE 07/07/16:** The CFA Child Poverty Group was considering the wider issues; District Councils leading on Universal Credit. District Council leads to progress provision of information on universal credit. **UPDATE 09/11/16:** Mike Hill to pursue and feedback. Claire Bruin to speak to Lisa Faulkner and feedback. **UPDATE 06/01/17:** Given the time elapsed no further action is proposed. **Action: I Green / M Hill / C Bruin**	**No further action**

MINUTE & ITEM TITLE	ACTION REQUIRED / UPDATE	STATUS
Meeting Date: 14.01.16		
180. Community Resilience Strategy	The Board's District Council support officer undertook to liaise with the Service Director on local planning in South Cambridgeshire, with the aim of avoiding duplication and identifying gaps in what was in place **UPDATE 09/11/16:** This has been overtaken by the Transformation Programme which Sue Grace is leading and there is on-going dialogue. Liz Robin to check the position with Sue Grace before this action is closed. **UPDATE 06/01/17:** This action is confirmed as complete. **Action: L Robin**	**Completed**
Meeting Date: 26.05.16		
214: Quality Premium 2016-17:CCG Choice of Local Indicators	CCG Head of Operational Planning to supply list of factors on which the quality premium bonus would be awarded, and to supply implementation plan **UPDATE 07/07/16:** This work was expected to be completed in late July, when the information requested could be supplied to the HWB. **UPDATE 09/11/16:** Sue Last to send a briefing to the Board with a list of the quality premium factors. **UPDATE 30/11/16**: A brief report be submitted to the Board's January meeting, including details of where progress was and was not being made. **Action: S Last**	**On-going**

MINUTE & ITEM TITLE	ACTION REQUIRED / UPDATE	STATUS
Meeting Date: 07.07.16		
224: Cambridgeshire Summary Joint Strategic Needs Assessment (JSNA) 2016	Issues around freehold properties estate management issues / key worker housing to be the subject of further discussions between the District Support Officer and Matthew Winn. **UPDATE 09/11/16:** Alex Parr to liaise with Iain Green to confirm that this discussion has taken place. **UPDATE 06/01/17:** This action is confirmed as complete. **Action: A Parr/ I Green**	**Completed**
226: Long-Term Conditions JSNA – update report	Details of specific work areas which were not implementing the JSNA findings to be circulated to all HWB members so that they could help unblock them. **UPDATE 09/11/16:** Liz Robin to speak to A Mavrodaris and provide feedback. **Action: L Robin**	**On-going**
Meeting Date: 15.09.16		
235. Safeguarding Adults Board Annual Report 2015-16	To share with the Board any recommendations arising from the review of the increase in reported cases of abuse and/ or neglect in care homes in 2015-16 compared to the previous year when this information was available. **Action: C Bruin**	**On-going**

MINUTE & ITEM TITLE	ACTION REQUIRED / UPDATE	STATUS
236. Cambridgeshire Local Safeguarding Children Board (LSCB) Annual Report 2015-16	To draft a letter to NHS England for the Chairman's signature seeking an assurance that an adequate mechanism is in place to ensure that they are able to discharge their statutory duties if they are not able to attend meetings with the LSCB. **Action: A Jarvis** **UPDATE 23/10/16: Awaiting confirmation from Andy Jarvis that the response from NHS England in relation to Minute 236 above covers the points to be raised.**	**In progress**
238. Community Resilience Strategy	To arrange a workshop to bring together representatives from District and partner organisations and officers. **UPDATE 09/11/16:** Claire Bruin to speak to Sarah Ferguson and provide feedback. **Action: C Bruin/ S Ferguson**	**On-going**
Meeting Date: 17 November 2016		
244. Health and Care System Sustainability and Transformation Programme - MOU	Officers would explore the inclusion of an enabling clause regarding shared risk and gain in the Local Authority Appendix to the MOU. If it was not possible to include such a clause an explanation of why this was not possible would be provided. **UPDATE 06/01/17:** A short clause was added to the MOU. **Action: L Robin**	**Completed**
	The Chief Executive of Cambridgeshire County Council and Peterborough City Council would be invited to sign off the Local Authority Appendix on behalf of both authorities. **UPDATE 20/12/16:** The Chief Executive agreed to sign off the MOU on behalf of Cambridgeshire County Council. **Action: L Robin**	**On-going**

MINUTE & ITEM TITLE	ACTION REQUIRED / UPDATE	STATUS
	District and City Councillors would each take the STP MOU Local Authority Appendix through their own democratic processes (for example, Cabinet) before final sign-off by the Chairman of the Health and Wellbeing Board. **UPDATE 06/01/17:** Work is continuing with regards to sign off by district and city councils. **Councillors Abbott, Cornwell, Ellington, Schuman and Palmer**	**On-going**
	The Voluntary and Community Sector representative would provide feedback on where she felt the voluntary sector could contribute via the Chief Executive of the Cambridgeshire and Peterborough NHS Foundation Trust. **Action: J Farrow/ A Thomas**	**On-going**
245. Forward Agenda Plan	Reports on the Cambridgeshire and Peterborough Health and Care System Sustainability and Transformation Programme to be made by the Chief Officer, Cambridgeshire and Peterborough Clinical Commissioning Group. The January report to include an update on organisational planning. **Action: T Dowling**	**Completed**
	Add an item on dual diagnosis of mental health and substance misuse issues to the January agenda. **Action: R Greenhill** **UPDATE 30.11.16**: Added to the Forward Agenda Plan for March 2017.	**Completed**

MINUTE & ITEM TITLE	ACTION REQUIRED / UPDATE	STATUS
	Reflect on whether any information items on the March agenda might be circulated outside of the meeting. **Update: The forward Agenda for March was discussed at the Health and Wellbeing Officer Support Group meeting, and items were identified which could be circulated outside the meeting.** **Action: L Robin**	**Completed**
	Consider the inclusion of a development session on understanding county council, district and city council and NHS budgets and budget processes. **Action: L Robin/ K Parker**	**On-going**
	Add an item on Primary Care Strategy to the January agenda. **Action: R Greenhill** **UPDATE 30.11.16:** Added to the Forward Agenda Plan for January 2017.	**Completed**
	Add a development session on the future development of primary care in Cambridgeshire, including the location of services, integrated use of the estate and estate development. **Action: K Parker**	**On-going**
	Add a report on the output from the November development session to the agenda for the January meeting. **Action: R Greenhill** **UPDATE:** Added to the Forward Agenda Plan for January 2017.	**Completed**

Agenda Item No: 4

OUTCOMES FROM 17 NOVEMBER DEVELOPMENT SESSION

To: **Health and Wellbeing Board**

Date: **19 January 2017**

From: **Director of Public Health**

	Officer contact:
Name:	Dr Liz Robin
Post:	Director of Public Health
Email:	Liz.robin@cambridgeshire.gov.uk
Tel:	01223 703259

1.0 PURPOSE

1.1 To present the outcomes from a development session held for members of the Cambridgeshire Health and Wellbeing Board (HWB) on Thursday 17 November 2016.

2.0 BACKGROUND

2.1 A development session was held for members of the Cambridgeshire HWB from 10am to 1pm on Thursday 17 November at Pathfinder House, Huntingdon. Following the development session on 14 June 2016, a priority was agreed by the Cambridgeshire HWB to hold a session on "Developing and retaining the future health and care workforce". The purpose of the session would be to identify recommendations for representatives of the HWB to take back to their organisations to action.

2.2 The development session was in two parts. In Part 1, members received an update on the local Devolution Plans for Cambridgeshire which was facilitated by Kevin Hoctor and Dr. Liz Robin. Part 2 was planned and facilitated by the Local Government Association (LGA), as part of the LGA's programme of support to the health and wellbeing system nationally.

2.3 Additional contributions to Part 2 were received from Lucy Dennis (Health Education England) and Paul Evans (Cambridgeshire County Council). The agenda for the session included:

Part 1 - Update on Cambridgeshire Devolution

Part 2-

- Overview of Workforce issues and opportunities
- Setting the Plans into a national context
- Oversight role of the Health and Wellbeing Board
- Recommendations and next steps

2.4 The session was attended by 19 representatives for the Cambridgeshire HWB and included representation from other organisations including Health Education England (Head of workforce partnership), Local Government Shared Services (LGSS) Workforce planning lead, Cambridgeshire County Council (Head of Workforce Development) and the Greater Cambridge Greater Peterborough Enterprise Partnership (LEP).

2.0 OUTCOMES FROM THE DEVELOPMENT SESSION

3.1 The following outcomes have resulted from the development session.

- Links were established between Cambridgeshire HWB and the Local Workforce Advisory Boards (LWAB). The latter have responsibility to

produce a joint strategy for workforce planning across health, social and tertiary care in Cambridgeshire and Peterborough.
- Contact details of partners such as the LEP and LGSS have been passed onto the LWAB.

3.2 Members discussed areas that further consideration should be given to:

- Importance of all workforce strategies to recognise and address the wider determinants of workforce planning e.g. housing & transport infrastructure and the impact of growth and new communities.
- Consider commissioning the LWAB & LEP to leverage the apprenticeship levy keeping the funding locally.
- Recognise that Cambridgeshire HWB can hold to account the Council & Health service executive to have a joint strategy and could be more specific about what the joint strategy should reflect e.g. joint training.
- Consider what a future workforce want from us locally e.g. single place for all our training pathways, career structure in care creating a "job family" across health and social care and opportunity to progress through recognised training and recruitment routes.
- New opportunities to work differently ensuring the right partners are included in strategy development e.g. involvement of district council partners

3.3 As a result of the development session the Health and Wellbeing Board are receiving the Cambridge & Peterborough workforce strategy for information and discussion (See Appendix 1). This strategy is produced by the LWAB as part the Sustainable Transformation Programme but is not a stand-alone strategy and is supported within the wider context of system-wide transformation for the local health and social care system.

4.0 ALLIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

4.1 Discussion at the development session related mainly to the Priority 6 of the Cambridgeshire Health and Wellbeing Strategy: to work together effectively, but the theme of workforce development will have impacts on other priorities within the strategy.

5.0 RECOMMENDATION

5.1 The Health and Wellbeing Board is asked to consider the Cambridge & Peterborough Workforce Strategy and how the Board can further support the development of a whole system strategy across Health and social care.

Cambridgeshire and Peterborough Integrated Workforce Strategy

Submitted by:	Lucy Dennis Head of Cambridgeshire and Peterborough Workforce Partnership (Health Education England)
Review Dates:	Local Workforce Advisory Board 8th December 2016 Health and Wellbeing Board (Cambs) 19th January 2016

NHS
Health Education England

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

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Executive Summary

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

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

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

Our Ambition – Vision for the workforce by 2020

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

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

1 Improving supply

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

2 Improving retention

3 New role development

4 Scaling up new ways of working and up-skilling

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

5 Leadership development

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

1 Improving supply

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

Ambition

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

Transformation

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

How

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

Quality of Education

Ambition

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

How

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

New Routes

Ambition

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

Transformation

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

How

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

Housing and Transport

Ambition

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

Transformation

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

How

- Work with Local Authorities and planners toprovide information on areas of workforce growth and need in relation to housing a transport
- Work with all partner organisations to prepare clear, consistent and accessible information on local housing and transport for Cambridge and Peterborough so that our recruits can make informed choices about their future residence

Case Study: Healthy New towns – Northstowe

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

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

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

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

2 Improving Retention

Ambition

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

Transformation

- Development of a system wide staff health and wellbeing framework

How

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

3 New Role Development

Ambition

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

How

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

Case Studies: New role development

Clinical pharmacists in General Practice

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

Integrated workers

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

Emotional Health and Wellbeing Workers

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

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

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

Nursing Associate

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

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

4 Scaling up new ways of working and up-skilling

Workforce Planning

Ambition

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

Transformation

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

How

Transactional

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

Workforce Optimisation

Ambition

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

Transformation

- Work with external stakeholders to develop technologies for local adoption

How

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

Clinical Networks

Ambition

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

Transformation

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

How

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

System Investment Plans

Ambition

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

Transformation

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

How

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

Devolution

Ambition

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

How

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

Integrated working

Ambition

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

Ambition

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

Management plans for where we will achieve integration through:

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

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

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

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

CASE STUDY: New ways of Working

Agile working by the Wisbech Neighbourhood Team

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

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

5 Leadership development

Ambition

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

How

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

Appendices

National and Local Context

Service

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

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

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

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

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

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

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

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

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

Table 01

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

Workforce

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

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

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

Governance

This strategy is not intended to replace or supersede inter-organisational strategies but instead to support their direction setting so that organisational workforce strategies demonstrate alignment with the Cambridgeshire and Peterborough Integrated Workforce priorities. The Cambridgeshire and Peterborough (C&P) system has a long history of partnership working in relation to workforce. Through Health Education England's (HEE) local governance structures, the healthcare system has been able to work collaboratively to strategically plan; commission and quality assure education and training, workforce transformation, and support leadership development across the system

As one of the STPs delivery units, the Local Workforce Action Board (LWAB) will bring together health, social care, and other stakeholder organisations across a broad range of workforce issues so that the people elements of the STP strategy can be identified and delivered across the health and care system. It will also be responsible for the local delivery of HEE's Mandate and strategic priorities, these will include areas such workforce planning, training and wider development, leadership, and organisational development.

The LWAB will develop four key products these are:

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

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

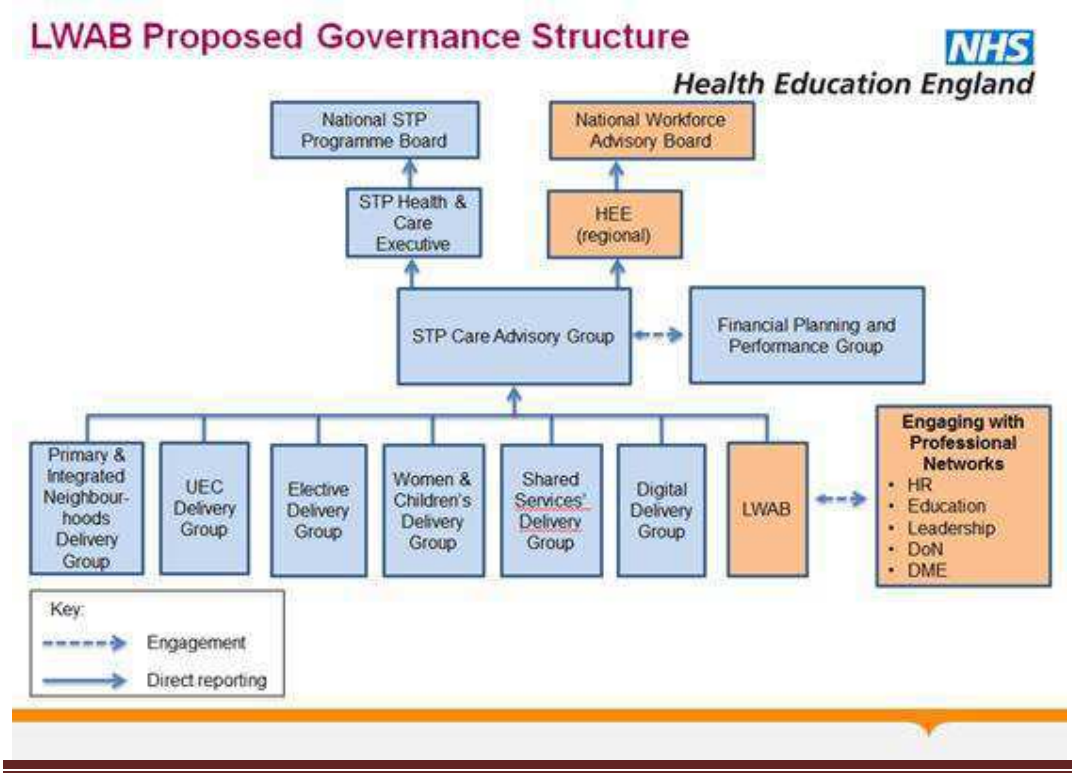


Image 1: LWAB proposed governance structure (HEE, 2016)

The Workforce context to 2020

Local demography

GROWTH

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

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

73,000 new dwellings forecast up to 2036

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

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

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

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

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

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

LONG TERM CONDITIONS

Cambridgeshire

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

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

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

Population change and **rising obesity**

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

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

1 in 16 adults suffer from **diabetes**

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

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

MENTAL HEALTH

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

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

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

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

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

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

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

Housing and Transport

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

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

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

Affordability Ratios

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

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

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

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

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

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

Local Labour Market Context

This section will cover the following:

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

Workforce profile

HEALTH

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

SOCIAL CARE

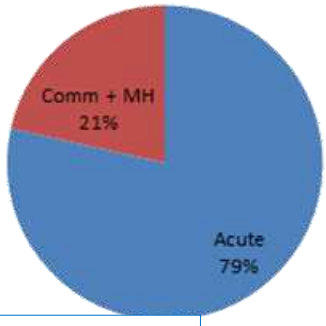
In social care, the majority (83%) of the workforce in Cambridgeshire and Peterborough are female and **the average age is 41-42 years old**. Cambridgeshire and Peterborough have similar profiles with around 82% of the workforce being British, 8-10% are from within the EU and 8-10% from outside the EU,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

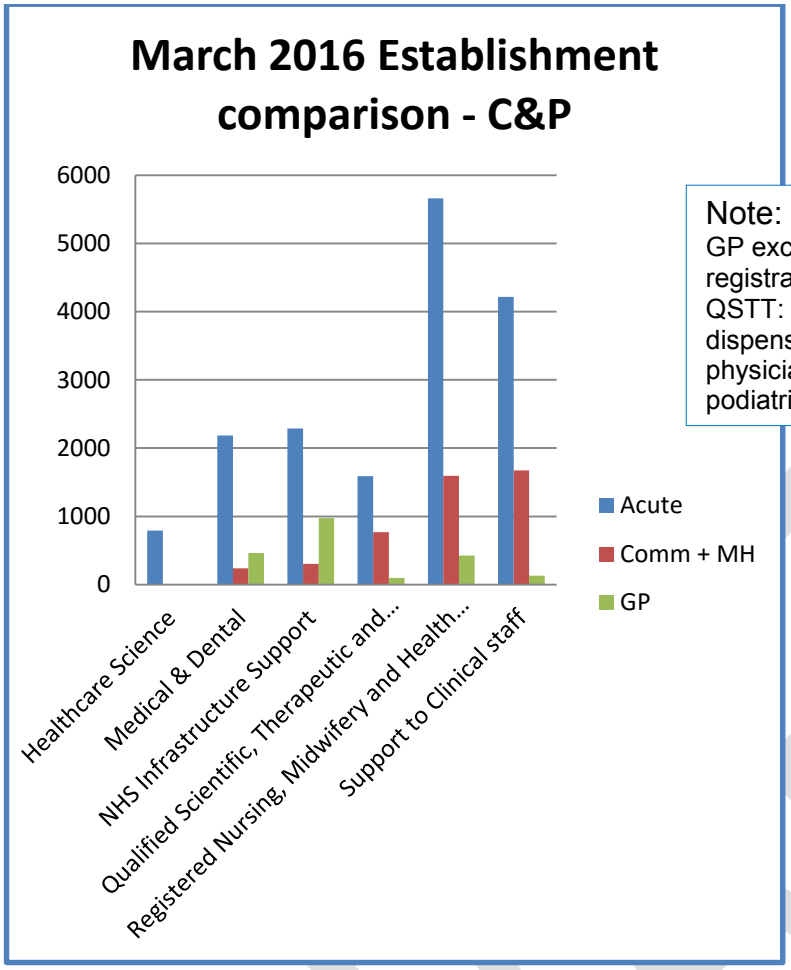
Establishment

HEALTH

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

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





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

General Practice

105 Practices

3 GP Federations

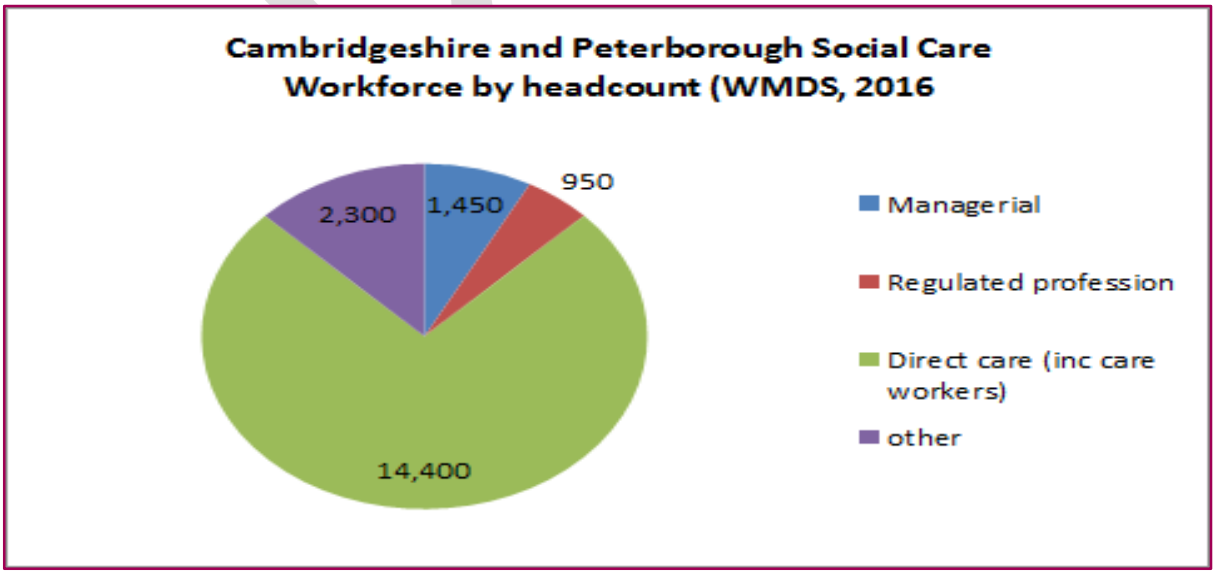
Headcount = 2,737 staff.

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

Table 04 NHS workforce (May 2016)

SOCIAL CARE

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



Vacancy rates

HEALTH

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

Source: Trust forecasts, May 2016

SOCIAL CARE

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

Retirement

HEALTH

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

Source: ESR Data Warehouse 2016

SOCIAL CARE

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

Net Loss

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

Progression

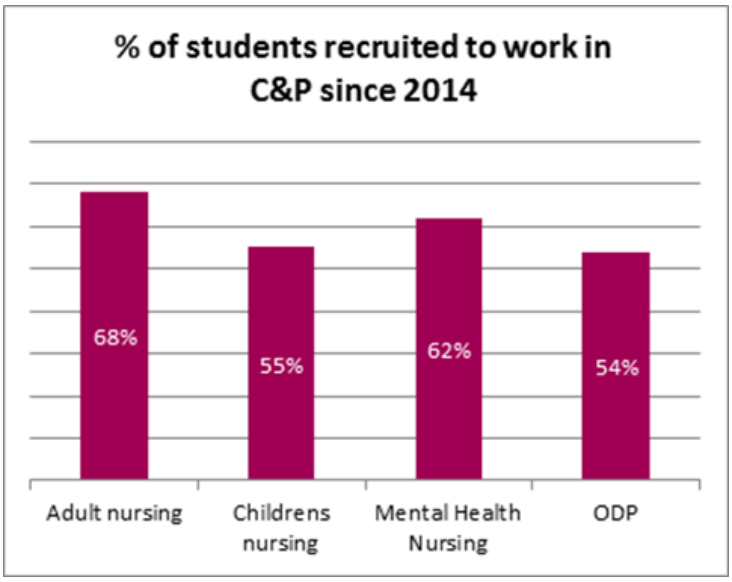
HEALTH

Non-medical and AHP

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

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

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



Progression Contd…

HEALTH

Medical

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

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

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

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

SOCIAL CARE

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

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

Temporary Workforce

HEALTH

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

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

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

SOCIAL CARE

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

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

Projected Growth

HEALTH

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

SOCIAL CARE

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

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

Workforce Context to 2020 - Summary

Key Issues

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

Population

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

Operational risk

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

Workforce risk

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

High Level Workforce Work Programme January 2017 – January 2019

A high level delivery plan has been designed to translate the ambitions from this workforce strategy in key improvement programmes. This sets out the key Improvement Areas, responsible officers, projects and timeframes.

Improvement areas	SRO (wte)	Projects	Ambition	Priority Short term <6months Medium term 6-12 Long term 12-24 months
Workforce planning	Bill Irish	• Assess workforce **Demand data and intelligence**: • Basics: vacancies, forecast est., age profile, retirements, sickness absence • Advanced: net promoter, staff engagement scores etc.	1234	S
		• Assess planned **Supply data and intelligence**: • Basics: non-medical outturn & attrition, changes to investment in trainee posts, medical fill rates and historical training issues etc. • Advanced: Student and trainee survey feedback etc.	1234	S
		• **Triangulate workforce data and intelligence** across specific pathways to agree short, medium and long-term opportunities for sustainable workforce re-design, drawing on national and regional best practice.	1234	S
		• Implement and align a strategic **workforce and service planning framework** aligned to the STP, under-pinned by a single data and intelligence function, to inform commissioning new and ongoing professional development of staff	1234	S
Training and wider development (potential Opp)	David Wherrett	• Develop a system wide **Workforce Investment Plan**, in which all providers commit to investment priorities in relation to Apprenticeships (via LEVY), Pre-Registration, CPD and wider workforce transformation (including leadership and OD)	4	M
	Bill Irish	• Develop a system wide **Supply Improvement Programme**: • Expanding flexible training routes for supply shortage areas (flexible work based training routes, Implementing GPN education framework, RTP etc.) • Implementation of the regional Employability Framework (recruitment to training, retention in training, recruitment to organisations and retention in employment) • Accelerate activities to improve the quality of the Clinical Learning Environment (enhanced models of coaching, mentoring, clinical champions) • Maximise workforce versatility (developing integrated care workers patient navigators, B1-3, developing apprenticeship standards mapped to MSc, scaling up Advanced Practice roles, skills passports, rotational training programmes, staff housing issues, a C&P wide nurse bank (including for GP), shard on-call rotas, employment contracts / clinical governance arrangements that enable multi-site working etc.)	1 4	L

Improvement areas	SRO (wte)	Projects	Ambition	Priority Short term <6months Medium term 6-12 Long term 12-24 months
Leadership / OD (potential opp)	Anita Pisani	• Develop a Tiered Leadership Package (early, mid and senior leaders); focusing on behaviour change, resilience and system leadership etc. and targeted in critical areas (general practice)	4 5	M
		• Agree a system Talent Management Framework targeted to critical supply shortage areas.	5	M
		• Provide Quality Improvement in core training (mandatory, CPD, Apprenticeship standards etc.)	1	M

Accountable Officer	Matthew Winn	Clinical Chair(s)	Jo Bennis	FD	Mark Robbins	HR	Anita Pissani

Underpinning Documents

Cambridgeshire and Peterborough data pack HEE. 2016.09.28

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

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

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

Cambridgeshire and Peterborough Health and Care System Sustainability and Transformation Plan. (2016)

2014. FIVE YEAR FORWARD VIEW.

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

HealthAndWellbeingStrategy-Draft-July2016 PBouroguh.

Outline Workforce Strategy Checklist PDF.

think_integration_web_2014.

Cambridgeshire JSNA.

Peterborough JSNA

Vanguard Workforce Self Assessment Framework (2).

Council, P., 2012. Growing the right way for a bigger, better Peterborough.

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

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

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

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

CAMBRIDGESHIRE BETTER CARE FUND PLANNING 2017 - 19

To: **Health and Wellbeing Board**

Meeting Date: **19 January 2017**

From: **Charlotte Black, Service Director: Older People's Services and Mental Health, Cambridgeshire County Council**
Cath Mitchell, Acting Director of Primary Care and Integration, Cambridgeshire and Peterborough CCG

Recommendations: **The Health and Wellbeing Board is asked to:**

1. Comment on and agree the proposals set out at 4.2 to inform the development of the Better Care Fund Plan for 2017-19; and
2. Agree to receive a more detailed performance update alongside a draft Better Care Fund plan at its meeting in March 2017.

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1. PURPOSE

1.1 The purpose of this paper is to:

- Provide a brief overview of progress in delivery of the Cambridgeshire Better Care Fund (BCF) Plan in 2016/17; and
- Seek guidance on Cambridgeshire's approach to the Better Care Fund, including further joint work with Peterborough City Council, to inform development of the BCF plan for 2017 – 19.

2 BACKGROUND

2.1 The Better Care Fund (BCF) creates a pooled budget in each Health and Wellbeing Board area, intended to assist health and social care services work more closely together. In 2016/17, Cambridgeshire's BCF budget is £48,464k. This was formed through a reorganisation of existing funding used to provide health, social care and housing services across the county. In April 2017, Cambridgeshire will be required to submit a new, jointly agreed BCF Plan, covering a two year period (April 2017 to March 2019).

2.2 The Health and Wellbeing Board is required to agree the Better Care Fund plan for Cambridgeshire. Guidance and timescales for the BCF have not yet been published; a verbal update will be provided at the meeting.

3. BCF ACTIVITY AND PERFORMANCE 2016/17

3.1 Cambridgeshire's 2016/17 BCF Plan was approved by NHS England in August 2016. The majority of the fund is used to provide existing services, which have been aligned to support joint planning and monitoring of activity and outcomes. These BCF activity areas are described in Appendix A. Alongside existing service spending, £1,702k was made available to support a range of transformation projects which would support us in delivering against the BCF key performance indicators, which are:

- A reduction in non-elective admissions to acute hospital
- A reduction in admissions to long-term residential and nursing care homes
- An increase in the effectiveness of re-ablement services
- A reduction in Delayed Transfers of Care (DTOC) from hospital
- A reduction in the proportion of adults receiving long-term social care
- Maintained patient satisfaction with local NHS services

3.2 BCF-funded activity has significantly progressed a number of initiatives across the local system in 2016/17, including:

- **Neighbourhood Teams:** Four 'Trailblazer' pilot sites have been refining the multi-disciplinary team (MDT) proactive case management model. These sites have seen joint work in MDTs across health, social care and the voluntary sector; lessons are now being rolled out to other neighbourhood teams. Further work is being undertaken to develop patient pathways and training plans for the consistent use of the Rockwood Frailty Tool across the system.
- **Data Sharing:** This project is supporting the development of an approach to 'pseudonymisation' of patient data to support the case finding process; a proof of concept technical solution has been developed; the first data has been transferred. Once complete this work will support easier matching of records

between health and social care to identify vulnerable people, with appropriate information safeguards in place.

- **Falls prevention:** a joint falls pathway has been developed and work to implement the pathway is ongoing. A pilot project has been operating since July in St Ives; learning from the evaluation will be rolled out across Peterborough and Cambridgeshire.
- **Joint Approach to Wellbeing:** Health and Local Authority commissioners are considering joint approaches to commissioning a system-wide approach to community resilience building & wellbeing services to improve outcomes and maximise use of existing investments. As part of this it has been agreed to establish a single wellbeing network across Peterborough and Cambridgeshire, which will offer individuals who are vulnerable - or are in the early stages of needing help - to access appropriate support from across the voluntary and community sector. In addition, approaches to developing social prescribing models are also being explored.
- **Care Home Support Team:** Support workers have been recruited to work with care homes in order to reduce inappropriate referrals to hospital. Regular professional breakfast meetings have been booked in each locality – Cambridge, Peterborough & Huntingdonshire.
- **Intermediate Care Teams:** Integrated Care Workers continue to be recruited across the system to provide care for people with health needs, in order to support earlier discharge from, or prevent unnecessarily prolonged stays in hospital as well as supporting early discharge from community hospital rehabilitation units.
- **Protection of social care:** The BCF has continued to provide vital support to social care services including reablement, domiciliary care and residential and nursing care. BCF funding has also supported the development of Cambridgeshire County Council's Adult Early Help Service.
- **Disabled Facilities Grant (DFG) review:** a review of the countywide approach to DFG, in order to provide a better service and release savings by providing support earlier and encouraging people to consider whether the accommodation they are living in will be suitable for them longer term.

3.3 The most recent performance update was submitted to NHS England at the end of Quarter 2. Performance on non-elective admissions was 5.7% worse than planned; DTOC performance was also worse than planned. Against the target of 1,203 bed days per 100,000 population, the target has not been achieved with an increase from 1,494 bed day delays per 100,000 population in Q1 to 1,531 in Q2. This trend has continued during Quarter 3 and it is expected that activity will remain worse than plan during the final quarter of the year. Whilst at the end of Quarter 2 the social care indicators were on track, significant pressure during quarter 3 has increased the risk associated with social care indicators.

3.4 To mitigate this in the final quarter of the year, the County Council and CCG have together reviewed use of the transformation funding within the BCF. Uncommitted funding within the budget is to be used to support initiatives that will have an impact on these performance metrics within Quarter 4, with a particular focus on improving performance on Delayed Transfers of Care and reducing non-elective admissions to hospital. Investments have been agreed in reablement capacity; voluntary sector involvement in case management; bed-based intermediate care provision; and initiatives to increase capacity in the domiciliary care and residential care sectors. These investments should

help to mitigate against the increased demand currently being experienced across the local system.

3.5 However, it is important to note that success in these indicators is reliant on a significantly wider range of factors than activity contained within the BCF Plan. Even with the additional activity described above, it is likely that overall performance will continue to be worse than target. Whilst BCF-funded activity will have successfully had an impact on preventing non-elective admissions and reducing DTOCs, this has not been sufficient to mitigate all underlying demand and increased pressures across the system. This highlights the challenge of maintaining the BCF as a separate programme of activity in delivering reductions in these indicators. In considering principles for future BCF planning, officers propose that BCF activity surrounding these areas should be more closely integrated into wider health system transformation accordingly (see paragraph 4.2 below).

3.6 By the date of the next Health and Wellbeing Board meeting in March, provisional year end data will be available, along with early evaluation of the measures outlined above. It is proposed that a more detailed report on performance, including the specific impact of BCF initiatives, be presented to the next Health and Wellbeing Board to inform discussion of the draft BCF Plan for 2017-19.

4 PLANNING FOR BCF 2017 – 19

4.1 At the time of writing, BCF guidance and funding allocations for 2017/18 and beyond have not yet been published. They are expected in January 2017 (delayed from 18 November); if they have been received by the date of the meeting, a verbal update will be provided. From information released to date, the following changes are expected:

- The policy framework and guidance will be wider in scope than purely BCF and will incorporate the wider integration agenda.
- The plan will cover a period of two years - 2017/18 and 2018/19.
- An uplift in funding is expected in the CCG minimum contribution; A new 'improved' BCF settlement will also see additional funding allocated to local authorities directly from central government, from 2017/18 (Peterborough) and 2018/19 (Cambridgeshire)
- The national conditions will be reduced to three: plans must be jointly agreed; a real terms increase in social care funding will be required; and a requirement to invest in NHS-commissioned out of hospital services. However, areas will likely still be required to discuss their approach to meeting previous national conditions.

4.2 Since the agreement of 2016/17 BCF plans, the local system has collectively signed up to a Sustainability and Transformation Plan (STP), and new governance arrangements have been established covering health and social care services across the Cambridgeshire and Peterborough CCG area. Over the same period there has been a significant increase in joint working between local public sector organisations in Cambridgeshire and Peterborough through the development of proposals for local devolution. These developments offer an opportunity to review the local approach to

Better Care Fund plans to reduce the risk of duplication and improve the chance of success. The following proposals are presented for discussion by the Health and Wellbeing Board:

- **Greater alignment of BCF activity with the STP and local authority transformation plans.** In its first two years, the BCF has maintained a separate project structure for many of its transformation projects. Given the fact that many BCF performance targets are dependent on activity across the STP Delivery Boards, further alignment is necessary. It is proposed that the BCF should shift to commissioning activity either from the HCE/ STP or local authority transformation programmes as appropriate, to reduce duplication and ensure that all partners can be engaged with the correct pieces of work. The BCF plan would describe activity to be commissioned, and responsibility for implementation would be passed to the most appropriate group. It would include specific targets in relation to performance indicators for BCF-commissioned activity as well as clarity on the primary governance.
- **Greater alignment of Cambridgeshire and Peterborough BCF Plans.** BCF transformation activity has always been aligned to some extent between Cambridgeshire and Peterborough. As most health and social care service transformation activity is now system wide, it is proposed that there should be further alignment of the two plans, with a single set of activity and common budget categories across the two areas. Separate BCF budgets would still be maintained in line with statutory requirements, and each Health and Wellbeing Board would still be responsible for agreeing plans.
- **A single commissioning Board for Cambridgeshire and Peterborough.** At present there are two separate boards in Cambridgeshire and Peterborough overseeing BCF activity – the Cambridgeshire BCF Delivery Board and Greater Peterborough Area Executive Partnership Commissioning Board. To support more effective joint commissioning it is proposed that these are replaced by a single board across Cambridgeshire and Peterborough. This would support a more joined up approach to planning and allow a more coordinated approach between the two areas and enable streamlined reporting into the two Health and Wellbeing Boards.

4.3 Whilst the submission dates for the next BCF Plan have not yet been published, it is anticipated that the Health and Wellbeing Board will have the opportunity to discuss the draft BCF Plan at its meeting in March, before a final submission to NHS England.

5 RECOMMENDATIONS

5.1 The Health and Wellbeing Board is asked:

- To comment on and agree the proposals set out at 4.2 to inform the development of the Better Care Fund Plan for 2017-19; and
- To agree to receive a more detailed performance update alongside a draft Better Care Fund plan at its meeting in March 2017.

5 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

5.1 The BCF is relevant to priorities 2, 3, 4 and 6 of the Health and Wellbeing Strategy:

- 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 together effectively.

Source Documents	Location
Cambridgeshire BCF Plan 2016/17	Available online: https://cmis.cambridgeshire.gov.uk/ccc_live/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/24/Committee/12/Default.aspx

APPENDIX A – LIST OF CAMBRIDGESHIRE BCF SPENDING CATEGORIES

Scheme Name	2016/17 Amount	Description
Promoting Independence	£9,343,206	A wide range of services that provide support to people to enable them to remain living independently in their own homes. Services include the Integrated Community Equipment Service; Handyperson scheme; Home Improvement Agency; Assistive Technology and provision of the Disabled Facilities Grant.
Reablement services - Intermediate Care and Reablement	£12,832,000	Short term interventions in both health and social care which support people to retain or regain their independence
Neighbourhood Teams	£17,049,000	Neighbourhood teams are integrated community-based physical and mental health care teams for over 65-year olds and adults requiring community services. They work closely with GPs, primary care, social care and the third and independent sector to provide joined-up responsive, expert care and treatment.
Carer Support	£1,850,000	Advice, information and direct support for carers
VCS Commissioning	£2,952,408	A variety of contracts held with the voluntary sector that support our goals
Discharge Planning and DTOCS	£1,900,000	Services that promote effective and timely discharge from hospitals back into the community
Transformation projects	£1,702,000	Investment in transformation projects to support BCF objectives
Funding for Risk Share	£836,000	Risk share funding
TOTAL BCF VALUE	**£48,464,614**	

Agenda Item No: 6

PRIORITY 1 REPORT FROM THE CHILDREN'S TRUST EXECUTIVE PARTNERSHIP

To:	**Health and Wellbeing Board**
Meeting Date:	**19 January 2017**
From:	**Service Director, Strategy and Commissioning**
Recommendations:	**The Health and Wellbeing Board is asked to review and comment on the Children's Trust Executive Partnership's annual report.**

Background:

The Children's Trust Executive Partnership (CTEP) consists of five members: the Executive Director, Children Families and Adult Services at Cambridgeshire County Council (Chair), the Lead Member for Children's Services at Cambridgeshire County Council and the three Chairs of the Area Partnerships (East Cambridgeshire and Fenland, Huntingdonshire and South Cambridgeshire and City). Other partners may attend meetings by invitation as the work programme dictates

CTEP collates an annual report on activities which contribute to Priority 1 of the Health and Wellbeing Board, 'Ensuring a positive start to life for children, young people and their families'. This year the report includes

- relevant projects from the 3 Area Partnership Plans
- relevant projects submitted by Partnership members
- key areas of concern emerging through the work of partner organisations.

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Ensure a Positive start to life for children, young people and their families

Activities that contribute to Priority 1 of the Health and Wellbeing Strategy

September 2015 to September 2016

Report from the Children's Trust Executive Partnership

Collated by Gill Hanby Area Partnerships' Manager Gill.hanby@cambridgehire.gov.uk

The Children's Trust Executive Partnership (CTEP) report to the Health and Wellbeing Board annually on progress against the Health and Wellbeing Plan Priority 1 - 'to ensure a positive start to life for children, young people and their families'

This report outlines

1. Activity taking place across the County Council
   Cambridgeshire County Council services are key providers of activities supporting Priority 1. Requests for examples of work were sent to Heads of Service
2. Activity taking place within the Area Partnerships Plans (Marked*)
   There are 3 Children and Young People's Area Partnerships in Cambridgeshire, East Cambs and Fenland; South Cambs and Cambridge City and Huntingdonshire. Each partnership has an action plan and all relevant activities within the 3 Area Plans are included.
3. Examples of activity taking place within Area Partnership partner organisations (marked**) Partners were invited to contribute any relevant activities to the report. Activities do not reflect the whole range of activities provided by partners

Area Partnership members were also asked

> *What are the key areas of concern in your area with regard to children's health and what could be done to resolve them?*

Full details of responses to this question are included in Appendix 1. In summary points raised include

- It would be useful to include learning in making a positive start. Accelerating achievement; transitions to secondary school and being prepared for work are key concerns
- Better parenting to address lack of support for children and young people; lack of supervision of children; provision of meals; mal nutrition of children are issues identified by partners
- Violence in relationships is a concern
- Drug/alcohol and mental health problems for parents and young people and issues for young people caring for parents with problems are concerns
- Lack of exercise by children and young people is a concern
- How is delivery of Priority 1 actions co-ordinated? Who leads on an action and how do people get in touch if they want to contribute?

The Contribution of Area Partnerships:
Area Partnership plans contributed 10 of the 32 listed projects in this exercise. In particular activities contributed to

- Reducing the impact of poverty on children and young people
- Creating opportunities for young people
- Increasing self-esteem and skills
- The Accelerating Achievement agenda

The projects listed have involved a wide range of partners including, universities; schools, Further Education Colleges, community partnerships and groups; District, City Councils and County Councils; arts organisations; voluntary organisations and Job Centre Plus

Area Partnership members work together to address local needs and develop actions that add value to the work of any one organisation. All 3 partnerships have a track record of developing work on small or zero budgets and testing new ideas and approaches.

Projects of common interest emerging for 2017 include emotional wellbeing; skills for employment and accelerating achievement

Cambs Health and Wellbeing Strategy. Priority 1
Ensure a Positive start to life for children, young people and their families

Activities that support the delivery September 2015 - 2016

Action 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

Initiative	**Holiday Lunch Programme****
	Free lunches offered in various community buildings during all of the school holidays. In the summer we saw high numbers of families accessing the lunches – they are targeted at higher need neighbourhoods and families already in receipt of pupil premium or other benefits. The holiday lunches include a play element and the opportunity to find out more about food and nutrition –recipes are made available to families along with any leftovers!
Lead organisation	ChYpPS at Cambridge City Council
Partners	local churches and businesses offer food and volunteers
Evidence of positive Outcomes	High number attend Positive feedback from users Families coming to other activities at other times of the year increase in scrapstore membership Children being physically active and engaged in positive activities
Barriers encountered	We need to ensure that the offer targets families who need support but is still an open access offer – we want to avoid stigmatising families particularly for the holiday lunch programme. Not all schools give out the publicity and many rely on promoting services online which we know doesn't work for all families. Many children access our services independent of their parents, we are aware that many are not looked after during the holidays and are often left to their own devices, have little money and are hungry

Initiative	**Supporting parents eligible for Free 2's childcare to make positive steps into work***
	Provides skills opportunities linked to local need. Developed information sharing with Job Centre Plus to facilitate bespoke support for families
Lead organisation	Children Centres – Wisbech, Whittlesey, Soham
Partners	Job Centre Plus
Evidence of positive Outcomes	Working with small numbers but information sharing means support is tailored more accurately to need
Barriers encountered	Capacity to develop the initiative. Plenty of ideas for projects and opportunities using local resources but no capacity to take forward

Initiative	**Increasing the Up-take of Free School Meals ***
	Information sharing between County Council and District Councils means families applying for benefits who are eligible for Free School Meals can be identified. Follow up of eligible families is undertaken by the Educational Welfare Benefits Team (CCC) Phase 2 will look at a wider range of benefits and how information sharing can lead individuals and families to the appropriate support quicker and more easily
Lead organisation	Educational Welfare Benefits Team (Cambs County Council)
Partners	District and City Councils
Evidence of positive Outcomes	Targeted approaches can be made to families eligible for Free School Meals
Barriers encountered	Not all young people in receipt of free school meals are taking up the meal itself

Initiative	**Support migrant families to access adequate childcare to reduce incidents of children left at home or in inappropriate situations***
	Initial work explored what childcare was being used and why. Local community involved in designing solutions which involved local people training to provide a range of childcare options in their local community • Baby sitting • Child Minding • Fostering
Lead organisation	Rosmini Centre
Partners	
Evidence of positive Outcomes	Skill base of local community increased Increased awareness of what constitutes appropriate childcare Increased provision of more appropriate and accessible childcare
Barriers encountered	There have been barriers linking with statutory organisations but these have been resolved. Many of these are generated by lack of clarity of who to approach

Initiative	**FAB Project** (Family and Baby)
	Supporting vulnerable families that have babies admitted to Neonatal units. Provides non-medical emotional and social support and a pathway for transitioning into the community after discharge. Joint project between Children's Centres and hospitals. Involves nominated family worker attending the Unit one morning a week to visit families and be available to help with issues around housing, finance applying for benefits or support, linking families to groups, and providing support on parenting, and accessing support for mental health issues
Lead organisation	Cambridgeshire Children's Centres (CCC)

Partners	NHS trusts Addenbrookes, Hinchingbrooke, Kings Lynn and Peterborough
Evidence of positive Outcomes	Significant reduction in families referred to Social Care from the units Having a family worker present on the units has given both staff and families access to support at a much earlier stage and therefore reduces the need to escalate to higher tier services
Barriers encountered	Need more contact time on the ward Some projects were delayed due to recruitment checks within the hospital, all are now up and running

Initiative	**Jack Warren Green Reccy Sessions and other one off play projects****
	Weekly open access play sessions for children living on the Jack Warren Green estate in Abbey. Sessions deliver art and crafts, sport, forest schools activities and encourage the children to tell us the sorts of things they would like to do. This has led to one off projects eg arts projects with Kettles Yard. A high percentage of children who attend these sessions have a disability. Many children come from large families, live in social housing and there are high levels of disadvantage. We anecdotally know that there are quite a few workless families in the area.
Lead organisation	ChYpPS at Cambridge City Council
Partners	Metropolitan Housing
Evidence of positive Outcomes	Children engage in all sessions. They are familiar with the ChYpPS logo and come to events that we organise in the area, they are happy to join in with anything we offer! Children have ideas for projects they would like to see – levels of participation are high Safeguarding concerns – several logged for children in this area and we continue to monitor some of these families
Barriers encountered	**Resources**. We have funding to deliver this work from Metropolitan Housing but can only deliver one session a week. There are high needs and we could easily deliver more **Discrimination** - particularly from families who are negative about those with disabilities. E.g. children coming back from the Harbour School on the school minibus described by a parent as 'the dribble bus'

Initiative	**Cambridgeshire Time Credits Programme**
	Time Credits are a community currency which people earn for volunteering with participating organisations. For each hour they give they receive a credit which can be spent on a range of activities from after school clubs to entry to the Tower of London. The County Council are currently funding a three year programme with three priorities 1) Strengthening Families 2) Skills and employment 3) Supporting Older People A number of Time Credits Earn Partners support young people and parents with Mental Health issues
Lead Organisation	Cambs County Council
Partners	Include Lifecraft, Richmond Fellowship, Centre 33
Evidence of positive outcomes	52% can afford to do more 56% say had a positive impact on quality of life 52% feel happier 72% know more about services and support 52% have increased their social contact Partners report that the local networks enable them to make contact with other community organisations which opens out the network of support/engagement opportunities for their members
Barriers Encountered	

Initiative	**Online Applications for Education Welfare Benefits**
	The Education Welfare Benefits Team is continually developing and implementing new systems to capture parents details for checking for Education Welfare Benefits entitlements linked to the introduction of the Universal Free School Meals (FSM);15 hours Free child care for 2 years olds and Early Years Pupil Premium (EYPP) Parents can apply for 15 hours Free child care for 2 years olds (Funded 2 codes);Early years pupil premium and Free School meals in a single application
Lead Organisation	Education Welfare Benefits team, Cambs County Council
Partners	Parents
Evidence of positive outcomes	Increased number of codes issued for use within early years settings. June – Sept 2016 1,293 Funded 2's applications processed (almost double same period 2015) Families entitled to free school meals and with children entitled to early years pupil premium can now also apply for 15 hours free child care for 2 year old at the same time. This enables Education Welfare Benefits Team to check for Education Welfare Benefits entitlements throughout the child's school life 1128 re-eligible claims have become active since July 2016
Barriers Encountered	

Initiative	**Early Years Pupil Premium (EYPP) details collected Online and via Applications from Early Years settings**
	Parents applying for Early Years Funding under the universal entitlement to childcare, supply their details on one application with the Early years setting. Details captured allow Educational Welfare Benefits Team to check entitlement of new children starting each term
Lead Organisation	Education Welfare Benefits Team, Cambs County Council
Partners	Early Years Settings, parents
Evidence of positive outcomes	Increased number of applications with parents details to that allow checking for entitlements to take place 6500 EYPP claims made via new EYPP provider portal and online applications facility 4,000 EYPP claims rolled over to FSM claims, 450 are active claims Where new process is embedded children's' entitlement to benefits can be re checked throughout their school life
Barriers Encountered	Engaging all the settings to request families to complete the data with the signed declaration

Initiative	**School Information Management System report from Schools of Parents' details to check for FSM entitlements**
	Parents supply their details on 1 application when they join a new school. Information is collected by the school and sent to Education Welfare Benefits Team
Lead Organisation	Education Welfare Benefits Team, Cambs County Council
Partners	Schools; ICT Services Cambs County Council
Evidence of positive outcomes	Increase applications with parents details to check for FSM entitlement, and recheck for entitlement throughout the child's school life 2 000 new claims (from 103 schools) processed in 3 months. 130 now active
Barriers Encountered	Engaging all schools to amend their admission form, to allow data collection to happen with the signed deceleration, in time for the September intake. Due to timing of project being signed off, some schools had already sent welcome packs to new starters. So implementation been phased over 2 years to allow all schools to update their admission forms to capture the details needed. Will be implemented by September 2017

Initiative	**District Council Data Sharing to check for Education Welfare Benefits entitlements***
	Families agree when applying for House Benefit to allow their details to be shared with Education Welfare Benefits team to check for Education Welfare Benefits for all children agreed 2 to 19 years old
Lead Organisation	Education Welfare Benefits Team
Partners	Fenland District Council; East Cambs District Council
Evidence of positive outcomes	Increased applications with parents details that can be checked for FSM entitlement and rechecked for entitlement throughout the child's school life 60 applications processed from applications via District Councils. 24 entitled to benefits instantly Easier to capture customers details at same time they are applying for a qualifying benefit Same system currently being implemented with South Cambs and Cambridge City and will be rolled out to Huntingdonshire
Barriers Encountered	IT issues between Councils, took time to resolve but have now been worked around and data comes through securely

Initiative	**National Citizens Service Partnership with Castle and Granta Special Schools**
	4 week NCS programme including 2 residentials to support the development of transferable life, social and employability skills. To promote and develop an awareness of social action and community resilience
Lead Organisation	Youth Support Services Cambs County Council
Partners	Cambridgeshire Community Foundation, Castle School, Granta School, various third sector organisations
Evidence of positive outcomes	All SEND and LAC young people completed the programme gaining accreditation and developing skills e.g one young person can now use public transport independently and another with profound SEND has a volunteering placement
Barriers Encountered	Additional funding was required to ensure sufficient support for the young people

Initiative	**Secondary Health Related Behaviour Survey, 2016**
	Responses from 7, 081 Year 8 (13/14 Years) and Year 10 (14/15 Years) pupils in 29 of 31 secondary schools across Cambridgeshire. Data is available by school, postcode and school and postcode to individual schools and on a locality, area, district and county basis Data available on young people's mental and emotional wellbeing (worries, life satisfaction, adults they can trust, resilience and self- esteem), bullying, violence and aggression
Lead Organisation	Administered by the Education Wellbeing Team Funded by Public Health
Partners	Management Information, CFA and Public Health Intelligence
Evidence of positive outcomes	Data provides basis for cross service planning through informing the JSNA, commissioning (e.g. Public Mental Health Strategy) service planning (anti-bullying website work) and provides evidence of the impact of programmes (e.g. Anti-bullying). SHEU, the Survey Team picked up a number of cause for concern replies (e.g. self-harming, suicidal feelings) from some student responses which although they are identifiable by year group and gender individual students are not identifiable. The child protection leads in each school were contacted and reinforced to all students in the year group the support and care available if they ask for help.
Barriers Encountered	Non-recurring funding for the Survey Two schools in East Cambridgeshire and Fenland committed to doing the survey but due to IT issues they didn't complete it - data is therefore incomplete for this area

Initiative	**Local Authority Anti-bullying Website**
	Support and guidance for schools, young people, parents, carers, families on how to prevent, reduce and respond to incidents of bullying. To be available on the Learn Together Cambridgeshire website. Content includes whole school review materials and details of support from within the Local Authority and from outside agencies. Will be linked to the Keep Your Head Website (Public Health)
Lead Organisation	Anti Bullying Steering Group
Partners	Cambs Race Equality and Diversity Service, Special Educational Needs And Disability Information, Advice and Support Service, Special Educational Needs and Disability Services, Education Wellbeing Team. Locality Teams, Early Years and Child Care, Education Officers, Pinpoint, Public Health, primary, secondary and special schools
Evidence of positive outcomes	Active and fully engaged Steering Group Positive feedback from schools, pupils and parent organisations when resources piloted Will monitor website 'hits'.
Barriers Encountered	No dedicated funding. Delay in placing on website (now to complete December 2016)

Action 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

Initiative	**Heads Up***
	Projects offering early intervention mental health support for 4-11yr olds via primary school delivered in East Cambs; Fenland and Cambridge City
Lead organisation	Ormiston
Partners	Schools, Locality Teams (Cambs County Council)
Evidence of positive Outcomes	Projects recently completed, awaiting final reports Lunchtime self-referral projects focussing on friendship and confidence activities attracted 30+ young people to every session (Cambridge City)
Barriers encountered	Difficult to engage schools in Cambridge City – possibly because referral to project required a CAF to be generated. Project leaders felt that given the level of concern they were addressing in the project a CAF was unnecessary

Initiative	**Friendly Fishes (**Early Support Special Educational Needs and Disability (SEND) Groups)
	Groups support SEND children referred in to Early support. Groups provide structured play session, with early learning goals and development assessments from the Early years foundation stage (EYFS) and supports parents in promoting the development of their child and access to other specialist services
Lead organisation	Specialist Teaching Team,
Partners	Children's Centre, Physiotherapist, occupational health, Speech and Language, parents
Evidence of positive Outcomes	Participants, at age 4, achieve better score in the early years foundation stage than a peer with a similar SEND profile who didn't attend group Participants transition better into Preschool and School, and have better support plans tailored to their needs
Barriers encountered	Significant reduction in SEND services reducing the level of support able to be provided to the families

Initiative	**Transgender Youth Support Project**
	A new support service for transgender young people which includes counselling and one to one support and advocacy and support through schools and learning
Lead Organisation	Youth Support Service Cambs County Council
Partners	Schools, SexYouality, Centre 33, Public Health
Evidence of positive outcomes	New service developed to meet identified need Engaged significant numbers of young people and their families – exceeding targets set Counselling service has attracted three times the initial target. All Youth Support Staff and some partners have completed gender awareness training Cambs County Council staff have increased confidence working with these issues
Barriers Encountered	Funding General awareness of gender issues amongst professionals

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

Initiative	**SummerDaze****
	Free open access programme of play opportunities promoted via SummerDaze brochure which goes out to all city children in primary schools and is posted on our website. Opportunities provided to encourage children to take part in different kinds of activities, some risk taking and to actively encourage parents to play with their children. Many parents are more interested in care provision where they don't have to do anything. We support parents to be more confident, developing their play skills and hopefully improving their relationships
Lead organisation	ChYpPS at Cambridge City Council
Partners	Cambridge University Museums, History Works, Abbey People, Sports Development at Cambridge City, Angling and Fish Preservation Society
Evidence of positive Outcomes	Numbers who attend Positive feedback from users Families coming to other activities at other times of the year Increase in scrapstore membership Children being physically active and engaged in positive activities
Barriers encountered	We need to ensure that the offer targets families who need support but is still an open access offer – we want to avoid stigmatising families particularly for the holiday lunch programme. Not all schools give out the publicity and many rely on promoting services online which we know doesn't work for all families. Many children access our services independent of their parents, we are aware that many are not looked after during the holidays and are often left to their own devices, have little money and are hungry

Initiative	**Home Start** - Volunteer based home-visiting service**
	Some families with young children need additional support to cope with parenting and health issues in the family to give their children the best possible start in life. Home-Start Cambridgeshire provides early intervention through tailored weekly peer support in the family home for up to six months, as well as a weekly group for some families. This additional support helps families to better cope with stress and conflict in the family, and improve confidence in parenting. It helps families to achieve stronger family relationships, expand support networks and improve health and wellbeing Home-Start Cambridgeshire services are delivered by 100+ trained volunteers. Home-Start co-ordinators recruit, train and supervise volunteers to support parents with young children. Volunteers support each family for 2 hours/week in the family home for up to 6 months

Lead organisation	Home-Start Cambridgeshire
Partners	Referrers: Health Professionals, Social Care Services and Children's Centres
Evidence of positive Outcomes	Based on parents' self-reported progress: - 97% improved bonding with their children - 97% improved management of children's behaviour - 96% coping better with mental health condition - 95% feeling more confident in their parenting skills - 91% feeling less stressed and anxious Parents are more willing to accept support from non-statutory service provider
Barriers encountered	- Referrals are not always made at the earliest opportunity - Some parents are reluctant to disclose concerns to statutory service providers and therefore do not receive timely support - CCC no longer supporting this service - securing alternative funds requires additional resources and expenses - Unable to replace departing volunteers due to unavailability of timely funding

Initiative	**Community Reach Fund**
	Grass roots seed funding administered by Youth Support Service, Youth Community Co-ordinators to support parents of 0-19 years olds to deliver groups and projects in their communities to build resilience and self help
Lead Organisation	Youth Support Service, Cambs County Council
Partners	3rd Sector organisations; Children's Centres; Parish Councils Area Partnerships
Evidence of positive outcomes	Development of several projects across the county including additional branches of Little Miracles, Parenting Groups, Holiday Clubs and specialist equipment to increase accessibility at numerous centres
Barriers Encountered	Capacity to build and sustain effective relationships with individuals requiring significant support with a variety of issues e.g governance, safeguarding and funding

Initiative	**Cambridgeshire Time Credits Programme**
	A range of earn partners use Time Credits as a community tool to help them reach their aims which include developing parenting skills for families in challenging situations
Lead Organisation	Cambs County Council
Partners	Children's Centres across roll out areas; Pinpoint (Cambs); Little Miracles (Fenland)
Evidence of positive outcomes	Additional activities after school and in community Practical tasks completed Personal skills developed Better relationships between community members and service providers
Barriers Encountered	

Action 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

Initiative	**Gamlingay Economic Development Project****
	Young people identified who have difficulty in acquiring and retaining employment. Core problem appears to be that they are ill prepared to either get jobs or to keep them Funding obtained from a local developer through s106 agreement to run a 2 year programme targeting these young people and in particular those who are NEET or at risk of becoming NEET Currently delivering mentoring programme through the youth cub and work experience and apprenticeship offers from local businesses
Lead organisation	Forward Gamlingay
Partners	Be Active
Evidence of positive Outcomes	To date local businesses have been very willing to participate
Barriers encountered	capacity to deliver this work as delivery relies mainly on volunteers

Initiative	**Children's Engagement Officer**
	Employed for 2 years–brief to engage children in the decision making of the Council via representation at area committees, local surveys, agenda days and Take Over Day Focus on getting children to tell City Council what they like / dislike about their local communities, as well as the sorts of projects they would like to see delivered and the sorts of initiatives they think would work better with children's involvement
Lead organisation	Cambridge City Council
Partners	Various – depends on project
Evidence of positive Outcomes	Children recently attended the North Area Committee to tell councillors what they think of their neighbourhood Children have completed two city wide surveys commenting on their neighbourhood Children actively involved in improvements to local parks and open spaces
Barriers encountered	Adult agenda sometimes gets in the way of hearing what children have to say Some children are reluctant to engage because they have given their views on things before and don't believe it will make a difference Not all children are confident to speak out Post is only funded for two years and this work takes time to develop

Initiative	**Supporting Positive Emotional and Mental Health in the Community** (Godmanchester)*
	A range of community based initiatives; training and support that is aiming to promote positive emotional wellbeing; build resilience and increase community capacity to support those with mental health needs (emerging to crisis)
Lead organisation	Godmanchester Baptist Church
Partners	Community Groups, Schools, Town Council, Locality Team (CCC), Health Services
Evidence of positive Outcomes	Excellent feedback from 2 BLOB workshops (helping frontline practitioners and volunteers talk about mental health with service users) Community activities promoting positive mental health taking place Primary school using the BLOB Tree to encourage children to start to talk about mental health and emotions from reception
Barriers encountered	

Initiative	**Top Secret ***
	An arts based project that encourages young people to develop personal and work ready skills whilst participating in a professional performance project
Lead organisation	Festival Bridge
Partners	NIE Theatre Company, Ramsey Million Partnership; Hunts District Council; Cambs County Council; Hunts Regional College, Urban and Civic (Developers); schools
Evidence of positive Outcomes	Before and after assessments showed… • Better appreciation of personal skills and qualities • Participation in new activities and experiences • Broadened awareness and interest in work/careers related to different art forms
Barriers encountered	Difficult to get buy in from people with direct access to young people and to support recruitment. This kind of project would be really useful to young people who lack confidence; have limited aspirations or have difficult home environments but help to recruit and support participation by these groups is needed

Initiative	**Work Readiness** (pilot project in Cambridge City)*
	Support to targeted group of Y10 students preparing them for future; looking at work readiness; aspirations and confidence Referral criteria included potential to be NEET and needing additional support around transition into training or further education Run over 15 weeks, 1.5 hours a week after school Sessions included: CV writing, interview technique, visiting ARU, personality profiling, job search, looking at apprenticeships and going to college All offered the opportunity to take up work experience with the City Council
Lead organisation	ChYpPS at Cambridge City Council
Partners	School; Anglia Ruskin University
Evidence of positive Outcomes	2 participants completed work experience with City Council Waiting for final report
Barriers encountered	Finding right person to liaise with in school

Initiative	**Thriving****
	Improving young people's mental health services Commissioned to inform redesign of mental health services, this project ensure children and young people are listened to by people making decisions about mental health services. The report is helping to inform the redesign of local mental health services 4 local groups of children and young people aged 8 -20 years were involved, including young carers. We wanted to find out about their opinions and experiences of mental health, including using mental health services. We also wanted to know what information would help them, and what words they use and understand when talking about mental health. They told us they wanted to see: • information provided using words and images that are meaningful to them; • stories of how other children and young people have managed different mental health problems; and • help to develop resilience; how to 'bounce back' after a difficult time. As part of Thriving, we also made a number of suggestions to help improve children and young people's emotional wellbeing and mental health. This includes: • promoting a better understanding of 'looking after yourself' and what this means, to help maintain good mental health and well-being; • investing in Peer to Peer support • encouraging schools to talk about mental health to their students, as well as it being a core element of their Personal Social and Health Education curriculum • promoting the value of counselling in schools as a significant investment in helping young people maintain good mental health.
Lead organisation	Healthwatch Cambridgeshire
Partners	Healthwatch Peterborough
Evidence of positive Outcomes	Thriving findings went to the Emotional Health and Wellbeing Board meeting on 4th May 2016. At this meeting the Board said that the learning points will be incorporated into their plans for redesigning services. Thriving also helped young people know more about mental health by fighting stigmas associated with it. It helped them be more confident when sharing their experiences of metal ill-health. Young people said that, after each session, they felt more confident about where to go if they ever needed help to cope with their mental health
Barriers encountered	It is sometimes difficult to approach the subject of mental health without touching on young people's sensibilities; it can be challenging when schools/youth groups are not prepared, or don't have the capacity, to provide the support that young people need. Due to the busy school schedule and the different ways schools work, every project needs to be tailored differently making it time consuming.

Initiative	**My Own Mind** – young people's mental health**
	Report on Ely College students' attitudes to stress and anxiety. Sixth Form and Social Care Students explored opinions and experiences of mental health of other students and their ideas for making support work better Survey and 2 focus groups – total of 107 students participating Questions: • Ever feel stressed or anxious? • What makes them stressed or anxious? • Coping strategies Findings: • Most had felt stressed and anxious at least once, at some point in their lives • Felt most stressed by exams; things that occurred at school; outside home • Almost half keep stressful and anxious feelings to themselves • Lots talk to friends and or family members about their feelings • Most have enough help to cope with stress and anxiety

	• Girls said talking to someone would help them cope • Boys prefer doing some kind of activity, running/gym What young people recommend: • Stigma should be tackled. Understand how young people themselves feel about stress and how to deal with it • Recognise the importance of talking to someone • Use real life examples of how people deal with stress and anxiety • Young people in helping each other • Having a quiet room in college for students to go if they need help • More opportunities to talk confidentially and informally with teachers • Support provided in familiar and comfortable settings
Lead organisation	Healthwatch Cambridgeshire
Partners	Ely Sixth Form College
Evidence of positive Outcomes	• Issues raised with schools, County Council, the Clinical Commissioning Group and other organisations • Recommendations incorporated into the plans for redesigning children and young people's mental health services. • helped young people know more about mental health by fighting stigmas associated with it • Young people felt more confident about where to go if they ever needed help to cope with their mental health • After the project the school started working with Centre33 on counselling support • Healthwatch Cambridgeshire has returned to the school to work with different groups of young people and continue the discussions on mental health
Barriers encountered	It is sometimes difficult to approach the subject of mental health without touching on young people's sensibilities, it can be challenging when schools/youth groups are not prepared, or don't have the capacity, to provide the support that young people need Due to the busy school schedule and the different ways schools work, every project needs to be tailored differently making it time consuming

Initiative	**Cambridgeshire Time Credits Programme**
	Time Credits are supporting young people's voice through the work of Voice; Wisbech youth groups and a range of Cambs County Council and Cambridge Housing Society groups
Lead Organisation	Cambs County Council
Partners	Cambridge Housing Society; Wisbech Youth Group; North and South Cambridge Locality teams; Railway House, Ely Young Peoples Project; The Staithe;120 Mill Road
Evidence of positive outcomes	Positive feedback from young people engaged
Barriers Encountered	

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

Initiative	**Research to understand the impact of interventions to prevent young people becoming NEET**(not in education, employment or training)* A 5 year longitudinal study of the impact of transitions projects in Fenland on young people's risk of becoming NEET
Lead organisation	Anglia Ruskin University
Partners	Schools, Locality Teams (CCC)
Evidence of positive Outcomes	Transitions project appear to: • Show that teachers are accurate in identifying children of concern • Be effective at improving emotional symptoms or 'mental fitness' • Have little impact on behavioural symptoms • Suggest that early intervention should be targeted, not universal • Have a sustained impact over the first year at secondary school
Barriers encountered	

Initiative	**Soham Vocabulary Project** (pilot)* Aims to increase vocabulary of pre-school children. 6 weekly sessions supported by local services with different theme each week. Interaction involves promoting new vocabulary and promoting key messages to parents. Take away resources include a story about the visitor of the day
Lead organisation	Soham Partnership
Partners	Children Centre, primary school, local services eg fire/police/district council
Evidence of positive Outcomes	Not yet complete but initiative will be evaluated
Barriers encountered	

Initiative	**Readiness for School** (Pilot project South Cambs)** Ensures children are adequately prepared to make a good start in school, leading to higher achievement levels Volunteer based home-visiting program aims to achieve - good morning and bedtime routines - use of stimulating materials in the home - parental engagement with child's development - child able to play and share with other children - child able to use the toilet independently and understand basic hygiene - basic self-help skills such as putting on coat and shoes - child recognises own name when written down and can use a pencil/crayon
Lead organisation	Home-Start Royston and South Cambridgeshire
Partners	Home-Start Cambridgeshire
Evidence of positive Outcomes	Too early to report
Barriers encountered	

Initiative	**Wisbech Adventure Playground**
	Free play providing opportunities for children to learn to cooperate, collaborate, develop their creativity and their personal development. Play leaders ensure safety and child protection, generate programmes and structures in consultation with children and families. It is all inclusive in its approach
Lead Organisation	Cambs County Council
Partners	Local councillors; organisations working across Waterlees ward
Evidence of positive outcomes	Partnership workshop informed 20:20 programme; Waterlees Community Plan; Wisbech Garden Plan 1500 children and families attending play day in August 2016 Case studies show impact on community integration, behaviour, attendance at school and safeguarding
Barriers Encountered	

Initiative	**Anti- bullying Tools and Resources**
	Programme to prevent, respond to and reduce the incidence of bullying
Lead Organisation	Personal Social and Health Education Service
Partners	Primary Schools
Evidence of positive outcomes	Positive feedback from participating schools
Barriers Encountered	

Initiative	**Conflict Resolution and Peer Mediation Programme**
	Train peer mediators to help children address their disputes and reach solutions. An aid to promoting positive relationships and readiness to learn
Lead Organisation	Personal Social and Health Education Service
Partners	Primary Schools
Evidence of positive outcomes	Positive feedback from participating schools
Barriers Encountered	

Key areas of concern regarding children's health
A response from Area Partnership Members and member Organisations

Forward Gamlingay

We have ongoing problems with drug abuse and even though Forward Gamlingay has worked for over 10 years to make a difference to this I do not think we have had any impact.

We are aware that a worrying number of young people think that violence is acceptable in their own relationships.

We have a lot of gypsy and traveller families but children are well integrated and we have a gypsy youth worker. However, keeping the boys in education is very difficult and keeping tabs on where they are is impossible due to our position on the county boundary.

We have far too many young people leaving school completely unprepared for work and with no qualifications and nothing to put on a CV. The fault for this must rest in part with the schooling they receive which is delivered out of county at the moment. However, Gamlingay is in the process of becoming a feeder for CMAT which we are hopeful will mean things will improve

We have quite a number of young carers - generally for parents with substance abuse and/or mental health problems

Home Start

The five years between birth and school are vital for a child's development. What goes on inside a family during these years strongly determines the opportunities and life chances children have. Children who are raised in a stable, loving, family environment are more likely to have a positive and healthy future.

Improving the mental health of parents is key to improving the mental health of children and young people. For maximum impact, this should be focused on children aged 0-3 in particular. There is increasing evidence to suggest that the ideal age to impact on a child's development and improve social and emotional capability is from age 0-3 years.

Home-Start Cambridgeshire's early intervention is targeted 100% at the above and yet this type of service is not a priority for the CCC as evidenced by withdrawal of funds. There is scope to work in partnership with statutory services and non-statutory organisations but it is very difficult without some support from CCC. Home-Start Cambridgeshire will continue to seek and secure funds to ensure families have access to Home-Start support in their own homes but cannot guarantee this will always be the case without some financial support from CCC.

Cambridge City Council

We have concerns about the following:

- Children who are left to play out very late in the afternoon / evening who do not have a time to be in or know if there will be a meal available when they get home
- Children who are malnourished, this is different to the obesity agenda although we think there are some children who are obese and eat badly we are also aware of some very underweight children
- Children who are not getting enough exercise, or time outside of their organised activities (hot housed or not allowed out to play)
- Younger children with mental health issues including low self-esteem and confidence as well as children who find the transition from primary to secondary challenging

South Cambs and Cambridge City Area Partnership

Resources:

- Lack of resources for 1:1 or small group work
- Community Development, long term support needed to build community capacity
- Work supporting families where children are falling behind in achievement is only addressing the tip of the iceberg

Gaps:

- Family support is often lacking
- Prevention – needs to be recognised, encouraged and developed

- Need to include learning in ensuring a positive start. Cambridgeshire is not making the progress desired and is not closing the gap between those in poverty (pupil premium) and SEND children and "normal" children.

Delivery:

- Is there any co-ordination of activities under each action? How are gaps and overlaps identified?
- Are initiatives working together?
- Who is leading and how does anyone wanting to contribute get in touch?
- Voluntary and Community Sector are involved in delivery but are they involved in development?
- Need to look at wider contribution organisations can/do make not just specialist services. How do we recognise/measure these?

Agenda Item No. 7

UPDATE REPORT - NEW HOUSING DEVELOPMENTS AND THE BUILT ENVIRONMENT JOINT STRATEGIC NEEDS ASSESSMENT.

To: Health and Wellbeing Board

Date: 19 January 2017

From: Iain Green, Senior Public Health Manager Environment and Planning

1.0 PURPOSE

1.1 This report is to update the Health and Wellbeing Board on the progress on actions arising from the New Communities Joint Strategic Needs Assessment (JSNA) to date. The full JSNA can be found at http://cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/new-housing-developments-and-built-environment.

2.0 BACKGROUND

2.1 The Health and Wellbeing Board, at their meeting on 17 March 2015, approved the JSNA on "New Housing Development and the Built Environment". Since the JSNA was approved it has been available on the Cambridgeshire Insights Website and has been presented to numerous local, regional and national organisations.

3.0 SUPPORTING PARAGRAPHS

3.1 **Use and Impact of the JSNA**

Cambridgeshire County Council

The JSNA is being used a key reference document within each directorate in the production of council policy, particular within the Economy, Transport and Environment (ETE) directorate. The JSNA is also being used an evidence base for key responses of the Council to planning applications within the county.

The findings of the JSNA have been incorporated into the Supporting New Communities Strategy and is being used in the "Community Hubs" programme.

District Councils

The JSNA has been shared with the District and City Councils and briefing sessions have been given to Planning Policy Teams which are currently preparing their Local Plans, specifically:

- Support to Huntingdonshire District Council on the relevant health related policies which can be included within the Hunts DC Local Plan.
- Specific guidance on Health Impact Assessments (HIA) requirements has been given to South Cambridgeshire District Council to defend the HIA at the Examination in Public.
- Specific guidance on HIA thresholds has been given to East Cambridgeshire District Council as part of their Local Plan production.
- The Fenland District Council Local Plan had already been adopted prior to the production of the JSNA, but the JSNA is being used as part of development control applications and has been presented to senior management teams within the Authority.

- The JSNA is being used by the Cambridge City Council as part of the negotiations on the large strategic sites, particularly regarding the need for early community provision and the need for primary and health care facilities.

Other Partnerships
So far the JSNA has been presented to several Local Health Partnerships and has been presented to the Cambridge sub-region Housing Board.

Northstowe Healthy New Town
The JSNA has been used a key source of evidence in the production of the Design Codes for Phase Two of Northstowe and is being used as a measure of delivery for the Healthy New Town Programme. For example the best practice contained within the JSNA on "nudge behaviours" are being incorporated into the design of the western park and the sports pavilion. In addition the JSNA has been shared at a national level with the other nine Healthy New Town sites as an example of good practice.

Clinical Commissioning Group
The demographic data within the JSNA is being used to plan services and is being used by Councils as a quick guide to understanding how "Health Services" are commissioned.

National and Regional
There have been requests to share the JSNA outside of the Cambridgeshire area including:
- Using the JSNA with Central Bedfordshire Council as part of a Health Impact Assessment Training Day.
- In order for Local Authorities to use "health" related polices including HIA policies effectively JSNA has prompted Public Health England to commission a package of Health Impact Assessment Training for Local Authorities within the Eastern Region.
- The JSNA is being used as an evidence base in the production of the Peterborough Local Plan.
- The JSNA has been shared with the Town and Country Planning Association (TCPA) as part of the national "Reuniting Health with Planning" project.

4.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

4.1 The JSNA is relevant to all priorities of the Health and Wellbeing Strategy 2012-17 although Priority 5: Create a sustainable environment in which communities can flourish is the most relevant.

5.0 IMPLICATIONS

5.1 This JSNA provides important evidence and information on the impact the built environment can have on health and wellbeing and service uptake in new communities. Much of the local data and information will be available online at www.cambridgeshireinsight.gov.uk in addition to the New Developments and the Built Environment JSNA report. This should allow users to have information on the built environment, social cohesion and current health service usage patterns in existing new communities to use in future strategies, commissioning and initiatives.

5.0 RECOMMENDATION/ DECISION REQUIRED

6.1 The Health and Wellbeing Board is asked to note the update report and suggest further opportunities to share and embed the JSNA, and to suggest ways to capture how the JSNA has made a difference.

7.0 Source documents:

Source Documents	Location
New Housing Developments and the Built Environment JSNA	http://cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/new-housing-developments-and-built-environment

Agenda Item No: 8

UPDATE ON THE PHARMACEUTICAL NEEDS ASSESSMENT FOR CAMBRIDGESHIRE (2017) & PUBLIC CONSULTATION JAN-MAR 2017

To: Cambridgeshire Health and Wellbeing Board

Date: 19 January 2017

From: Dr Kirsteen Watson, Consultant in Public Health Medicine, Cambridgeshire County Council, Chair of the Cambridgeshire Pharmaceutical Needs Assessment Steering Group

1.0 PURPOSE

1.1 The purpose of this report is to update the Health and Wellbeing Board (HWB) on the development of the Pharmaceutical Needs Assessment (PNA) for Cambridgeshire, 2017. This report also includes a short briefing on the new national pharmacy contract and implications for the statutory responsibilities of the HWB which were amended in December 2016.

2.0 BACKGROUND

2.1 All HWBs have a statutory responsibility to publish and keep up to date a statement of the needs for pharmaceutical services for the population in its area, referred to as a 'pharmaceutical needs assessment' (PNA).

2.2 The PNA has two key purposes:
- Firstly, it presents a summary of the number and distribution of pharmaceutical providers in Cambridgeshire and the access and services they provide in the context of local priorities. This information will be used by NHS England when making decisions on applications to open new pharmacies and dispensing appliance contractor premises; or applications from current pharmaceutical providers to change their existing regulatory requirements.
- Secondly, it provides an overview of locally commissioned services and potential future opportunities for pharmaceutical providers to contribute to improving the health and wellbeing of local residents. This can be used to inform commissioning decisions by local commissioning bodies including local authorities (public health services from community pharmacies), NHS England and Clinical Commissioning Groups (CCGs).

2.3 A PNA was undertaken for Cambridgeshire during June-December 2016. The PNA was undertaken in accordance with the requirements set out in regulations 3-9 Schedule 1 of the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013.

2.4 The PNA was led by a multi-agency steering group comprising representatives from Public Health, CCG medicines management, CCC

research group, the Local Pharmaceutical Committee , NHS England and Healthwatch. The Local Medical Committee was a corresponding member.

2.5 In the process of undertaking the PNA and the public consultation, the Steering group on behalf of the Cambridgeshire HWB will seek the views of a wide range of stakeholders to identify issues that affect the commissioning of pharmaceutical services and how pharmaceutical providers can help to meet local health needs and priorities.

2.6 All pharmacies and dispensing GP practices in Cambridgeshire were asked to complete a questionnaire describing their own service provision and their views on local pharmaceutical provision. 93 of 110 (85%) community pharmacies and 34 of 43 (79%) dispensing GP practices in Cambridgeshire responded to the questionnaire.

3.0 SUPPORTING PARAGRAPHS:

3.1 Key findings of the draft Cambridgeshire PNA 2017 in brief

- The HWB is asked to review the *6 page executive summary* for the draft PNA 2017 for consultation and note the key findings and recommendations. The full 126 page *Draft Cambridgeshire PNA 2017* is also available on the County Council website with the 19 January HWB meeting papers as a supporting document.
- In summary, the draft PNA proposes that Cambridgeshire is well provided for by pharmaceutical service providers and the PNA did not identify a current need for any new NHS pharmaceutical service providers in Cambridgeshire.
- There are 110 pharmacies across Cambridgeshire, and 43 dispensing GP practices. This translates to 23 pharmaceutical service providers per 100,000 registered population in Cambridgeshire. This is the same as the England average. The East of England average is only slightly higher at 24 per 100,000. There is also adequate access for the dispensing of appliances.
- It is recognised that need may change during the next 3 years. The local population is forecast to increase substantially in the coming years. Several large-scale housing developments are in progress and a number of factors may influence the potential need for additional pharmaceutical service providers. The PNA Steering Group will monitor the development of major housing sites and produce additional information to this PNA when necessary, to ensure that appropriate information is available to determine whether additional pharmacies might be required.
- The PNA also describes locally commissioned services and notes that providers of pharmaceutical services have an important role to play in improving the health and wellbeing of local people. They are easily accessible and are often the first point of contact, including for those who might otherwise not access health services.
- The PNA proposes that Cambridgeshire HWB consider community pharmacies to be a key public health resource and recognises that they offer potential opportunities to commission health improvement initiatives and work closely with partners to promote health and wellbeing. Commissioners are recommended to commission service initiatives in pharmacies around the

best possible evidence and to evaluate any locally implemented services, ideally using an evaluation framework that is planned before implementation. Pharmacies are able to, and should be encouraged to bid for locally commissioned health improvement programmes, along with other non-pharmacy providers.

- The recently published King's Fund report by Richard Murray '*Community Pharmacy Clinical Services Review*'[1] (Dec 2016) commissioned by the Chief Pharmaceutical Officer, recommended that there is a need in the medium-term to "ensure that community pharmacy is integrated into the evolving new models of care alongside primary care professionals. This will include enhancing the support they provide to people with long-term conditions and public health, but should not be limited to these." The PNA proposes that at a local level, in light of the recommendations in this report, the Health and Wellbeing Board should encourage the involvement of pharmacies and pharmacy teams in developing local plans and systems of integrated working.

3.2 Public consultation on the Draft Cambridgeshire PNA

- It is proposed that a public consultation on a draft PNA report will be undertaken from 23 January 2017 to 26 March 2017. This will be available online at: **www.cambridgeshireinsight.gov.uk/pna**. The public consultation questionnaire is included in the HWB papers.
- Posters to advertise the PNA Consultation to the general public are being sent to all community pharmacies, GP practices and local libraries. Respondents will be encouraged to complete the questionnaire online, although some paper copies with freepost envelopes will be available in these venues and additional paper copies can be requested from the Public Health department. Letters informing stakeholders of the PNA consultation and specifically inviting responses will be sent to neighbouring HWBs, District Councils, local MPs, local NHS providers, the Local Medical Committee and all voluntary organisations on the Healthwatch database. Healthwatch will also promote the consultation via their social media.
- The feedback gathered in the consultation will be reported and presented to the HWB in June 2017. This feedback will be used to review and revise the draft PNA and a final PNA published in July 2017.

3.3 Briefing on the local impact of the new national pharmacy contract (2016)

- On 20th October 2016 the Government imposed a two-year funding package on community pharmacy, with a £113 million reduction in funding in 2016/17.[2] This is a reduction of 4% compared with 2015/16, and will be followed by a further 3.4% reduction in 2017/18. Key changes were also made to the national pharmacy contract with the aim of creating a more efficient service which is better "*integrated with the wider health and social care system*"[3].

[1] Murray R. 'Community Pharmacy Clinical Services Review' The Kings Fund. (December 2016) Available at: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/12/community-pharm-clncl-serv-rev.pdf
[2] Department of Health. 'Community pharmacy in 2016/2017 and beyond: final package'. (Oct 2016) Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/561495/Community_pharmacy_package_A.pdf
[3] http://psnc.org.uk/funding-and-statistics/cpcf-funding-changes-201617-and-201718/

- Full details of the final Community Pharmacy proposals can be found in the Department of Health (DoH) report "*Community pharmacy in 2016/2017 and beyond: final package*"[4]. Appendix 5 of the PNA provides a summary of the proposed changes to the pharmacy contracts and the potential impact of these as assessed by the DoH and the national Pharmaceutical Services Negotiating Committee (PSNC) who represent all community pharmacies providing NHS services in England.
- The changes include a new 'Pharmacy Access Scheme' which aims to ensure that populations have access to a pharmacy, especially where pharmacies are sparsely spread and patients depend on them most. Qualifying pharmacies will receive an additional payment, meaning those pharmacies will be protected from the full effect of the reduction in funding from December 2016. Nationally 1,356 pharmacies have qualified for the scheme. In Cambridgeshire, 30 pharmacies have been identified which is 27% of all current pharmacies as at October 2016.
- As described in the DoH health impact assessment, it is complex to assess the impact of these changes on Cambridgeshire residents at this stage. There is no reliable way of estimating the number of pharmacies that may close or the services which may be reduced or changed as a result of the policy and this may depend on a variety of complex factors, individual to each community pharmacy and their model of business.
- The Cambridgeshire Local Pharmaceutical Committee will focus on supporting local pharmacies by keeping them up to date with changes/details, to meet the quality agenda, and to take up and deliver locally commissioned services more effectively.
- Of particular relevance to this PNA at this point in time is that amendments were also made to the pharmacy *National Health Service (Pharmaceutical Services, Charges and Prescribing) Regulations* in December 2016[5]. One key change was a new regulation which describes the potential consolidation of two or more pharmacies onto one existing site. A new pharmacy would be prevented from stepping in straight away if a chain closes a branch or two pharmacy businesses merge and one closes which would protect two pharmacies that choose to consolidate on a single existing site – where this does not create a gap in provision.
- "*Applications to consolidate will be dealt with as "excepted applications" under the 2013 Regulations, which means in general terms they will not be assessed against … the pharmaceutical needs assessment ("PNA") produced by the HWB. Instead, they will follow a simpler procedure, the key to which is whether or not a gap in pharmaceutical service provision would be created by the consolidation….. If the NHSCB is satisfied that the consolidation would create a gap in pharmaceutical services provision, it must refuse the application. The opinion of the HWB on this issue must be given when the application is notified locally and representations are sought (regulations 12 and 13). If the application is granted and pharmacy premises are removed from the relevant pharmaceutical list, if the HWB does not consider that a gap*

[4] Department of Health. 'Community pharmacy in 2016/2017 and beyond: final package'. (Oct 2016) Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/561495/Community_pharmacy_package_A.pdf
[5] National Health Service England. ' The National Health Service (Pharmaceutical Services, Charges and Prescribing) (Amendment) Regulations 2016' (2016 No.1077) Available at: http://www.legislation.gov.uk/uksi/2016/1077/contents/made

in service provision is created as a consequence, it must publish a supplementary statement published alongside its pharmaceutical needs assessment recording its view (regulation 3)."[6]

- As such, in the event of a proposed consolidation in future, in accordance with Paragraph 19 of schedule 2 of the regulations the Cambridgeshire HWB will publish a supplementary statement which will become part of the PNA, explaining whether, in its view, the proposed removal of premises from its pharmaceutical list would or would not create a gap in pharmaceutical services provision that could be met by a routine application
  (a) to meet a current or future need for pharmaceutical services; or
  (b) to secure improvements, or better access, to pharmaceutical services.
- The PNA steering group will continue to monitor any potential closures or mergers of local pharmacies and issue appropriate statements of fact as necessary in line with PNA requirements.

4.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

4.1 The PNA for Cambridgeshire is undertaken in the context of the needs of the local population. Health and wellbeing needs for the local population are described in the Cambridgeshire Joint Strategic Needs Assessment (JSNA). The PNA does not duplicate these detailed descriptions, and should be read alongside the JSNA.

5.0 IMPLICATIONS

5.1 The final PNA document will be reviewed by the CCC legal team before it is published, because of the importance that the PNA complies with regulations.

5.2 Over the coming years the population in Cambridgeshire is expected to both age and grow substantially in numbers. Several large-scale housing developments are in progress and a number of factors may influence the potential need for additional pharmaceutical service providers. To facilitate commissioning of pharmaceutical services responsive to population needs the PNA Steering Group will monitor the development of major housing sites and produce supplementary statements to the PNA if deemed necessary, in accordance with regulations.

5.3 The PNA steering group will also continue to monitor any potential closures or mergers of local pharmacies in response to the new pharmacy contract changes and issue appropriate statements of fact as necessary in line with PNA requirements.

[6] National Health Service England. ' The National Health Service (Pharmaceutical Services, Charges and Prescribing) (Amendment) Regulations 2016' (2016 No.1077) Page 13. Available at: http://www.legislation.gov.uk/uksi/2016/1077/contents/made

6.0 RECOMMENDATION/DECISION REQUIRED

6.1 The HWB is asked to note that:
1) a draft PNA document has been produced by the PNA Steering Group in close consultation with key stakeholders and partners;
2) a public consultation on the draft PNA is proposed to commence on 23 January 2017; and
3) the findings of the consultation and a full revised PNA report is due to be submitted to the HWB in June 2017;
4) the HWB has new additional statutory responsibilities under the *National Health Service (Pharmaceutical Services, Charges and Prescribing) Regulations* 2016 to produce a supplementary statement should any pharmacies propose a consolidation of two or more pharmacies onto one site.

7.0 SOURCE DOCUMENTS

7.1

Source Documents	Location
Pharmaceutical Services Negotiating Committee summary of NHS Pharmacy Regulations and amendments made on 5 Dec 2016 with links to legislation	***http://psnc.org.uk/contract-it/pharmacy-regulation/***
Murray R. 'Independent Review of Pharmacy Clinical Services'. Kings Fund. December 2016	***https://www.england.nhs.uk/commissioning/primary-care-comm/pharmacy/ind-review-cpcs/.***

Cambridgeshire Pharmaceutical Needs Assessment 2017

Draft report for public consultation

EXECUTIVE SUMMARY

1. Introduction

Since 1 April 2013, every Health and Wellbeing Board (HWB) in England has had a statutory responsibility to publish and keep up-to-date a statement of the needs for pharmaceutical services for the population in its area, referred to as a 'pharmaceutical needs assessment' (PNA). This PNA updates the 2014 Cambridgeshire PNA and describes the pharmaceutical needs for the population of Cambridgeshire, including Cambridge City, East Cambridgeshire, Fenland, Huntingdonshire and South Cambridgeshire. A separate PNA is produced by the Peterborough Health and Wellbeing Board.

The PNA will be used by NHS England when making decisions on applications to open new pharmacies and dispensing appliance contractor premises; or applications from current pharmaceutical providers to change their existing regulatory requirements. Of note, decisions on whether to open new pharmacies are made by NHS England, not by the HWB. As these decisions may be appealed and challenged via the courts, it is important that PNAs comply with regulations and that mechanisms are established to keep the PNA up-to-date.

The PNA will also inform decisions by local commissioning bodies including local authorities (public health services from community pharmacies), NHS England and Clinical Commissioning Groups (CCGs) on which NHS funded services are provided locally and where pharmacies may be able to deliver commissioned services (such as Stop Smoking and Sexual Health Services).

2. Process

As in 2014, the specific legislative requirements in relation to development of PNAs were duly considered and adhered to. The development of the revised PNA for 2017 was overseen by a multi-agency steering group.

Information from the JSNA and Public Health sources were used to describe pharmaceutical provision throughout the county and local health needs that may be addressed through pharmaceutical services. All pharmacies and dispensing GP practices in Cambridgeshire were asked to complete a questionnaire describing their service provision. 93 of 110 (85%) community pharmacies and 34 of 43 (79%) dispensing GP practices in Cambridgeshire responded to the questionnaire.

In the process of undertaking the PNA, views are being sought from a wide range of key stakeholders to identify issues that affect the commissioning of pharmaceutical services and to meet local health needs and priorities. A public consultation will be undertaken from 23 January 2017 to 27 March 2017 to seek the views of members of the public and other stakeholders, on whether they agree with the contents of this draft PNA and whether it addresses issues that they considered relevant to the provision of pharmaceutical services.

The PNA will continue to be updated every three years and supplementary statements may be published before this if deemed necessary by the HWB. Given the significant planned growth of new developments across Cambridgeshire, the Senior Public Health Manager for Environment and Planning will continue to monitor and assess pharmaceutical need in these areas.

3. Understanding local health needs

Cambridgeshire is a predominantly rural county with few urban settlements, which can create challenges for local transport and access to services. The health of the Cambridgeshire population is generally similar to or better than the England average, but important local variations exist within the county.

The PNA should be viewed in conjunction with the Cambridgeshire Joint Strategic Needs Assessments which describe the health and wellbeing needs of the local population, and with national and local health data sources available through www.cambridgeshireinsight.org.uk. The PNA and the role of pharmacies should also be considered alongside the Cambridgeshire Health and Wellbeing Strategy, the Cambridgeshire & Peterborough System Transformation Plan and the Health System Prevention Strategy for Cambridgeshire and Peterborough.

The local population is forecast to increase substantially in the coming years, with the biggest increases seen in the age group of over 65 years. There are also several major housing developments underway across Cambridgeshire. The impact of this population growth on pharmaceutical needs is discussed in Section 6 of the PNA.

4. Current provision of local pharmaceutical services

Key finding: There is currently sufficient pharmaceutical service provision across Cambridgeshire. No need for additional pharmaceutical service providers was identified in this PNA.

Cambridgeshire has one pharmaceutical service provider per 4,258 people, equivalent to 23 pharmaceutical service providers per 100,000 resident population in Cambridgeshire. This is the same as the national average of 23 per 100,000 resident population and slightly lower than the East of England average of 24 pharmaceutical providers per 100,000 resident population. Estimates of the average number of people per pharmaceutical service provider across Cambridgeshire have remained relatively stable since 2011.

As of July 2016 there were:

- 110 pharmacies in Cambridgeshire (only slightly more than 109 in July 2013 and 101 in January 2011).
- 43 dispensing GP practices in Cambridgeshire (unchanged from July 2013 and January 2011).
- One Dispensing Appliance Contractor (unchanged since 2011).

Taking into account current information from stakeholders including community pharmacies and dispensing GP practices, the number and distribution of pharmaceutical service provision in Cambridgeshire appears to be adequate. The distribution of pharmacies and dispensing GP practices appears to cover the county well with few gaps and some concentrations. Some geographical gaps appear to exist in some of the less populated areas in the north and southern fringes of the county but these localities are served by suppliers from outside the county. In terms of postal addresses, across all of Cambridgeshire, there are only 67 postal addresses registered as a residential property that are located more than 20 minutes away by car from a pharmacy or dispensing surgery.

Review of the locations, opening hours and access for people with disabilities, suggest there is adequate access to NHS pharmaceutical services in Cambridgeshire. There appears to be good coverage in terms of opening hours across the county. Overall, out of 110 community pharmacies, 45

(41%) are open after 6pm and 26 (24%) are open after 7pm on weekdays; 90 (82%) open on Saturdays; and 22 (20%) open on Sundays. The out of hours service, Hertfordshire Urgent Care is required to arrange for the provision of a full course of treatment, if clinically necessary, before a community pharmacy is open.

Home delivery services can help to provide medications to those who do not have access to a car or who are unable to use public transport. Of the pharmaceutical providers who completed the questionnaire, 89 pharmacies (95.7%) and 21 dispensing GP practices (61.8%) have some form of delivery service in operation, more than in 2013.

The proportion of providers reporting that they have wheelchair access to consultation facilities has increased since 2013 from 80.4% to 93% of community pharmacies and from 86.8% to 88.2% of dispensing GP practices.

All community pharmacy and GP dispensing practices who responded to the questionnaire considered local provision to be 'adequate' or better, with 39% of pharmacies and 56% of dispensing GP practices reporting provision as 'excellent' and 55% of pharmacies and 41% of dispensing GP practices as 'good'.

5 The role of pharmacy in addressing health needs

Section 5 describes the services provided by local pharmaceutical providers: 'Essential Services' which all pharmacies are required to provide; 'Advanced Services' commissioned by NHS England to support patients with safe use of medicines and the NHS national seasonal flu vaccination programme; and health improvement services locally commissioned by Cambridgeshire County Council.

Medicines advice and support

Through the provision of advanced services including Medicine Use Reviews (MURs), Dispensing Review of Use of Medicines (DRUMs), clinical screening of prescriptions and identification of adverse drug events, dispensing staff work with patients to help them understand their medicines. This also ensures that medicines are not omitted unnecessarily and that medication allergies and dose changes are clearly documented and communicated. In the community, pharmacists should continue to work with GPs and nurse prescribers to ensure safe and rational prescribing of medication.

Medication errors in care homes for older people can also be reduced by reviewing the safety of local prescribing, dispensing, administration and monitoring arrangements in the provision of medication to older people in care homes. Cambridgeshire and Peterborough Clinical Commissioning Group (C&P CCG) employ a small team of CCG pharmacists and pharmacy technicians to work collaboratively with GP practices and care homes to rationalise prescribing, optimise medicines usage and reduce medicines waste.

Services and support to encourage healthy lifestyle behaviours

Providers of pharmaceutical services also have an important role to play in improving the health and wellbeing of local people beyond providing and supporting the safe use of medicines. The NHS Community Pharmacy Contractual Framework requires community pharmacies to contribute to the health needs of the population they serve and the recent changes to the 2017/2018 pharmacy contract have included quality payments to pharmacies who are accredited as 'Healthy Living Pharmacies'. Community pharmacies can contribute to the health and wellbeing of the local population in a number of ways, including direct service provision, for example Emergency Hormonal Contraception, along with

providing ongoing support for lifestyle behaviour change through motivational interviewing, providing information and brief advice, and signposting to other services.

Community pharmacies are easily accessible and can offer a valuable opportunity for reaching people who may not otherwise access health services. Pharmacy support for the public health and prevention agenda could therefore be especially valuable in more deprived communities or for vulnerable groups who have a variety of poorer health outcomes (e.g. migrant workers; traveller communities; ethnic minorities; older people). Community pharmacies can be involved in addressing health inequalities and targeting initiatives and resources to improve the health of the poorest fastest.

Preventative approaches are important to ensure people remain healthy and independent in the community for longer, and to reduce the unsustainable cost of health and social care services for this growing population. Support for people to ensure that they remain healthy for as long as possible through the provision of healthy lifestyle advice is important. Community pharmacies can also support self-care where appropriate, as well as referring back to the GP service or signposting clients to other appropriate services. This could be particularly important for frail older people and those with multiple conditions.

Community pharmacies all participate in six public health promotion campaigns each year, as part of their national contract. Further opportunities exist to encourage healthy behaviours such as maintaining a healthy weight and taking part in physical activity such as providing advice, signposting services and providing on-going support towards achieving behavioural change, for example, through monitoring of weight and other related measures. Opportunistic alcohol screening and provision of brief advice is another area where pharmacies could potentially contribute to improving the health of the local population. This could, for example, potentially be integrated into agreements around medication checks.

Pharmacy staff can play a role in promoting awareness of good mental health, for example signposting to information about local support networks, mental health help lines etc. Pharmacy providers are also involved in part of the public advice and campaign network to increase public awareness of antibiotic resistance and the rational approach to infection control matters regarding, for example, MRSA and C difficile.

The following local services are currently commissioned from community pharmacies:

- *Smoking Cessation 'CAMQUIT'* (commissioned by Cambridgeshire County Council (CCC))
  The Community Pharmacy Smoking Cessation Service in Cambridgeshire illustrates how community pharmacies can improve population health through smoking cessation services, as evaluated by NICE. Smoking cessation services are commissioned from some community pharmacies in Cambridgeshire but this has decreased in the past two years. The contribution of pharmacies towards quit levels has also decreased from 12% in 2013/2014 to 6% in 2015/2016 and the lost to follow up rates have increased. Community pharmacies remain well placed to ensure services are accessible to the smoking population and evidence suggests community pharmacies can improve quit rates. The provision of commissioned smoking cessation services in pharmacies is currently under review to address service provision and quality concerns.

- *Chlamydia Screening and Treatment* (commissioned by CCC)
  Community pharmacies are easily accessible for young people and are crucial for offering treatment of chlamydia infections. Only 26 pharmacies have signed up to the Cambridgeshire

chlamydia screening programme and only 0.9% of chlamydia tests performed in Cambridgeshire were collected from pharmacies. Although there is some opportunity to expand, this is limited by the number of pharmacies that do not have the appropriate facilities to offer screening. There is also potential for offering advice on barrier contraception methods for both males and females and for raising awareness of HIV, chlamydia and other STIs.

- *Emergency Hormonal Contraception (commissioned by CCC)*
  Pharmacies in Cambridgeshire are offered the opportunity to receive training and a contract to provide Emergency Hormonal Contraception (EHC), which is available as a locally commissioned service in some community pharmacies. The EHC Service is currently being delivered by 28 pharmacies across Cambridgeshire, as part of the overall contraception service offered by sexual health, contraception clinics and GP practices across Cambridgeshire, and there are opportunities to expand. It is advised to offer chlamydia screening when Emergency Hormonal Contraception is provided, since those requiring such contraception may also be at risk of infection. The extent to which local services signpost to services or carry out testing when EHC is provided is regularly examined in an audit, as recommended in the 2014 PNA.

- *Needle and Syringe Exchange Service* (Drug & Alcohol Action Team (DAAT), CCC)
  The Cambridgeshire Drug and Alcohol Action Team (DAAT) commission services to provide specialist drug and alcohol treatment across Cambridgeshire. Currently Adult drug and alcohol services are provided by 'Inclusion' and Young People services are provided by CASUS. Further information can be found at: www.cambsdaat.org. A 'Drug and Alcohol JSNA' was published in September 2016 which provides an overview of legal and illicit drug and alcohol misuse needs for the Cambridgeshire population.
  People who use illicit drugs are often not in contact with health care services and their only contact with the NHS may be through a needle exchange service within a community pharmacy. At a minimum, the pharmacy can provide advice on safer injecting and harm reduction measures. In addition, community pharmacies can provide information and signposting to treatment services, together with information and support on health issues other than those that are specifically related to the client's addiction. Across Cambridgeshire, 34 community pharmacies across Cambridgeshire are sub-contracted by the DAAT commissioned provider *Inclusion* to provide access to sterile needles and syringes, and sharps containers for return of used equipment.

- *Supervised Administration Service* (DAAT, CCC)
  Once clients are being treated within the NHS, community pharmacies can provide supervised administration of drug therapies and instalment dispensing. Clients often need support to prevent them stopping treatment. 34 community pharmacies across Cambridgeshire are sub-contracted by the DAAT commissioned provider *Inclusion* to provide a Supervised Administration Service, which requires the pharmacist to supervise the consumption of prescribed medicines at the point of dispensing in the pharmacy, ensuring that the dose has been administered to the patient.

- *Outreach NHS Health checks service (pilot) (CCC)*
  In summer 2016, Cambridgeshire County Council trained 11 Pharmacies in the Wisbech area, Fenland, to deliver outreach NHS Health Checks as part of a 6 month pilot. The NHS Health Check is a health check-up designed to spot early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia, in adults in England aged 40-74 without a pre-existing condition. The rural, market town of Wisbech was chosen for the pilot as it has a high prevalence of

cardiovascular disease, a high number of local residents unable to attend their GP practice, and a number of proactive community pharmacies in the area.

- *Directly observed therapy (DOT) service for Tuberculosis (TB) patients (C&PCCG/ CCC)*
  The CCG in conjunction with public health and local respiratory clinics are exploring commissioning a Directly Observed Therapy (DOT) service for tuberculosis (TB) patients from a limited number of community pharmacies across the geography of the CCG. This will provide care closer to home for non-infectious patients who require support in adherence with their prescribed TB medication.

In conclusion, the Cambridgeshire Health and Wellbeing Board consider community pharmacies to be a key public health resource and recognise that they offer potential opportunities to provide health improvement initiatives and work closely with partners to promote health and wellbeing. There are opportunities to develop the contribution of community pharmacies to all of the currently commissioned services. Pharmacies are able to, and should be encouraged to bid for locally commissioned health improvement programmes, along with other non-pharmacy providers. Local commissioning organisations should continue to consider pharmacies among potential providers when they are looking at the unmet pharmaceutical needs and health needs of the local population, including when considering options for delivering integrated care. Commissioners are recommended to commission service initiatives in pharmacies around the best possible evidence and to evaluate any locally implemented services, ideally using an evaluation framework that is planned before implementation.

The King's Fund report 'Community Pharmacy Clinical Services Review' (December 2016) commissioned by the Chief Pharmaceutical Officer recommended that there is a need in the medium-term to "*ensure that community pharmacy is integrated into the evolving new models of care alongside primary care professionals. This will include enhancing the support they provide to people with long-term conditions and public health, but should not be limited to these*." At a local level, the Health and Wellbeing Board should encourage the involvement of pharmacies and pharmacy teams in developing local plans and systems of integrated working.

6 Pharmaceutical needs associated with Future Population Changes and Housing Growth

Over the coming years the population in Cambridgeshire is expected to both age and grow substantially in numbers. An increase in population size is likely to generate an increased need for pharmaceutical services, but on a local level changes in population size may not necessarily be directly proportionate to changes in the number of pharmaceutical service providers required, due to the range of other factors influencing local pharmaceutical needs. Several large-scale housing developments are in progress and considerations when assessing needs for local pharmaceutical service providers should be based on a range of local factors specific to each development site. These are further described in Section 6 of the PNA report.

To facilitate commissioning of pharmaceutical services responsive to population needs the Health and Wellbeing Board partners will, in accordance with regulations, monitor the development of major housing sites and produce supplementary statements to the PNA if deemed necessary, to ensure that appropriate information is available to determine whether additional pharmacies might be required. In accordance with the amended *NHS regulations* (Dec 2016), the HWB will also produce a supplementary statement when required, if two or more pharmacy sites consolidate into one, assessing any gaps in local pharmaceutical and health needs.

Public Consultation
Draft Cambridgeshire Pharmaceutical Needs Assessment (PNA) 2017

1. Introduction

What do you think about local pharmacies and dispensaries in Cambridgeshire?

About this consultation

We, the Cambridgeshire Health and Wellbeing Board (HWB), are looking at whether we have enough providers of pharmaceutical services for the population of Cambridgeshire. Pharmaceutical services include filling prescriptions, selling medicines that don't need to be prescribed by a doctor, giving advice about medicines, supporting people to quit smoking, and other services. These services can also supply appliances.

We have spoken to GPs, community pharmacies and patients about what local people need now from pharmaceutical services. We also asked what people might need in the future. We have written a report based on what we have learned so far, called a Pharmaceutical Needs Assessment or PNA for short. This report will be used by NHS England when making decisions on applications to open new pharmacies. We would like to know what you think about the draft PNA.

What is the purpose of the consultation?

We want to know your thoughts about what we have written about pharmaceutical services in Cambridgeshire, and if the PNA covers what is important to you regarding the pharmaceutical services you need. We want to know how easy it is for you to get and use medicines or medical equipment safely and access the services you need or want from pharmacies. Your views will be summarised and included in the final report.

Please give us your feedback using the questionnaire below. A 2 page summary below describes the key findings in our draft report. More detail is also available in the 6 page summary or the full draft PNA document which is available online at www.cambridgeshireinsight.gov.uk/pna

Timeline for the consultation

This consultation will run from 23 January to 27 March 2017. This is the time you have to comment on the draft of the PNA.

We will revise the draft based on the feedback we get, and present a report to the Cambridgeshire Health and Wellbeing Board. We plan to publish the final PNA by July 2017.

Please complete the following survey to let us know your views by 27 March 2017
Please click "next" below to begin the survey.

If you would like a copy of this document either in paper format, on audio cassette, Braille, large print or in other languages please contact us:
E-mail: PNA@cambridgeshire.gov.uk
Tel: 01480 379493

The information you are providing will assist informing CCC in provision of services and will be held in accordance with the Data Protection Act 1998. On clicking "next" you confirm you are happy for your response to be used in the consultation analysis and results. Your responses may be included as valid answers, even if you do not click "Submit" at the end of the survey.

2. Summary of Key Findings from the draft Cambridgeshire Pharmaceutical Needs Assessment (PNA) for 2017

Local pharmaceutical services

- Cambridgeshire is well provided for by pharmaceutical service providers. This PNA recommends that no new NHS pharmaceutical service providers are needed across Cambridgeshire at present.

- There are 110 pharmacies across Cambridgeshire and 43 dispensing GP practices. This works out at 23 pharmaceutical service providers per 100,000 people in Cambridgeshire, which is the same as the England average. The East of England average is only slightly higher at 24 per 100,000. There is also adequate access for the dispensing of appliances.

- We recognise that this may change during the next 3 years. The local population is forecast to increase substantially in the coming years. Several large-scale housing developments are in progress and a number of factors may influence the potential need for additional pharmaceutical service providers. The Health and Wellbeing Board partners will monitor the development of major housing sites and produce additional information to this PNA when necessary, to ensure that appropriate information is available to determine whether additional pharmacies might be required.

- 85 % of pharmacies and 79% of dispensing GP surgeries responded to our PNA questionnaire about service provision. Of those responding all considered provision to be either ‘excellent’ ‘good’ or ‘adequate’ across the county.

- There appears to be good coverage in terms of opening hours for most days of the week. The extended opening hours of some community pharmacies are valued and should be maintained. 26 pharmacies are commissioned by NHS England to open for 100 hours a week and the out of hours provider, Urgent Care Herts is required to arrange medications when clinically necessary until a community pharmacy opens.

- Many pharmacies (96%) and dispensing GP practices (62%) reported that they offer some kind of home delivery service which can help to provide medications to those who do not have access to a car or who are unable to use public transport. This was substantially more than in 2014. Many pharmacies and dispensing surgeries also report they have wheelchair access.

The role of pharmacy in improving the health and wellbeing of the local population

- Providers of pharmaceutical services have an important role to play in improving the health of local people. They are easily accessible and are often the first point of contact, including for those who might otherwise not access health services.

- Community pharmacies can contribute to the health and wellbeing of the local population in a number of ways, including providing information and brief advice, providing on-going support for behaviour change, motivational interviewing, and signposting to other services.

- As part of their national NHS contract, all pharmacies offer services to support individuals to understand their medicine and ensure they take them safely. 78 community pharmacies (84%) reported that they offer flu vaccinations to those at risk under the NHS Seasonal Flu vaccination programme, commissioned by NHS England. The Cambridgeshire & Peterborough

Clinical Commissioning Group also employs some pharmacists too work locally to support the administering of medicine in care homes.

- Many pharmacies are commissioned (paid) by Cambridgeshire County Council Public Health department to play a role in supporting particular healthy behaviours. These include helping people to give up smoking, sexual health testing and advice and specialist drug and alcohol treatment and support:
    - Stop smoking activities in community pharmacies in Cambridgeshire have decreased since 2014, and there are still many community pharmacies that do not provide a smoking cessation service. There is potential for further development in this area.
    - All pharmacies in Cambridgeshire have been offered the opportunity to deliver the Community Pharmacy Chlamydia Screening and Treatment service. Only 26 pharmacies are signed up to the chlamydia screening programme so there is also opportunity to expand this across Cambridgeshire. Chlamydia screening is offered when Emergency Hormonal Contraception (EHC) is provided, since those requiring such contraception may also be at risk of infection.
    - Pharmacies in Cambridgeshire have the opportunity to receive training and provide emergency hormonal contraception – 28 pharmacies are currently commissioned to do this.
    - 34 pharmacies have also been sub-contracted by the Cambridgeshire Drug and Alcohol Action Team provider *Inclusion* to provide specialist drug and alcohol treatment and support. This includes access to sterile needs and syringes and supervising the administration of some drugs to reduce drug dependence and misuse.
    - All pharmacies support six Public Health campaigns every year which involves putting up posters and offering information, as part of their NHS contract. Opportunistic alcohol screening and providing brief advice on reducing alcohol consumption is another area where pharmacies could potentially contribute to improving the health of the local population in future. Also, many pharmacies currently offer weight management advice and advice on physical activity.
- Cambridgeshire Health and Wellbeing Board consider community pharmacies a key public health resource and recognise that they offer potential opportunities to commission health improvement initiatives and work closely with partners to promote health and wellbeing. Pharmacies are encouraged to bid for local health improvement contracts to provide services. Commissioners are recommended to commission service initiatives in pharmacies around the best possible evidence and to evaluate any locally implemented services, ideally using an evaluation framework that is planned before implementation.
- The Royal Pharmaceutical Society (RPS) recommends that pharmacists collaborate with each other and with other healthcare professions, to develop models of care which enable commissioners to deliver joined-up, patient-centred health and social care. This could be particularly important for frail older people and those with multiple or long-term conditions. At a local level, the Health and Wellbeing Board should encourage the involvement of pharmacies and pharmacy teams in developing local plans and systems of integrated working.

3. Questions

1. How did you find out about the survey (eg in a Pharmacy, a GP surgery, CCC website)? Please specify below:

2. Are you responding as:

- [ ] A member of the public
- [ ] A health or social care professional
- [ ] A pharmacist or appliance contractor
- [ ] On behalf of an organisation

4. Questions (Members of the Public only)

Only members of the public to complete Q3 - Q7

3. Do you regularly use a community pharmacy? *

- [ ] Yes
- [ ] No

4. Do you regularly use a dispensary at a GP surgery? *

- [ ] Yes
- [ ] No

5. How often do you use community pharmacies or dispensaries in Cambridgeshire? *

- [ ] Never
- [ ] Less than 3 times a year
- [ ] 3 to 12 times a year
- [ ] More than 12 times a year

6. How often do you use each of the following services? *

	Never	Less than 3 times a year	3 to 12 times a year	More than 12 times a year
Fill a prescription	☐	☐	☐	☐
Buy non-prescription medicines	☐	☐	☐	☐
Get a repeat prescription	☐	☐	☐	☐
Give the pharmacist your old or unwanted medicines	☐	☐	☐	☐
Ask a pharmacist for advice (eg medicines advice, how to improve your health, etc)	☐	☐	☐	☐
Use a Dispensing Appliance Contractor	☐	☐	☐	☐

Other service - please specify:

7. Do you feel that the purpose of the pharmaceutical needs assessment (PNA) has been explained sufficiently? *

- ☐ Yes
- ☐ No

If no, please let us know why:

5. Questions (for all)

8. Do you think that pharmacy services are available at convenient locations and opening times? *

- ☐ Yes
- ☐ No

If no, please let us know why:

9. Do you agree with our conclusion that we have enough pharmacies across Cambridgeshire and do not currently need any more? *

- [ ] Yes
- [ ] No

If no, please let us know why:

10. Do you agree with the key findings about pharmaceutical services in Cambridgeshire? *

- [ ] Yes
- [ ] No

If no, please let us know why:

11. Do you think the draft PNA adequately describes current pharmaceutical services in Cambridgeshire? *

- [ ] Yes
- [ ] No

If no, please let us know why:

12. Do you know of any pharmaceutical services that are not described in the PNA? *

- [ ] Yes
- [ ] No

If yes, please let us know which services:

13. Do you think that the needs for pharmacy services for the population in Cambridgeshire have been adequately identified? *

- [ ] Yes

- [ ] No

If no, tell us what you think they are:

14. Do you have any other comments? *

- [ ] Yes
- [ ] No

Please explain:

6. About You

15. What is your gender? *

- [ ] Male
- [ ] Female
- [ ] Other
- [ ] Prefer not to say

16. What is your age? *

- [ ] Under 18
- [ ] 18-24
- [ ] 25-34
- [ ] 35-44
- [ ] 45-54
- [ ] 55-64
- [ ] 65-74
- [ ] 75 or over

17. Are you.. *

- [ ] In education (full or part time)

- [ ] In employment (full or part time)
- [ ] Self-employed (full or part time)
- [ ] Retired
- [ ] Stay at home parent / carer or similar
- [ ] Other (please specify):

18. What is your postcode? (This will be used to identify common concerns by location, not to identify you personally) *

19. Do you have a disability that impacts on the way you travel? *

- [ ] Yes
- [ ] No
- [ ] Prefer not to say

20. How would you describe your ethnic background? *

Agenda Item No. 9

SUSTAINABILITY AND TRANSFORMATION PLAN (STP)

To: Health and Wellbeing Board

Date: 19 January 2017

From: Jessica Bawden, Director of Corporate Affairs, Cambridgeshire and Peterborough CCG

1.0 PURPOSE

1.1 The purpose of this report is to update the Health and Wellbeing Board on the latest Sustainability and Transformation Plan (STP), published by the Sustainability and Transformation Programme team on 21 November 2016.

2.0 BACKGROUND

2.1 Cambridgeshire and Peterborough's latest five-year Sustainability and Transformation Plan (STP) to improve local health and wellbeing was published on 21 November 2016.

2.2 Led by local clinicians, the STP has been developed by all local NHS organisations and local government officers, and through discussion with our staff and patients. It aims to provide solutions to the county's challenges to deliver the best possible care to keep the population fit for the future and take joint responsibility for improving health and wellbeing.

2.3 The plan addresses the issues highlighted in our Evidence for Change (March 2016) and the main reasons why changes are needed in the local health and care system. It details how we propose we could improve services and become clinically and financially sustainable for the future.

2.4 Following on from the interim STP summary published in July where we forecasted that as a system we will have a £250m financial deficit by 2020/21, the STP outlines that this is in addition to £250m of savings and efficiency plans individual Trusts and the Clinical Commissioning Group (CCG) need to deliver over the same period. This makes a total system-wide financial challenge of £500m over the next four years. It also estimates the need to invest £43m to improve services over these four years, which increases the total system-wide financial challenge from £500m to £543m.

2.5 The scale of the changes required is significant and we all recognise the delivery will be challenging.

3.0 KEY ISSUES

3.1 Through discussion with our staff, patients, carers, and partners we have identified four priorities for change as part of the Fit for the Future programme, and developed a 10-point plan to deliver these priorities:

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

3.2 **We have translated the STP into a programme of improvement projects, each of which reports to a delivery group**

Our priorities will be delivered through eight delivery groups, responsible to Accountable Officers who are Chief Executive Officers from across the health and social care system.

The groups cover clinical services, workforce and support services. The clinical delivery groups include public health and care services and are designed to encourage system-wide working and to allow for patient-led care to be at the forefront of everything we do.

Delivery Groups

Urgent and Emergency Care Accountable Officer: Roland Sinker, CUH	**Women & Children** Accountable Officers: Matthew Winn, CCS & Wendi Ogle-Welbourn, CCC & PCC	**Elective** Accountable Officer: Tracy Dowling, C&PCCG	**Primary Care & Integrated Neighbourhoods** Accountable Officer: Aidan Thomas, CPFT
Shared Services Accountable officer: Stephen Graves, PSHFT	**Digital Delivery** Accountable Officer: Stephen Posey, PHT	**Workforce & Organisational Development** Accountable Officer: Matthew Winn, CCS	**System Delivery Unit** Accountable Officer: Lance McCarthy, HHCT

Improvement projects

Service area	Improvement projects
Urgent and emergency care	Reduce demand for hospital care through: • Integrated NHS 111 and out of hours with clinical hub • Develop and deliver a mental health first response service to enable 24/7 access to mental health

	• Re-design the clinical model for intermediate care (community beds, re-ablement and therapy) • Ambulances: dispatch on disposition, hear and treat, divert to community services • Reduce re-admission rates through supported discharge • Extent and enhance ambulatory care services as alternatives to admissions • Develop primary and urgent care hubs in rural communities • Reduce length of stay in hospital
Women and children	• Introducing a 7-day-a-week paediatric community nursing (for children who would otherwise require emergency/urgent care in the hospital setting) • Maternity developments such as the 'saving babies lives' care bundle • Improving the care models for children with asthma and children's continence services • Developing an integrated children and family health and wellbeing service for 0-19 year olds (universal services) • Improve the mental health support for children and young people
Elective care	• Achieve shorter, faster, more effective treatment pathways • Models of care to enable GPs and consultants to share decision making • Develop GP referral support to address unwarranted variation in referral practice • Maximise clinical thresholds for effective services • Standardise high volume elective treatment pathways (hip, knee, arthroscopy, cataract, glaucoma, cardiac, ENT) • Reduce outpatient follow-up activity through virtual clinics, technology for results • Deliver productivity gains in provider trusts
Primary care and integrated neighbourhood teams	• CVD and stroke prevention • Improve identification and management of patients with hypertension and atrial fibrillation • Improve uptake of NHS Health Checks • Improve uptake and completion of cardiac rehabilitation • Mental Health • Implement enhanced primary mental health care (PRISM) • Ensure mental health service model matches capacity and demand • Implement mental health strategy across the system • Diabetes • Support self-care, provide enhanced patient education and virtual patient reviews • Develop a proactive integrated model of care for people with long term conditions • Design and implement the 8 diabetes NICE care processes • Respiratory • Improve respiratory patient identification • Develop specialist community expertise • BLF 'Love your lungs' and spirometry testing

	• Implement new medicines management and prescribing practices including minimise triple therapy for COPD
Shared services	• Merger of HHT and PSHFT to enable shared service savings • Explore back office consolidation across primary care at scale • Implement a single approach to procurement across C&P • Develop and sign off strategic estate plans, (including potential for primary care co-location, including other public services like Citizens Advice)
Digital delivery	• Digital opportunities: tele-medicine, tele-monitoring, GS1, remote monitoring, internet of things • Shared Wi-Fi, infrastructure for professional and citizen – all health and care locations • Paper free care delivery
Workforce & Organisational Development	• Develop a system wide Workforce Investment Plan, in which all providers commit to investment priorities in relation to Apprenticeships (via LEVY), Pre Registration, CPD and wider workforce transformation • Link to supply improvement programme and design a tailored programme for primary care, linking to case load management trailblazers

3.3 All of the leaders across the system are being asked to sign a Memorandum of Understanding (MoU) as a demonstration of their commitment to work together, share budgets, deliver agreed clinical services and ensure that together we provide health and care services that are clinically and financially sustainable.

3.4 Eleven delivery groups have been set up to deliver the 'Fit for the Future' 10-point plan – led by chief executives officers from across the system. The 11 groups have identified 53 improvement areas which are being scoped and measures for success developed, including quality key performance indicators and targets, and key milestones.

3.5 If patients and carers want to be part of the discussion and work with us to develop solutions, they can contact the team on contact@fitforfuture.org.uk

4.0 IMPLICATIONS

4.1 If the Trusts and CCG meet their savings and efficiency plans, and all aspects of the STP are delivered, this will achieve the savings and efficiency target (of £500m) and produce a small NHS surplus of £1.3m (by 2020/21).

4.2 Due to the high levels of acute hospital activity, and resulting deteriorating financial position in our system, we are looking at ways to accelerate the pace of change and focus early investment on the areas that will have greatest impact on reducing hospital activity levels.

4.3 Our priorities are to increase the amount of care delivered closer to home and to keep people well in their communities.

4.4 There will be more opportunities for patients, carers, and local people to be involved with the specific improvements we would like to make, and we will provide opportunities for staff

and local people to help shape proposals for service change and to be involved with any formal consultation process. Any changes to services will also be open to scrutiny by the County Council's Health Committee.

4.5 The proposals will be further developed over the next few months. If anyone wants to be part of the discussion please contact the team via email: contact@fitforfuture.org.uk

5.0 RECOMMENDATION/DECISION REQUIRED

5.1 The Health and Wellbeing Board are required to comment upon and note the STP.

6.0 SOURCE DOCUMENTS

Source Documents	Location
• Cambridgeshire and Peterborough Sustainability and Transformation Plan – October 2016 • Sustainability and Transformation Plan summary document – updated, November 2016 (also attached as a PDF) • Frequently Asked Questions – Third edition, November 2016	All available at www.fitforfuture.org.uk/what-were-doing/publications/

Fit for the Future

Working together to keep people well

How health and care services in Cambridgeshire and Peterborough are changing

This is an update to the Sustainability and Transformation Plan Interim Summary, published in July 2016

@fitforfuturenhs
fitforfuturenhs
fitforfuture.org.uk

Cambridgeshire County Council

PETERBOROUGH CITY COUNCIL

NHS

1 Why do we need to change?

Our health and care services face challenges

Ours is one of the most, if not ***the*** most, challenged health systems in England, making it essential that we work together to develop robust plans for long-term change.

The population of Cambridgeshire and Peterborough is growing rapidly. Our population is diverse, it is ageing, and it has significant inequalities. There are also more people with long term conditions, such as diabetes, and there are higher levels of obesity.

In addition, we are facing practical challenges:

- healthcare is not as good in some places as in others, and does not always meet the standards that it should
- recruiting and retaining staff is a challenge for all health and care services
- our health, local authority, and other care services are not always joined up. They do not always meet people's individual needs, and they do not always balance physical health with mental health and wellbeing
- local needs are growing and changing. Our average age and levels of sickness are all growing, and faster than in other parts of the country
- overall, we spend too much of our time and resources treating illnesses which can be prevented or kept under control in better ways
- The current health system is financially unsustainable. The local system has a total annual budget of more than £1.7billion for NHS services, but we spend about £160million more than that each year. We need to deliver our current plans and radically change the way we provide services. If we don't do both of these things the deficit is projected to increase to £500million by 2020/21.

The Sustainability and Transformation Plan (STP) proposes ways in which we can deliver the best possible care to keep our population fit for the future, and address our service and financial challenges.

What you've told us so far

During the last 18 months, we held listening events across our area to seek your views on the health and care system. We heard that:

- you want to be empowered to stay healthy
- you want easy access to information about health
- you want to understand how to use the right health and care service at the right time
- when you need care urgently, you would rather use a local service than be sent to A&E
- you want consistent access, such as opening hours for services
- you want care as close to home as possible
- children's services need to be co-ordinated better
- you would be happy to be sent home from hospital sooner if you had visits from a nurse to support you
- you do not want to be sent home too early with no support – you are concerned about needing to be readmitted
- you need better communication and planning before you leave hospital
- you want the people who provide health and care services to collaborate and work more closely together.

2 Our five-year plan to make Cambridgeshire and Peterborough Fit for the Future

This document tells you about our proposals, both to meet your ambitions for health and care and to make services financially and clinically sustainable.

The NHS and local government officers have come together to develop a major new proposed plan to keep Cambridgeshire and Peterborough Fit for the Future. We have also been asking you how you think we can manage our challenges. Our plan aims to:

- improve the quality of the services we provide
- encourage and support people to take action to maintain their own health and wellbeing
- ensure that our health and care services are financially sustainable and that we make best use of the money allocated to us
- align NHS and local authority plans.

It has been developed by our health and care organisations. We are working together and taking joint responsibility for improving our population's health and wellbeing, with effective treatments and consistently good experiences of care. The work is being led by local doctors and other medical professionals, supported by NHS England and NHS Improvement.

Fit for the Future sets out a single overall vision for health and care, including:

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

We are well placed to make the changes we need and have a lot to be proud of. Cambridgeshire and Peterborough has a committed and expert health and care workforce. We provide some excellent services to which people travel from other parts of the country. We host groundbreaking research and deliver excellent medical education and training. We have a resourceful voluntary sector, strong organisations, active local communities, and we work alongside research and technology industries which are world leaders in improving healthcare.

3 What are the priorities?

Through discussion with our staff, patients, carers, and partners we have identified four priorities for change and we have developed a 10-point plan to deliver these priorities.

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

1 People powered health and wellbeing

We will help people to make healthy choices, keep their independence, and shape decisions about their health and care. We will work with community groups and businesses so that people of all ages have good health, social, and mental wellbeing support.

Our first aim is to prevent illness and support people to take control of their own health and wellbeing. We will develop health services which work alongside patients and carers, social care, and housing providers, and which help to build strong communities.

We want patients to become equal partners with those caring for them, make more decisions about their own treatment and, with advice and support, become increasingly confident to manage their own conditions, supported by technology.

Summary of what we propose to deliver.

Housing and business - working in partnership with communities and businesses to provide employment, housing in new developments, and an environment to keep people healthy.

Where possible, we are influencing the design of new housing developments to reinforce active lifestyles and introduce smart technology that promotes independence for older people.

Prevention - helping people to keep healthy, dealing with problems earlier, and making sure people who are likely to fall ill are supported to keep well.

We will do this by implementing our Health System Prevention Strategy for Cambridgeshire and Peterborough. The strategy sets out practical steps to make this happen.

Psychological wellbeing - making support and treatment for people with mental ill health as available as it is for those with physical health conditions, mainstreaming mental health and prevention.

We will reduce stigma, support employers to have healthy workplaces, and reduce suicides.

Starting young - working together to ensure that there is support for children and young people with mental health and physical health problems, whatever their age.

We are joining up children's services across the NHS and local authorities, including Child and Adolescent Mental Health Services (CAMHS) and emotional health and wellbeing services, children's community health services, and local authority services for those aged 0-19 (which may include children's centres).

Reaching out - engaging those at high risk through the third sector and trusted networks.

Our neighbourhood teams, primary care, and social care will work with the voluntary and community sector to identify those at risk of poor or deteriorating health. Community-based workers will support those with a severe mental illness or dementia, migrant workers, travellers, and our wide range of diverse communities who may need help to access services in a different way.

Self-care - supporting patients to make decisions about their own treatment and become more confident to manage their own conditions.

Our GPs, consultants, and nurses will make it easier for people with long term conditions to manage their own care by adopting best practice for supporting self-care.

Ageing well - we must improve independence and wellbeing in older age and prevent health and care needs from escalating.

To achieve this, we will focus on physical activity and reducing falls, holistic approaches, and care for older people's mental health.

We need to link up health and social care.

Peterborough Public Workshop

2 Neighbourhood care hubs

More health and care services will be provided closer to people's homes and we will help people stay at home when they're unwell.

We aim to coordinate care better so that it meets the needs of the individual. We aim to pay close attention to the health and care services necessary to keep people living at home successfully, because we know this is the best way to keep people healthy and to maintain their independence.

When people become unwell, we will take every opportunity to spot warning signs and focus local support to help people live with long term health conditions.

We would like to see more joint working between local health and social care, with GPs playing a central role, supported by hospital clinical teams.

As much care as possible must be led by primary care (GPs). We are supporting our GPs to share best practice, work together, access advice from hospital consultants and to provide the enhanced primary and community care that our local people need.

Summary of what we propose to deliver.

Time to care - testbeds to support GPs.

Our 'Time to care' programme aims to support our 105 GP practices to manage increasing patient demand, help them to become more efficient, and to provide better quality of care to their patients. It also aims to improve the way in which GP practices work with local hospital, community, social care, and voluntary sector providers to provide proactive care close to the patients' home.

Neighbourhood teams - multi-disciplinary teams, led by GPs targeting those at risk (such as those with long term conditions, frail, elderly).

We aim to build on our neighbourhood teams which are staffed by district nurses, matrons, social workers, therapists, and pharmacists to provide integrated, proactive care for those with long term conditions, such as the dying, care home residents, and mental health service users.

Community experts - specialist clinicians will support neighbourhood teams.

To support the neighbourhood teams we need an integrated team of community-based experts to care for the more complex patients and provide advice and education. However, more needs to be done to ensure that access to the teams is fair, that the teams can access advice, and clinicians are able to review complex patients together to agree a management plan.

Sharing knowledge - this is a central role of the patient care plan, and electronic access to patient information across the system.

Proactive and person-centred care relies on there being one single care plan, owned by the patient and their family; one electronic care record accessible by all; one set of best practice protocols all can adopt; and one route through which expert opinion can be accessed day or night.

Embedded mental health - ensure community mental health is within neighbourhood teams, and that there are links to liaison psychiatry and recovery.

Our neighbourhood teams already provide joined up community mental health services. We want to join up our community and mental health teams further to make sure the psychological needs of people with long term conditions and the physical health needs of patients with severe mental illness are met consistently.

Learning disabilities – implementing 'transforming lives'.

We have been working closely with the councils to implement 'transforming lives' for people with learning disabilities. The Collaboration for Leadership in Applied Health Research and Care (CLAHRC) is evaluating the use of integrated personal health and care budgets for people with learning disabilities.

Your own bed, not a hospital bed - for end of life and intermediate care.

We aim to provide more rehabilitation closer to, or at, home to retain a patient's independence, and provide more end of life care at home, rather than in hospital.

3 Responsive urgent and expert emergency care

We will offer a range of support for care and treatment which is easily accessible, from telephone advice for urgent problems to the very best hospital emergency services when the situation is life-threatening.

This will be supported by better co-ordination, for example referral through NHS 111, close working with the ambulance service, and clear information provided to patients about which services are available - and how to reach them - when they have an urgent health need.

It is not good for patients to stay in hospital for longer than they need to be there, as it can have a negative impact on their recovery and ability to maintain independence. We must therefore make sure patients in hospital beds really need to be there, and that they are not delayed when moving through the steps on their care plan.

We have been through a process to designate our three A&E departments against the national Keogh urgent care definitions. As a result of this process, we have determined that it is in the best interests of our local population to maintain the current levels of provision, namely a specialist emergency centre at Addenbrooke's Hospital and an emergency department at Peterborough City Hospital. Hinchingbrooke Hospital will retain its A&E department and will continue to be able to manage the current caseload of minor injury and major medical cases, with a physician-led service.

Since our three hospitals are already struggling to meet existing levels of emergency demand, and our volume of planned hospital procedures is significantly above that of similar health systems, we need to improve our community-based urgent care and our emergency services radically such that hospital is a last resort. There are several strands to this improvement work.

Summary of what we propose to deliver.

Ambulance services - alternatives to hospital admission.

We are working with our ambulance teams to make sure that only patients who really need to be transferred to hospital are taken there. We are implementing 'hear and treat', 'see and treat', and 'see, treat, and convey' systems which allow paramedics, supported by other medical professionals, to decide whether options other than transfer to hospital are more appropriate.

Right call, first time - integrated urgent care and clinical hub.

From October 2016, if you call 111 and you need to speak to a clinician you will be able to do so. This service is provided by our expanded integrated urgent care service and clinical hub. The aim is to make sure that patients receive the most appropriate care that best meets their needs. This will ensure that our hospitals' emergency services are reserved for serious/life threatening injuries or illnesses.

Minor injury - walk-in minor injury services.

Following our review of the three Minor Injury Units, (MIUs), in East Cambridgeshire and Fenland, we have undertaken extensive engagement with the public, providers, and other stakeholders on a range of options for the future. Taking this feedback into account, we have identified significant opportunities to deliver more joined-up, effective, and efficient local urgent primary care services which reflect the rural geography, deprivation, and demography.

Whilst no formal decisions have been taken, we are now working with local stakeholders to develop the details behind a number of options, including the development of three rural urgent primary care hubs which will focus initially on integrating local primary, minor injury, and community services. This will move on to include development of point of care testing and consultant support, via telemedicine links. We intend to develop and test the first phase of any new urgent primary care model over the next 12 months, which will inform further engagement and, potentially, consultation. We are also doing an analysis of all options put forward as part of our early engagement work.

Right call, first time for mental health concerns - dial 111 - press 2 if you have a mental health concern.

We are embedding mental health including community crisis services, liaison psychiatry, and Suicide Prevention Strategy. We are investing £2m of urgent and emergency care funding in an evidence-based, community first response service which provides urgent out of hours assessment and support to people in mental health crisis.

More support for people leaving hospital - we have a very high level of people staying in our hospitals for longer than they need to be.

We believe it is not good for any patient to stay in hospital for longer than medically necessary and we are putting in place processes to ensure that patients are discharged on time, including on-site social care staff to support discharge from hospital.

24/7 standards – in consultant-led services

Our three urgent and emergency care hospital departments will meet the government's seven-day service standards with early and daily consultant input to reduce the length of time people spend in hospital.

4 Systematic and standardised care

Doctors, nurses, and other health and care professionals will work together across Cambridgeshire and Peterborough to use the best treatments and technology available.

Where it is important to provide services from several sites across the area, we believe we can use our skills and expertise collectively to achieve better results through doctors and nurses working across more than one hospital site and sharing their expertise.

We expect that maternity services will also remain at the Rosie Hospital in Cambridge, at Hinchingbrooke Hospital, and at Peterborough City Hospital.

Evidence tells us that standardised care is often higher quality and lower cost. Networking between medical professionals will help us to deliver savings, as well as helping to ensure that the additional costs associated with increased clinical standards, especially seven day services, are minimised.

Summary of what we propose to deliver.

Networks of care - where services are provided from more than one site, we will use specialised skills and expertise collectively to raise quality everywhere.

Medical professionals at our hospitals are beginning to agree how to work as operational networks for planned, unplanned, routine, and specialised care. These networks will share information about appropriate patient referrals and the best treatment, and building workforce resilience through better career development and shared out of hours arrangements.

Patient choice hub - improving quality of referrals and align capacity and demand.

A new patient choice hub is being developed with the aim of improving quality of referrals, ensuring that clinical thresholds are adhered to, that capacity and demand are lined-up across available providers, and managing procedures across the health system rather than in organisations.

Centres of clinical excellence - clinical consistent pathways across all providers to improve outcomes and efficiency, with fewer, more specialist centres across our hospitals.

We need to create centres of clinical excellence that use consistent procedures and policies across all service providers. We have identified some quality and efficiency benefits from combining procedures.

- Orthopaedics: We are considering centralising specialised orthopaedic trauma services (such as fragility fractures from falls) at Peterborough City Hospital and Addenbrooke's Hospital, to achieve a higher standard of care.

  We are also investigating the case for reconfiguring planned orthopaedic services, by increasing the number of low-complex procedures at Hinchingbrooke Hospital (such as routine knee and hip replacements), to improve the quality and sustainability of services at all three hospitals. We expect to consult on these proposals in 2017.

- Stroke: National stroke indicators show that we perform below the national average on a number of stroke areas, including access to specialist rehab and early-supported discharge. In addition, inpatient and community bed-based stroke and neurological rehabilitation care is fragmented across multiple sites.

  In order to improve the services offered to our patients we are considering providing all bed-based stroke and neurological rehabilitation on a single site and to establish an enhanced early-support discharge team, so many more patients can receive rehabilitation and support at home. We expect to consult on these proposals in 2017.

  We have also considered whether we need one or two hyperacute stroke units (we have one in Cambridge and one in Peterborough), and have concluded that at present we should retain our two hyperacute stroke units.

Modern maternity - improving quality, choosing home births, standardisation and continuity.

For obstetric and neo-natal services we have considered the viability of our three obstetric (maternity) units, each with a co-located midwife-led unit, and concluded that all three should remain. However, we need to enhance networking between the three units to share knowledge and improve care for expectant mothers and women in labour.

Acute paediatrics - supported by strengthened community services.

Hospital stays for children and young people should be kept to a minimum. We will develop community care with enhanced community nursing, and with GPs and paediatricians working better together.

5 Continued world-famous research and services

We have world-class specialised care, but we are always looking for ways to be better. We will work together with our local research organisations and businesses to make this happen.

We believe we can achieve consistently better results for people with more serious needs, such as for heart and lung services or complex surgery, in fewer, specialist units which make best use of the world-class expertise of our specialist consultants.

Much specialised care is already centred at our two world renowned hospitals: Addenbrooke's Hospital and Papworth Hospital for cardio-thoracic care. For this reason, major changes to specialised services do not feature significantly in our plan. However, there are some specific areas where we can improve, especially due to growing demand.

Summary of what we propose to deliver.
Cancer - improvements in waiting times and best practice services. We are working to implement the recommendations of the Cancer Taskforce Strategy and to achieve world-class cancer outcomes. The establishment of 'Cancer Alliances' is crucial to this.
Specialised mental health - We provide limited specialised mental health locally in a small number of low secure beds and Child and Adolescent Mental Health Services. The East of England region has been identified as one of three areas without a mother and baby unit for those with severe mental health problems following childbirth. We aim to address this, and our mental health strategy also prioritises the development of perinatal mental health services in the community.
Cardiology - Cardiology services will be provided across Cambridgeshire and Peterborough. Papworth Hospital which, following its move to the Cambridge Biomedical Campus next to Addenbrooke's Hospital, will lead the service across both organisations. Together with Peterborough and Stamford Hospitals NHS Foundation Trust, it will provide a vital role in supporting improved 24/7 access to cardiology opinion, as well as community-based services that focus on prevention.

How does the NHS support carers?

Cambridge Public Workshop

Ely Public Workshop

Most of us prefer to travel 100 miles for an operation for someone who's done it before.

Patient stories - how things could look in the future

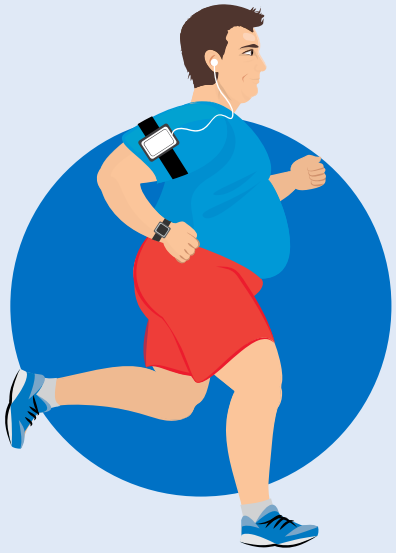
Better safe than sorry

When, on a Sunday morning outing, eight year old Olivia fell off her bike and banged her head, her mother Gemma didn't know what to do. She thought about driving to A&E or dialling 999 but remembered seeing posters saying that 111 was a better option for injuries that were not serious or life threatening.

She called 111 and they arranged for Olivia to see a GP later that morning. The GP, Martin, examined Olivia and advised Gemma about what to look out for following a head injury, and what to do if Olivia's condition changed. Martin directed Gemma to the NHS Choices website for further information.

In the afternoon, and using the information that she had been given, Gemma became concerned that Olivia was getting worse, not better. Following the advice that GP Martin had given her earlier she took Olivia to the hospital. The specialist children's team could access Olivia's notes and details of what had happened so Gemma didn't need to repeat her story. Olivia was observed for six hours and discharged fit, well, and keen to get back to playing with her friends.

Looking forward – keeping active



Mark gave up playing rugby after a broken wrist and had become an armchair fan at the age of 39. He still enjoyed regular evenings out, and was ashamed to admit that his smoking had increased since he gave up sport. But Mark remained convinced he was still fit and healthy – with nothing to worry about.

Aisha, Mark's GP, was not so sure. Responding to an invitation for a regular check-up, Mark was told that he was significantly overweight, with warning signs suggesting he was at risk of developing diabetes. Aisha knew that persuading Mark to make the lifestyle changes he needed would require both a plan and support.

First, she connected him to the local smoking cessation service, which organised drop-in sessions Mark could easily get to, and put him in touch with a fitness coach who could recommend an exercise programme to suit him.

She also realised that Mark's smartphone was his window on the world, and suggested some websites and a wellbeing app to help him plan and stick to his diet and fitness regime.

Care shaped around the patient

After she turned 80, Doreen found her health deteriorating. Doreen has diagnoses of diabetes and emphysema (COPD), as well as early stage dementia. She lives with her husband, Roy, who is 82, who also has diabetes but is otherwise fit and cares for her.

Paul, her GP, invited Doreen for her annual assessment. Based on her increasing frailty, he accepted her onto the caseload for complex, case-managed patients who are supported by a multidisciplinary team in the community. Angela, a member of the community team, is her care coordinator.

Paul and Angela worked with Doreen and Roy to create two plans. The first was a care plan which summarised Doreen's health needs according to her preferences and priorities, and what she and Roy would want in the event of a crisis or deterioration in health. The second, a self-care plan, allowed Doreen to describe her goals and needs for caring for herself safely at home, and identified how she could be supported in doing so by Roy and the health system.

Living beyond psychosis

Jack was becoming increasingly isolated; he had stopped attending school and seeing his friends, and had complained of hearing voices. Following a comprehensive assessment at which he was considered to have developed an early onset psychosis, he was referred to the early intervention service. He began a three-year programme tailored to his needs. The service worked with Jack to deliver a holistic care plan.

Family therapy enabled Jack and his family to understand more about his experiences and to begin to resolve them.

Jack is now aware that he can choose to access a wealth of insight and to share experiences through social media. He is actively involved in monitoring his state of mind, has discussed in advance what he would like to happen in a crisis, and understands what to do if he becomes unwell again. His GP and the practice team are very involved with the care plan and can call on a range of support for Jack. Perhaps the most important connection was with an employment project which supported Jack through his college application. Now, in the second year of his course, Jack can see a much brighter future.

Neighbourhood care hubs

More health and care services will be provided closer to people's homes and we will help people stay at home when they're unwell.

People powered health and wellbeing

We will help people to make healthy choices, keep their independence, and shape decisions about their health and care. We will work with community groups and businesses, so people of all ages have good health, social, and mental wellbeing support.

Partnership worki

Everyone who provi
social and mental h
Cambridgeshire and
plan together and w

Workforce: growing our own

We have wonderful, talented people working in our health and care system. We aim to offer rewarding and fulfilling careers for our staff with opportunities for them to develop their skills and grow professionally. This way we can develop staff, including for those areas where we have some staff shortages.

Using our land and buildings better

We want to bring all our NHS and local government sites up to modern standards. We want to make better use of our out-of-hospital sites, which may mean selling some buildings to invest in other modern, local facilities.

Responsive urgent and expert emergency care

We will offer a range of easily accessible support for care and treatment, from telephone advice for urgent problems to the very best hospital emergency services when the situation is life threatening.

Systematic and standardised care

Doctors, nurses and other health and care professionals will work together across Cambridgeshire and Peterborough to use the best treatments and technology available.

Continued world-famous research and services

We have world-class specialised care, but we are always looking for ways to be better. We will work together with our local research organisations and businesses to make this happen.

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A culture of learning as a system

We are committed to sharing knowledge across the whole health and care system, so the people working in our health and care organisations know they are part of the big picture.

Using technology to modernise health

Good information and advice helps people take control of their health. We will use apps and online tools to provide more rapid and reliable information.

6 Partnership working

Everyone who provides health, social, and mental health care across Cambridgeshire and Peterborough will plan together and work together.

We believe we must work across boundaries: between NHS and local authority social care; GPs and hospital care; and physical health and mental health.

None of our organisations can be sustainable acting alone; our financial challenge is too great. We need to work together in a way that we have never done before. In addition to new ways of working, and a new relationship between medical professional and patient, we can do more to collaborate in our non-patient facing services, including back office and clinical support services, and reduce duplication.

Collaboration between commissioners, including the Clinical Commissioning Group and local councils, NHS providers, and general practices, is crucial. There are examples in our system of where this is already happening and members of these organisations have already begun to work together as equal partners to a far greater extent than ever before.

Summary of what we propose to deliver.

Larger general practices - Many of our GP practices recognise the benefits for sustainability of working together as federations and larger primary care teams. We believe this will enable better access to resources through sharing and specialisation and closer working between GPs and their colleagues in hospitals. Development of the primary care workforce (GPs) is an important part of this.

We also recognise that people are supported by a network of formal and informal care, and aim to work in partnership with local organisations, such as faith groups and the voluntary sector.

Hospitals joining together - Hinchingbrooke Hospital and Peterborough and Stamford Hospitals are looking at coming together to bring about financial efficiencies and also meet their clinical and workforce challenges. They will be making a decision in late November, and, if it is agreed, they will join together in April 2017.

Papworth Hospital is preparing to move onto the Cambridge Biomedical Campus in 2018. This will lead to further formal collaboration with Addenbrooke's Hospital in due course.

Back office - We have started to rationalise overheads and support services. We will establish a shared HR back office that includes healthy workforce. We will also develop a single approach to procurement during 2017/18 and pilot this new approach within orthopaedics through joint procurement of all joint kits.

Financial incentives

Having committed to shared planning and transparency in tracking cost improvements and Quality, Innovation, Productivity, and Prevention (QIPP) delivery in 2016/17, we will look at ways to share risk and align financial incentives.

Health and social care

The Clinical Commissioning Group and local authorities are collaborating with the aim of aligning commissioning arrangements for mental health and healthy child services.

Working with the voluntary and community sector, and support for carers - Key to reduction of hospital admissions is coordinating support for people. Many relevant services and interventions are provided by voluntary and community sector organisations. All commissioners are seeking to work more closely with the voluntary and community sector.

Case Study: Peterborough is leading the way

In Peterborough, an Area Executive Board has been established to oversee nine programmes of work that will integrate care for all ages, spanning child health, ageing healthily, and how hospital is accessed. The programme brings together local GP practices in Greater Peterborough, Peterborough City Council, Peterborough and Stamford Hospitals NHS Foundation Trust, and Cambridgeshire and Peterborough NHS Foundation Trust, and is supported by an external company.

To enable the required change, improvements, and efficiencies in this plan to be delivered we have identified four key things that will need to happen to underpin our work across the system.

7 A culture of learning as a system

We are committed to sharing knowledge across the whole health and care system, so the people working in our health and care organisations know they are part of the big picture.

We want to develop a culture of learning. This means our staff developing a shared understanding of our services, priorities, and challenges, a common approach to analysing opportunities and problems, and finding solutions together.

We believe we can share knowledge and expertise from the specialist services in Cambridgeshire and Peterborough, making the most of our world-class medical and healthcare education and training, and using research to drive improvement.

We know we must invest in system-wide quality improvements. To be successful, our system must develop a shared understanding of all the interrelated issues and must be able to explain what it means to us as individuals and as organisations. Our plans must be understood by all our staff and patients.

We are developing a system-wide quality improvement and organisational development plan which will focus on a common culture and set of values across Cambridgeshire and Peterborough. Ultimately we want our staff to not only identify with their professional group and employer, but as a key partner to the Cambridgeshire and Peterborough health and care system's long-term sustainability.

We need to build on our research heritage and be at the forefront of adopting new therapies and delivery models for the patients of tomorrow.

8 Workforce: growing our own

We have wonderful, talented people working in our health and care system. We aim to offer rewarding and fulfilling careers for our staff, with opportunities for them to develop their skills and grow professionally. This way we can develop staff, including for those areas where we have some staff shortages.

We want staff to choose to work here and to see themselves as part of the whole health and care service in Cambridgeshire and Peterborough - this will help us where we have services that have staffing shortages.

Workforce data and intelligence from other parts of the country has provided us with the building blocks to design a workforce and transformation strategy.

In the short-term we have developed a whole systems approach to 'grow your own' and 'earn as you learn'. We are building on existing programmes and developing career pathways that begin at apprenticeship level and take individuals all the way through to registrant or advanced practitioner level. Our goal is for Cambridgeshire and Peterborough to provide high quality placements for those in training and to become one employer of choice, enabling us to retain those we train.

Over the longer term our system needs to work differently to ensure our staff are supported appropriately and retained. We need to ensure that the contribution of our mature workforce is retained and that they help us to develop competence and confidence in newer members of the workforce.

Many of the emerging new models of care, including our aspiration to operate in networks of care, require both the current and future workforce to work more flexibly across locations, in line with the demand for our services. Our human resources model will need to become more flexible and, where possible, we will do things in common to enable staff to move between organisations more easily.

Case Study: Skills for people-powered care

We have made progress towards training and developing our staff to deliver new roles:

- Funding from Health Education England supports training and research on integrated working in Neighbourhood Teams.
- Cambridgeshire County Council's Early Help Team helps individuals at an early stage, in the community.
- Cambridgeshire Better Care Fund's care home educators are learning from a local pilot and the Care Home Vanguards.

9 Using our land and buildings better

We want to bring all our NHS and local government sites up to modern standards.

We want to make better use of our out-of-hospital sites, which may mean selling some buildings to invest in other modern, local facilities.

We want to explore how we can work together to get more value from our land and buildings, and bring all our sites up to modern standards.

There is a great deal of building development in Cambridgeshire and Peterborough so we see opportunities for new strategic partnerships, such as the planned Hinchingbrooke Health Campus.

We have many community estates, some of which are poorly used, which provides us with the opportunity to reduce the number of buildings used and potentially develop new primary and community care facilities on the larger sites.

We want to promote co-location and shared working spaces which can bring teams together and foster integrated care delivery across health and social care agencies.

We have already started to work in a more coordinated way, not only across health and care but also with partner agencies including the fire and police services.

We want to use our estates to support new models of care. This could be through the creation of larger, modern, family and frailty-friendly hubs, where GPs can work side by side with community and social care staff, have direct access to diagnostics and specialist advice, and are enabled to diagnose and care for more patients without the need to refer to hospital. Over time we expect these hubs to replace much of outpatient care.

Local authority plans to bring NHS and local health and care resources together under one social/community/mental health/primary care roof, will go a long way to providing proactive care, rather than reactive care in hospital.

Similar changes are possible as back office services begin to collaborate more. The sites at Princess of Wales Hospital in Ely and North Cambridgeshire Hospital in Wisbech could be locations for these new neighbourhood hubs. Outline plans, which will help us respond to a growing population, local health needs, and poor current infrastructure, have already been drawn up for these two sites.

10 Using technology to modernise health

Good information and advice helps people take control of their health. We will use apps and online tools to provide more rapid and reliable information.

Shared information will help medical professionals in hospitals, GP practices, community teams, and social care to work together more effectively.

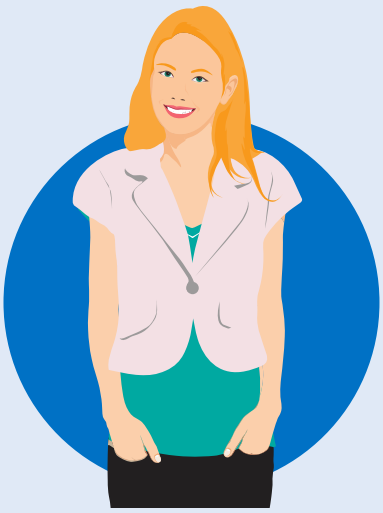
Technology will also help us to provide more reliable information for patients more quickly, and our clinicians will make sure technology is built in to new services.

Our ambition, supported by the 'Local Digital Roadmap' vision, is that by 2020 'patients and citizens, health and social care staff have access to quality, timely, and accurate information, regardless of place or time, to enable improved decision making and ultimately better outcomes for both the individual and the community'. We will deliver this in six themes:

- Data and information sharing
- Health apps
- Telehealth/remote monitoring
- Access
- Real-time information
- Health analytics

Staff stories – how things could look in the future

Making the right call



Joanne supports several people with long term health conditions, enabling them to continue to live independently at home. She has built up a lot of knowledge about signs to look out for and urgent care options, and has always felt that she has valuable insight into how the emergency admission process works and whether it could provide a better experience for patients and carers.

Now working within a larger, multi-disciplinary team she can play a greater role. For example, she has received coaching from a local hospital consultant from whom she can also access immediate support and advice. This includes examples of symptoms which should raise concerns, so Joanne has the reassurance that she knows when it is right to call an ambulance and how she can help to prevent emergencies.

Hospital care at home

Maqsood leads a newly-established team in St Neots. It helps to keep people living independently by providing intensive nursing input at home - so avoiding hospital admission or enabling earlier discharge.

Maqsood knows that the research evidence is clear. Too often, on admission to hospital the care and support networks on which older people depend fall away and with them their ability to live independently. He helped to co-design the service and has worked hard to develop his team, which brings together professionals across several organisations and focuses on each individual patient's needs.

For example, Mrs Barlow was one of the team's first patients, after she was discharged from hospital much sooner than she would have been before it was in place. She was able to recover at home, at first with high-level healthcare and daily contact with support workers, which then stepping down to every other day contact with a nurse. She even received home visits from the pharmacist to make sure her medication was correct.

To stop people going to A&E you must provide alternatives.

Huntingdon Public Workshop

Wisbech Public Workshop

People would be happy to be treated at home if they could get good support.

Peterborough Public Workshop

Ensure health staff on the ground are involved.

Mental Health is a key element to all patient pathways.

Wisbech Public Workshop

Staff stories – how things could look in the future

Joining up physical and mental health

Greg leads part of the liaison psychiatry service, which joins up mental health and physical health care when people need hospital treatment or urgent care. His team works in hospitals across Cambridgeshire and Peterborough.

As well as helping to make sure that the NHS meets its commitment to give mental health the same priority as physical health, Greg believes that his service is based on principles which are fundamental to transforming care services.

When people are admitted to hospital, the liaison psychiatry service focuses on helping them to recover and how they can be supported to return home. This requires a holistic approach - working across mental health and different hospital specialties, in partnership with the patient, and alongside carers, advocates, and social care providers - because keeping people well requires a team effort.

As a clinician, Greg wants to help shape new ways of working and sees his role as a great opportunity – both to help bring about better outcomes for patients, and to develop his own professional skills.

World-class hospital care – delivered closer to home

Visha, a Geriatrician, has always strived to provide the very best care available anywhere and, although they handle an enormous number of patients, she is proud of the outstanding results achieved by her hospital-based team.

Visha was recruited onto the transition team which managed the set up of a new service running satellite clinics. Working with Paul, one of the GP leads, she realised that this challenging change could mean even better treatment and an improved experience for patients. By setting up a buddying system, Visha's specialist expertise and Paul's broader experience were combined and Paul was supported to take on monitoring and care which would previously have required a hospital visit. Visha's team is now on rota to advise local GPs 24/7 via a hotline, so reducing the number of patients reaching them through A&E.

The practice at which Paul is based proved an ideal location for outpatient clinics. As a community 'hub', it is well-equipped and a new IT system enables Visha to access patient records and communicate with specialist colleagues - whether she is in the practice or on her ward.

What these changes mean for our finances

We have reviewed our finances thoroughly, including making comparisons with national figures and looking for opportunities to make savings and organise services more efficiently.

As reported in the summer, by 2020/21 we predict a system-wide £250m financial deficit. This is in addition to £250m of savings and efficiency plans individual trusts and the Clinical Commissioning Group (CCG) need to deliver over the same period. This makes a total system-wide financial challenge of £500m over the next four years.

If the trusts and Clinical Commissioning Group meet their plans, and all aspects of the Sustainability and Transformation Plan are delivered, this will achieve the savings and efficiency target of £500m and will actually produce a small NHS surplus of £1.3m (by 2020/21).

To enable all the proposed service improvements and developments within the STP to be delivered it will require an estimated additional investment of £43m. If this investment is to be locally funded it will need to be paid back, and therefore would increase the total system-wide financial challenge from £500m to £543m.

We believe that success lies in reducing demand, meeting the ambulatory care needs of sick children, people with long term conditions, and the frail elderly, in primary and community care settings, reducing hospital length of stay, improving our workforce utilisation and reducing our overhead costs.

We are confident that there is significant scope to both improve the efficiency of patients being admitted and discharged from hospital by reducing the differences in the care provided and to deliver care more effectively outside of hospitals.

We feel that there is also opportunity to reduce clinical support services costs, through sharing back office costs and organisational mergers, where beneficial.

There are a number of areas that we believe should produce additional benefits, including growing income from commercial opportunities, and by reducing the cost of debt repayments.

Our approach to implementation

Why this time is different

We know that there have been times in the past when we have not delivered plans in the way we intended to. This time it will be different because we have been able to work together, as equal partners across the system, to build collective awareness that a problem exists, to fully understand the root causes of this, and to use this information to identify solutions and build commitment for implementation and action.

We are committed to behaving differently, listening more, being clearer about principles for decision making, and getting better at making whole-system decisions together.

System leadership, system working

We recognise the importance of partnership working in order to implement the changes described in our Sustainability and Transformation Plan. This includes partnership working across our organisations as we move towards greater joint health and social care commissioning and services.

We have made the public commitment to return the health and care system to a sustainable position, and improve care for local residents and healthcare users – through a Memorandum of Understanding. The Memorandum of Understanding (MoU) states:

- **One ambition:** to return Cambridgeshire and Peterborough to financial, clinical and operational sustainability by acting as a single leadership team, with mutual understanding, aligned incentives and coordinated action with external parties (e.g. regulators).
- **One set of behaviours:** all partners agree to exhibit the beneficial behaviours of a single leadership team.
- **One long-term plan:** we are collectively responsible for delivering the plan that will achieve our long-term ambition, including capturing the savings opportunities identified that will enable us collectively and individually to return to financial sustainability.
- **One programme of work:** all system projects will be aligned to the Sustainability and Transformation Plan and under supervision of a Chief Executive Officer-sponsored delivery or design group.
- **One budget:** within NHS contracting, a number of financial incentive options will be considered.
- **One set of governance arrangements:** the Chief Executive leadership group, and the groups reporting to it, will be the vehicle through which system business is conducted.
- **One delivery team:** we have ensured that resources are in place to deliver our system's plan.
- **One assurance and risk management framework:** Strengthening trust and creating a sense of shared accountability.

What these changes mean for local people

We have considered the impact that the changes outlined in our Sustainability and Transformation Plan will have on the different groups within our local population. In particular, we have considered the impact on the patient groups who we feel could receive better services from us, namely those in relatively more deprived areas, those with multiple long term conditions, and the frail.

We have engaged with the public, patients, and carers when thinking about solutions to the problems we face, and worked with them to come up with proposals that are beneficial to our population. This is the beginning of our engagement and we want to do more to involve local people and staff in developing and delivering our plans.

We published our interim Sustainability and Transformation Plan summary in July, 'How health and care services in Cambridgeshire and Peterborough are changing', which was provided to staff, stakeholders, and the public.

Our forthcoming engagement with the public has three key aims:

1. **Publicising our plan:** We will continue to tell people about our vision for health and care, describing what it means for patients in more detail.
2. **Co-designing care models**: We will continue to work with patients and the public to ensure that the care we design has the patient at its heart and promotes independence. We will need to engage fully with the public about service redesign that will change how and where they access services.
3. **Supporting behavioural change among patients and the public:** We will work with the public to promote healthy behaviours and taking individual responsibility for health and wellbeing, stressing to our population the importance of leading healthy lives. We will provide education around appropriate and effective ways of using services including self-care, urgent care, and A&E.

Regional centres make sense, seeing a specialist who does it often.

Huntingdon Public Workshop

What do the changes mean for our staff?

We have worked through our solutions as a single leadership team. The staff we have involved in developing solutions have been tasked with putting patients first, over and above organisational or professional interests. With the Sustainability and Transformation Plan now developed, it is important that we are clear about what the changes mean for us as individual organisations.

The biggest change will be for the 20,000+ staff employed by our providers. The proposals have been developed by approximately 200 frontline staff and we have already started to plan how we will engage with staff more widely. By putting our patients at the centre, now and in the future, we are confident our staff will respond positively and feel that the opportunities presented are career enhancing.

We know that our workforce will need to grow in order to cope with our increasing population and growing numbers of people with complex health needs. This means that there will be an increase in staff numbers over the next five years, but this growth in head count will be less than it would need to be if we were not working together as a system.

The type of skills we will recruit will also differ in recognition of the need to supplement primary care with non-clinical staff who can focus on care coordination and provide social support. We need to make the best use of our most expensive, and often scarce, consultant workforce by sharing posts where appropriate.

Staff often train in our organisations but do not choose to stay because housing is too expensive, particularly in Cambridge. We are keen to address this and will seek to influence the planned new housing developments so that they include sufficient affordable homes.

Our move towards working as one network will see significantly greater collaboration between organisations. This may mean that we ask staff to work in different locations or with different working patterns. We will work with staff to alleviate any concerns they might have around this and we will ensure that the benefits of this new approach are made clear.

How you can get involved

There will be more opportunities for patients, carers, and local people to be involved with the specific improvements we would like to make, and we will provide opportunities for staff and local people to help shape proposals for service change.

We are committed to being as inclusive and open as possible. We will listen to all contributions and use these contributions to influence the decisions we make. You will be able to have a say in key decisions, including formal consultation.

If you want to be part of the discussion and work with us to develop solutions, please contact us via email on **contact@fitforfuture.org.uk**

You can also register on our website **www.fitforfuture.org.uk**

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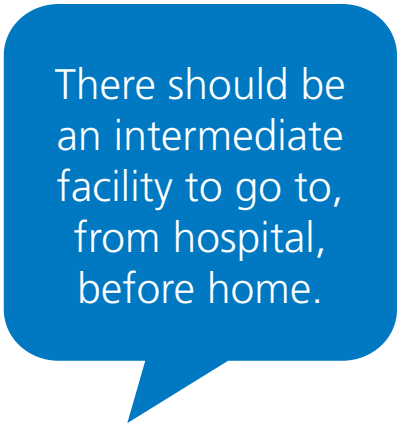
01223 725 304

Ely Public Workshop



Cambridge Public Workshop

Our Partners

Cambridgeshire Community Services NHS Trust

Cambridgeshire and Peterborough NHS Foundation Trust

Peterborough and Stamford Hospitals NHS Foundation Trust

Cambridge University Hospitals NHS Foundation Trust

Hinchingbrooke Health Care NHS Trust

Papworth Hospital NHS Foundation Trust

NHS Cambridgeshire and Peterborough Clinical Commissioning Group

Cambridgeshire County Council

PETERBOROUGH CITY COUNCIL

Fit for the Future

Working together to keep people well

Produced by Cambridgeshire and Peterborough Sustainability and Transformation Programme.
November 2016

Agenda Item No: 10

HEALTH AND CARE SYSTEM SUSTAINABILITY AND TRANSFORMATION PROGRAMME MEMORANDUM OF UNDERSTANDING: LOCAL AUTHORITY APPENDIX

To: **Health and Wellbeing Board**

Meeting Date: **January 2017**

From: **Director of Public Health**

Officer contact:	
Name:	Dr Liz Robin
Post:	Director of Public Health
Email:	Liz.robin@cambridgeshire.gov.uk
Tel:	01223 703259

1. PURPOSE

1.1 The purpose of this paper is to update the Health and Wellbeing Board with progress on sign off of the Cambridgeshire and Peterborough Sustainability and Transformation Programme Memorandum of Understanding (Local Authority Appendix) and to propose a phased approach to sign off.

2 BACKGROUND

2.1 At the November meeting of the Cambridgeshire Health and Wellbeing Board, the Board was asked to sign a Local Authority Appendix to the Cambridgeshire and Peterborough Sustainability and Transformation Programme Memorandum of Understanding. This is not sign off of the STP Plan itself, but of behaviours and principles which promote joint working across the system, while clarifying issues of local authority governance, democratic decision making and the role of elected Members. Further detail is provided in the paper presented to November's Health and Wellbeing Board (attached as Annex B).

3. MAIN ISSUES

3.1 At its November meeting the HWB Board agreed that:

1. Officers would explore the inclusion of an enabling clause regarding shared risk and gain in the Local Authority Appendix to the MOU. If it was not possible to include such a clause an explanation of why this was not possible would be provided;
2. The Chief Executive of Cambridgeshire County Council and Peterborough City Council would be invited to sign off the Local Authority Appendix on behalf of both authorities;
3. District and City Councillors would each take the STP MOU Local Authority Appendix through their own democratic processes (for example, Cabinet) before final sign-off by the Chairman of the Health and Wellbeing Board at the Board's next meeting on 19 January 2017;
4. The Voluntary and Community Sector representative would provide feedback on where she felt the voluntary sector could contribute in discussion with the Chief Executive of the Cambridgeshire and Peterborough NHS Foundation Trust.

3.2 Actions (1) and (2) have been completed and the amended STP MOU LA Appendix (attached as Annex A) includes an enabling clause regarding shared budgetary risk for specific programmes.

3.3 However action (3) – taking the STP MOU LA Appendix through District and City democratic processes has not proved feasible to deliver in the time available between the November and January meetings of the HWB Board Two factors contributed to this:

- The timing of key meetings over the two month period, particularly taking into account the Christmas/New Year break.
- Concerns raised by district officers about a lack of clarity in the STP MOU LA Appendix as to what was expected of District/City Councils,

and a recognition of the opportunity to make significant improvements from a District/City perspective.

3.4 In the discussion of the STP MOU LA Appendix in November, HWB Board members were supportive of the document and of the behaviours described and were keen to sign this off in January 2017. Given the important role of the Cambridgeshire Health and Wellbeing Board in promoting joint working and positive behaviours across the local health and care system, Cambridgeshire HWB Board members may wish to consider a two phased approach which is proposed as follows:

January 2017: HWB Board agrees to the Chair signing the STP MOU LA Appendix, to demonstrate the Boards' overall support for the principles of joint working outlined within it. A clear note is added to the signature stating that at this point the HWB Board cannot sign off on behalf of the District and City Councils, as further work (phase 2) is needed to re-word the MOU to fully clarify the role of District/City Councils in the document and to take it through each Council's democratic processes.

Early 2017: Work is carried out to revise the STP MOU LA to incorporate appropriate wording about the role of District and City Councils, to take the revised version through the democratic processes of each Council, and to incorporate any comments/feedback received.

HWB Board meeting 2017 (date TBC): Revised version of the STP MOU LA Appendix is brought back to the HWB Board for sign-off.

3.5 To avoid similar situations arising in future, a commitment should be given that the Health and Wellbeing Board District Officer (a non-voting member of the Board) should be involved in the initial drafting stage of future HWB Board documentation, to ensure that the District/City perspective is incorporated from the earliest stage.

3.6 An alternative approach is for the Cambridgeshire Health and Wellbeing Board not to sign off the STP MOU LA appendix until a revised version has agreed through democratic processes at each District/City Council. The potential disadvantage of this option is that Cambridgeshire HWB Board, which has a statutory duty to lead integration and collaborative working across health and social care, would then be signing the MOU up to six months later than other local signatories.

4.0 RECOMMENDATIONS

4.1 It is recommended that the HWB Board consider the phased approach to HWB Board sign off of the STP MOU LA Appendix, as laid out in paragraph 3.4.

4.2 As the initial phase of that approach, it is recommended that the HWB Board agree to the Chair signing the STP MOU LA Appendix, to demonstrate the Boards' overall support for the principles of joint working outlined within it. This is subject to a clear note with the Chair's signature, stating that at this point the HWB Board cannot sign on behalf of the District and City Councils, as further work (phase 2) is needed to re-word the MOU to fully clarify the role

of District/City Councils in the documentation, and to take it through each Council's democratic processes.

Source Documents	Location
Health and Care System Sustainability and Transformation Programme Memorandum of Understanding. Paper to Cambridgeshire HWB Board November 2017	https://cmis.cambridgeshire.gov.uk/ccc_live/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/495/Committee/12/Default.aspx

CAMBRIDGESHIRE AND PETERBOROUGH
SUSTAINABILITY AND TRANSFORMATION PROGRAMME
MEMORANDUM OF UNDERSTANDING

Appendix 1: Local Authorities and the C&P Sustainability and Transformation Plan

Introduction

- The local health economy within the Cambridgeshire & Peterborough Clinical Commissioning Group area has agreed a single Sustainability and Transformation Plan (STP) for 2016 – 2021, which has been approved by NHS England and NHS Improvement.

- All partners share an ambition to return the health and care system in Cambridgeshire and Peterborough to financial, clinical and operational sustainability, coordinating System improvements for the benefits of local residents and healthcare users by:
  - Supporting local people to take an active and full role in their own health
  - Promoting health, preventing health deterioration and promoting independence
  - Using the best, evidence-based, means to deliver on outcomes that matter
  - Focussing on what adds value (and stopping what doesn't)

  Cambridgeshire County Council (CCC) and Peterborough City Council (PCC) are key stakeholders in the development and delivery of the STP and will act as partners in the STP by working together to find solutions to ensure that healthcare, public health and social care services are aligned. However the Councils will only be able to do this in line with their statutory responsibilities, democratic and constitutional duties in the local authorities' governance arrangements

- The Cambridgeshire District and City Councils, which are members of the Cambridgeshire Health and Wellbeing Board, exercise a number of relevant functions including housing, land use planning, leisure services etc, which may also align to the wider STP Programme, and which are subject to their own democratic and constitutional arrangements.

- All partners across local authorities and the NHS are expected to support local Health and Wellbeing Strategies and Better Care Fund Plans. NHS partners will ensure that STP delivery is aligned with these wider partnership strategies and plans.

- An agreed set of behaviours and principles has been developed in order for CCC, PCC and the wider local authority membership of the HWB Board to support (and be supported) in the contribution to and delivery of the STP.

- These behaviours and principles outline how CCC, PCC and the wider local authority HWB Board membership will work together with the Health system, whilst adhering to their statutory duties and democratic and constitutional duties in the local authorities' governance arrangements

Key Behaviours:

CCC, PCC and the wider local authority Health and Wellbeing Board membership recognise the scale of change required to deliver the STP and that cultural change applies from leadership level to front line staff.

CCC, PCC and the wider local authority Health and Wellbeing Board membership will continue to build and promote trusting relationships, mutual understanding and where feasible take decisions together with the health system.

CCC and PCC representatives on the Health and Care Executive (HCE) will take full responsibility for making sure their staff are well briefed on system improvement work, drawing from system messages and materials. The HCE will ensure that relevant system messages and materials are shared with the wider HWB Board membership.

All members of the Health Care Executive and the Health and Wellbeing Boards will support and promote system behaviours for the benefit of local residents and healthcare users including:

- Working together and not undermining each other
- Behaving well, especially when things go wrong
- Engaging in honest and open discussion
- Keeping our promises – small and large
- Seeing success as collective
- Carrying through decisions once made

Key Principles:

The key principles of local authorities working with partners to deliver the STP plan are:

- Commitment to implementation at pace
- Use collective commissioning and buying opportunities to improve delivery outcomes and/or system savings
- Where appropriate, HCE representatives and other senior local authority officers to act as if part of a single executive leadership team, to coordinate system improvements for the benefits of local residents in line with the STP.
- Influence the view of regulators and external assurance bodies regarding the primacy of System sustainability enshrined in the STP and the joint commitment to it.
- Highlight and work to prevent cost shunting to other partners, subject to statutory requirements on both partners. (This should not preclude negotiation of agreements on pooled funding for specific services or areas of work).
- Adopt an invest to save approach
- Share information on new major service developments, savings, closures or relocations, and more generally share information in a timely manner when

needed to support development of partnership business cases and savings plans. This should comply with existing information sharing agreements and protocols.

- Align human, financial, estate and digital resources to deliver these changes where this adds value, delivers people-centred outcomes and saves money.

Democratic requirements and local authority governance

- CCC and PCC will participate in the Health and Care Executive (HCE) arrangements through their senior officer representatives acting as non-voting members of the HCE. This arrangement will recognise that local authority policy and financial decisions are subject to the constitutional decision making arrangements within their respective authorities, with are led by elected Councillors.

- CCC, PCC and Cambridgeshire District and City Councils will also participate in and support the STP through their local Health and Wellbeing Boards and shared programme management arrangements. Again, this arrangement will recognise that local authority policy and financial decisions are subject to the constitutional decision making arrangements within their respective authorities, which are led by elected Councillors.

- Local authorities support the commitment to longer-term planning, but the Partners recognise that local authorities are subject to democratic governance. Therefore the LAs must reserve the right to change their priorities in accordance with the priorities of their elected Councils

- CCC, PCC and wider local authority HWB Board membership cannot commit to sharing the opening financial risk in the STP, given that local authorities have a statutory requirement to balance their budgets and cannot operate at a deficit. Likewise, NHS partners are not expected to commit to meeting the financial risk of meeting statutory social care requirements.

- CCC and PCC have a particular statutory requirement to scrutinise proposals for NHS service changes as elected representatives of their communities, and must ensure the independence and integrity of those arrangements.

- The role of all Councillors to represent the views of their local constituents and speak up on their behalf is recognised. Councillors have a unique responsibility of advocacy with respect to their constituents. Nothing in this memorandum should undermine that.'

HEALTH AND CARE SYSTEM SUSTAINABILITY AND TRANSFORMATION PROGRAMME MEMORANDUM OF UNDERSTANDING: LOCAL AUTHORITY APPENDIX

To: **Health and Wellbeing Board**

Meeting Date: **November 2016**

From: **Director of Public Health**

Officer contact:	
Name:	Dr Liz Robin
Post:	Director of Public Health
Email:	Liz.robin@cambridgeshire.gov.uk
Tel:	01223 703259

1. PURPOSE

1.1 The purpose of this paper is to present the Cambridgeshire and Peterborough Sustainablity and Transformation Programme Memorandum of Understanding to the Health and Wellbeing Board and to ask for the Board's approval of Appendix 1: Local Authorities and the Cambridgeshire and Peterborough Sustainability and Transformation Plan.

2 BACKGROUND

2.1 All NHS organisations in the Cambridgeshire and Peterborough Health System have been asked to participate in the preparation of a five year strategic plan – the Sustainability and Transformation Plan (STP). Because local authority adult social care and public health services are interdependent with NHS services, Cambridgeshire County Council and Peterborough City Council have also been asked to plan jointly with the NHS and align our services with STP where appropriate. The role of District Council services is recognised and the District Council membership of the Health and Wellbeing Board reinforces this.

2.2 Development of the STP has been led by the Health and Care Executive (HCE) which is made up of the Chief Executives and Accountable Officers of NHS organisations including the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG), local NHS Hospitals, NHS Mental Health Services and NHS Community Services. The Director of Children, Families and Adults and the Director of Public Health from Cambridgeshire County Council and Peterborough City Council attend as non-voting members of the HCE.

2.3 A draft Cambridgeshire and Peterborough STP has been submitted to NHS England in accordance with national deadlines, and the CCG expects to publish the final STP in late November/early December.The STP includes reference to the Joint Strategic Needs Assessments (JSNAs) and Health and Wellbeing Strategies overseen by local Health and Wellbeing Boards. The Health and Wellbeing Board has received regular updates on the development of the STP. More information about STP planning is available on http://www.cambridgeshireandpeterboroughccg.nhs.uk/STP/

3. MAIN ISSUES

3.1 As part of the work on the STP, local NHS organisations are being asked to sign up to a Memorandum of Understanding (MOU), attached as Annex A. This MOU requires significant changes to ways of working across NHS organisations – essentially asking NHS Chief Executives to function as a single leadership team with mutual understanding, aligned incentives and co-ordinated action.

3.2 It is not feasible for Local Authorities to sign up to the full MOU due to decision making processes which are democratically accountable, and different financial and governance structures to the NHS. Because of this, a separate Appendix to the MOU has been developed for agreement by Local Authorities. This will require sign off by the Local Authority Chief Executive, and by Chair of the Health and Wellbeing Board (HWB), in line with the

statutory HWB role to promote integrated working across local authorities and the NHS.

3.3 The MOU Appendix: 'Local Authorities and the Cambridgeshire and Peterborough Sustainability and Transformation Plan' has four sections:

Introduction
The introduction briefly describes the context of the local health and care economy and the Sustainability and Transformation Plan, and the role of local authorities within this.

Key behaviours
This section describes the behaviours required from the Health and Care Executive and Health and Wellbeing Board members in order to build trust and relationships across the system, to deliver the STP.

Key principles
This section describes the key principles of how organisations will work together to deliver the STP.

Democratic requirements and local authority governance
This section outlines how senior officers and Health and Wellbeing Boards will work with NHS organisations to deliver the STP, while making clear that that local authority policy and financial decisions are subject to the constitutional decision making arrangements within their respective authorities, with are led by elected Councillors.

3.4 While the final sign off of the Local Authority STP MOU Appendix will be by the County Council Chief Executive and the Chair of the Health and Wellbeing Board, the Appendix has also been taken to the County Council Adults Committee and Health Committee, prior to approval by the HWB Board, due to the importance of both the adult social care and public health functions of the Council to effective transformation of the local health and care system.

3.5 The Adults Committee has approved the Local Authority STP MOU Appendix subject to the amendments which are highlighted as 'track changes' in Appendix B.

3.6 The Health Committee is discussing the Local Authority STP MOU Appendix on 10th November, and any amendments which the Health Committee request will be circulated following the meeting.

4 RECOMMENDATIONS

4.1 The Health and Wellbeing Board is asked

- to note the Cambridgeshire and Peterborough Sustainability and Transformation Programme Memorandum of Understanding for NHS organisations in Cambridgeshire and Peterborough
- to approve Appendix 1: 'Local Authorities and the Cambridgeshire and Peterborough Sustainability and Transformation Plan' for sign off by the HWB Board Chair.

Source Documents	Location

Sustainability and Transformation Plan information	http://www.cambridgeshireandpeterboroughccg.nhs.uk/STP/
Paper to Adults Committee (July 2016) on the Health and Care Executive Governance Framework	https://cmis.cambridgeshire.gov.uk/ccc_live/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/137/Committee/3/Default.aspx

Agenda Item No. 11

MENTAL HEALTH STRATEGY FRAMEWORK

To: Health and Wellbeing Board

Date: 19 January 2017

From: Martin Stefan, Deputy Medical Director, Cambridgeshire and Peterborough NHS Foundation Trust.
Clinical Lead (Community), Cambridgeshire & Peterborough Health & Care System Transformation Programme.

1.0 PURPOSE

1.1 This report brings to the attention of the Health and Wellbeing Board (HWB) the Sustainability and Transformation Plan (STP) Mental Health Strategy Document "Working together for Mental Health in Cambridgeshire and Peterborough – a framework for the next five years". This brings together a number of existing Mental Health Strategies, and places them in the context of the Five Year Forward View for Mental Health. It has been discussed and endorsed by the STP Clinical Advisory Group, the Health and Care Executive, the Cambridgeshire and Peterborough Clinical Executive Board and the Peterborough Health and Wellbeing Board.

2.0 BACKGROUND

2.1 The need for a coherent joint strategic document for Mental Health has been identified by local health and social care partners including the Health and Wellbeing Boards and was one of the key deliverables of the Proactive Care and Prevention Working Group of the STP. There is a clear requirement nationally for STP plans to address the Mental Health needs of their communities. This has been supported by a number of national developments including the publication of the recommendations of the National Taskforce for Mental Health ("The Five Year Forward View for Mental Health").

2.2 The document incorporates key strategic aims in the commissioning of Mental Health Services including the development of an integrated primary care mental health service (PRISM); Increasing Access to Psychological Therapies (IAPT) expansion and psychological input for Long Term Conditions, and the development of the First Response Service. There is a strong emphasis throughout on sustainable commissioning, prevention and health promotion.

3.0 SUPPORTING PARAGRAPHS

3.1 The strategy document has been produced by a small working group with representation from the CCG, CPFT and Public Health. It does not create new strategic priorities, but focuses instead on drawing together work which has been carried out by many people and organisations over the past few years, including a large number of discussions with service

users, carers and representatives of partner organisations, as well as existing mental health strategies; and places this in the context of the Five Year Forward View for Mental Health.

The full report is appended as Appendix 1 to this paper. It sets out a strategic approach under three headings which align with those described in the schematic developed by the Proactive Care and Prevention Clinical Working Group for integrated person-centred care:

- Prevention: promoting mental health and preventing mental illness.
- Community based care: developing an integrated approach to community based person centred care, focused on intervening early.
- Specialist care: timely acute, crisis and inpatient care when it's needed. Paying particular attention to admission and discharge processes, the management of interfaces between services and social services support.

4.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

4.1 This work supports the delivery of a number of the priorities highlighted in the Health and Wellbeing Strategy, and in particular Priority 4.

5.0 IMPLICATIONS

5.1 The changes set out in the Five Year Forward View for Mental Health are being resourced through an anticipated £1bn additional national investment for mental health by 2020/21. We expect to receive a proportion of this investment locally. We estimate that Cambridgeshire's share of this additional investment should equate to approximately £12.8m by 2020/21 (based on the funding formula in use in June 2016) but it is important to note that our high level costing work suggests that this level of additional investment is unlikely to be sufficient by itself to achieve full implementation of the Five Year Forward View or all of the priorities set out in this strategy. Further prioritisation will therefore be required, alongside analysis of detailed and fully costed business cases, coordinated through a new Mental Health Strategy Group.

6.0 RECOMMENDATION/DECISION REQUIRED

6.1 The HWB are asked to note and endorse the STP Mental Health Strategy.

7.0 SOURCE DOCUMENTS

Source Documents	Location
Working together for Mental Health in Cambridgeshire and Peterborough - A framework for the next five years	Annex to this report.

Fit for the Future
Working together to keep people well

Working together for Mental Health in Cambridgeshire and Peterborough

A framework for the next five years

Authors

Emma de Zoete	Cambridgeshire County Council and Peterborough City Council Public Health
Dr Martin Stefan	Cambridgeshire and Peterborough NHS Foundation Trust
Dr Emma Tiffin	Cambridgeshire and Peterborough Clinical Commissioning Group
Marek Zamborsky	Cambridgeshire and Peterborough Clinical Commissioning Group
Fiona Davies	Cambridgeshire County Council and Peterborough City Council

For the Cambridgeshire and Peterborough Sustainability and Transformation Programme

January 2017 DRAFT

Contents

1. Executive summary

This document has been written as part of our Sustainability and Transformation Programme. It sets out the key priorities and next steps for our health and care system to achieve the aspirations of the Five Year Forward View for Mental Health, alongside our local Sustainability and Transformation Programme plans, and work to implement the Care Act.

Although it has been produced by a small group, we have drawn on work which has been carried out by many people and organisations over the past few years, including a large number of discussions with service users, carers and representatives of partner organisations, as well as existing mental health strategies.

1.1. Our themes

There are three clear themes from strategy work to date:

I. **Sustainability:** prevention, early intervention, and attention to the broader determinants of health (such as housing and jobs) are crucial for our system to be sustainable.

II. **Integration** between physical and mental health care, and health and social care is not as good as it needs to be. Outcomes for people with physical and mental health problems are poor and there are cost effective things we could be doing to improve this. Service users and carers have identified that finding out what support is available and accessing services is frequently complex and therefore difficult. Bringing health and social care services together has been shown to help to make both of these areas easier. Integrated delivery of care has also been shown to put the individual at the heart of that care and to be more effective and to make better use of resources.

III. **Capacity and Demand:** services for people with mental health problems are really stretched, and there are problems at the interfaces (for example between primary and secondary care; health, social care and other organisations; services for children and adults).

1.2. Our approach

The Five Year Forward View for Mental Health, the Care Act 2014 and our local Sustainability and Transformation Plan set out clearly what needs to change. In delivering these changes our approach will focus on three areas:

I. **Prevention:** promoting mental health and preventing mental illness.

II. **Community-based care:** developing an integrated approach to community-based person-centred care, focused on intervening early.

III. **Specialist care:** timely acute, crisis and inpatient care when it's needed**.** Paying particular attention to admission and discharge processes, the management of interfaces between services and social services support.

1.3. Resources

The changes set out in the Five Year Forward View for Mental Health are being resourced through an anticipated £1bn additional national investment for mental health by 2020/21. We expect to receive a proportion of this investment locally. We estimate that our share of this additional investment should equate to approximately £12.8m by 2020/21 (based on the funding formula in use in June 2016), but it is important to note that our high level costing work suggests that this level of additional investment is unlikely to be sufficient by itself to achieve full implementation of the Five Year Forward View or all of the priorities set out in this strategy.

The national priorities for 2015/16 investment, IAPT, CAMH community eating disorder services, and early intervention in psychosis, have already received additional investment.

We have also invested Vanguard funding in a community-based first response service for mental health (see Box 3, page 22, for detail). Whilst we know there will continue to be national priorities for this investment, we also have local priorities which are key to ensuring that we create and maintain sustainable and effective mental health services in Cambridgeshire and Peterborough. There is work underway in the vast majority of these priority areas but often not at the scale needed.

1.4. Our vision for mental health

'That health and care services for people living with long term conditions, mental health problems or advancing age are sustainable, designed with the people and communities who use them around their needs and support them to be resilient, independent and enabled.'

1.5. Key priorities for 2016/17 and 2017/18

The key priorities for investment and focused work in 2016/17 and 2017/18 are set out below. The table combines nationally set priorities, as set out in the Five Year Forward View for Mental Health, and local priorities.

Table 1: Key priorities for investment and focused work 2016/17 and 2017/18

Pathway	2016/17	2017/18	Local focus	National aims**
Centrally-led Task Force priorities*				
Perinatal mental health	X		Improved access through specialist service provision and community provision in line with NICE stepped provision. 2016/17 further work to baseline current service provision, allocate investment and commission new services. Taken forward through perinatal mental health network group as part of STP work on Children and Maternity.	By 2020/21, increase access to specialist perinatal mental health support in all areas in England, in the community or inpatient mother and baby units, allowing at least an additional 30,000 women each year to receive evidence based treatment.
Crisis care	X		Plans in place for core/core 24 liaison psychiatry service standards (by 2020/21) in all acute trusts. Further implementation of our community-based first response model to the whole CCG, subject to success of pilot and funding. Continued implementation of crisis concordat action plan.	By 2020/21, all acute hospitals will have all-age mental health liaison teams in place and at least 50% of those will meet the 'Core 24' service standard as minimum.
CAMH emergency, urgent, routine	X		Continued work on the development and implementation of the ithrive model. New children's mental health service model commissioned, including primary mental health support, counselling in localities, and crisis/liaison services in acute trusts. Developing a co-commissioning approach with NHS England.	By 2020/21, at least 70,000 additional children and young people each year will receive evidence-based treatment. Local transformation plans refreshed by Oct 2016, and annually.
Integrated mental and physical healthcare pathways	X	X	Focused prevention and screening initiatives amongst those with serious mental illness (SMI). Smoke free mental health facilities by 2018. Access to psychological therapies (including IAPT) for Long Term Conditions (LTCs) and Medically Unexplained Symptoms (MUS), psychosis, bipolar affective disorder, depression and personality disorder. Supporting self-care for those with LTCs to have mental health support embedded within it.	By 2020/21, 25% of people with common mental health disorders will access services each year. Majority of services integrated with physical healthcare with 3,000 new mental health therapists co-located in primary care.
Primary Care				
Health trainer access for those with SMI	X	X	Improved access to health trainers for those with SMI. Initially investment made in 2016/17. Further work to align with other initiatives supporting self-care for LTCs.	By 2020/21, A reduction in premature mortality of people living with severe mental illness (SMI). 280,000 more people

Pathway	2016/ 17	2017/ 18	Local focus	National aims**
Social prescribing Medication management Peer experts/mentor and community health resilience building/ navigators	X	X	Learn from pilot and scale up enhanced primary mental health care. This will provide additional mental health resource/capacity within primary care for managing those with mental health problems of moderate to high severity and disability but who are stable, and have risk levels that can be managed in a primary care based service, with support from recovery coaches for those stepping down from secondary care. We will also integrate and/or develop interface with newly expanded neighbourhood teams, who will support those with deteriorating SMI. Further work to link existing community health/navigators within these models, and supported self-care.	having full annual physical health check. Physical care interventions to cover 30% of population with SMI on the GP register in 2017/18, moving to 60% in 2018/19.
Wider determinants				
Housing support Employment support Debt/benefit advice	X	X	Further work to scope potential for delivering improved services on housing, debt and employment services, and interface with enhanced primary care, supported self-care and neighbourhood teams.	A doubling in access to individual placement and support (IPS), enabling people with severe mental illness to find and retain employment.
Support for carers		X	Further work on supporting carers including well defined support pathways for carers.	
Primary Prevention				
Suicide prevention	X	X	Continued implementation of multi-agency suicide prevention strategy and findings of suicide audit (2016/17).	By 2020/21, the number of people taking their own lives will be reduced by 10% nationally compared to 2016/17 levels.
Anti stigma campaign work		X	Initial campaign work focused on young people and suicide for 2016/17. Build further joint cross system campaigns for 2017/18.	
Staff wellbeing programmes (non-NHS & NHS)	X	X	Programmes commissioned, or underway. Further work and investment to scale these up, with mental health as part of wider staff wellbeing programmes.	Continued implementation of health initiatives for NHS staff.
Improved resilience for children and young people Mental health skills/knowledge of professionals and parents.	X	X	Further development of the 'thrive' element of the ithrive model. 2016/17 focus on redesign and commissioned model. Non-recurrent funding for 2016/17 focused on development areas.	

Key: *Adapted from p.36 'The five year forward view for mental health'. See Annex A for a full copy of the five year table.
**Taken from 'Implementing the five year forward view for mental health'. NHS July 2016.

1.6. Next steps

Table 2 (page 10), shows what this means for our local system, and Table 3 (page 14), illustrates much of the work already underway to take forward these priorities. The purpose of this strategy is to describe our collective system-wide priorities on mental health so we can track progress against these. Overall progress in implementing this combined strategy will be reported through the STP. The principles of collaboration and logistics outlined in this document will underpin this work.

2. Where are we now?

2.1. Local Mental Health strategies

A number of documents about our local mental health strategy have been published, but they are not as joined up as they need to be.

We do not seek to duplicate or repeat in detail these previously published and agreed strategies. Links to them are at the end of this document. The purpose of this document is to place them in an overarching framework, and to describe how we will work together to implement our shared vision for Mental Health.

Across all the strategy work that our system has carried out in recent years, three common themes stand out:

I. **Prevention:** early intervention and attention to the broader determinants of health (such as housing and jobs) are crucial for our system to be sustainable.

II. **Integration:** between physical and mental health care, and health and social care is not as good as it needs to be. Outcomes for people with physical and mental health problems are poor and there are cost effective things we could be doing to improve this. Service users and carers have identified that finding out what support is available and accessing services is frequently complex and therefore difficult. Bringing health and social care services together has been shown to help to make both of these areas easier. Integrated delivery of care has also been shown to put the individual at the heart of that care and to be more effective and to make better use of resources.

III. **Capacity and Demand:** services for people with mental health problems are really stretched, and there are problems at the interfaces (for example between primary and secondary care; health and social care; services for children and adults).

2.2. What people have told us about mental health services in our communities

Throughout our engagement with service users, carers, clinicians, commissioners, and other partner organisations, a number of inequalities and gaps in the provision of mental health

care have been identified, and a number of consistent themes have emerged, particularly around access and crisis.

In general, people have told us they are concerned about:

- A lack of linkage and co-ordination between services with the need to improve communication and better sharing of information.
- Variable access to different types of services (in general and during crisis).
- A lack of open access services.
- A gap between GP care and access to specialist services.
- Fear of a 'cliff edge' when service users are discharged from specialist mental health services.
- Evidence of poor access to services, particularly when a crisis may be developing, creating an escalation of need.
- The need to join up services which support individuals, such as benefits and housing advice, with overall provision.
- Recognition of the vital role of peer and carer support.

These service issues and views reflect how the entire health system delivers mental health services alongside its partners. It is clear that we cannot look at one part of the system without considering the whole. To radically improve access to mental health services, people have said that we need to remove the barriers between GPs and hospitals and physical and mental health, and that we need to think of healthcare alongside support for the wider factors which influence mental health including employment, housing, benefits and support for families and carers.

2.3. Main JSNA messages

- With a growing population, Cambridgeshire and Peterborough has growing numbers of people with mental illness. In 2016, it was estimated that over 88,000 adults (aged 18-64 years) in Cambridgeshire and Peterborough have a common mental health disorder – by 2021 this figure will be 95,200, and by 2026 it will be 97,500.
- Suicide rates have been consistently higher than England rates in Peterborough (although this was not always statistically significant), until a drop was seen in 2012/14, making Peterborough's rates statistically similar to the England average.
- Hospital admissions rates for self-harm in those aged under 25 years are above the national average in both Cambridgeshire and Peterborough, with Peterborough the highest in the East of England.
- Patterns of service use suggest that acute 'crisis' services are being used more for mental health in Cambridgeshire, and particularly in Peterborough, when we compare with other areas. This is not explained by differences in population need.
- People with two or more long term conditions are seven times more likely to have depression.[1] 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.

Further detail and references on key local data is provided at Annex C.

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

3. Where do we want to be in five years' time?

3.1. Our vision for mental health

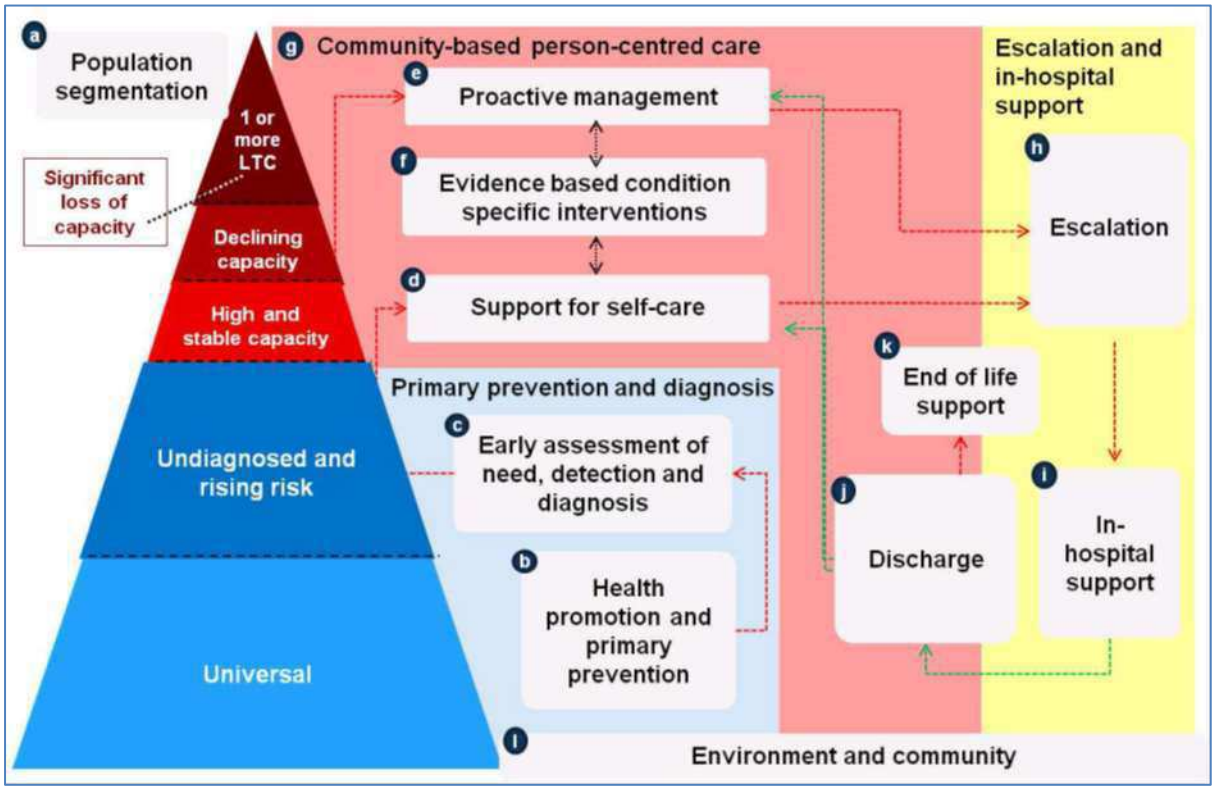
'Our vision is that health and care services for people living with long term conditions, mental health problems or advancing age are sustainable, designed with the people and communities who use them around their needs and support them to be resilient, independent and enabled.'

It is important to know that this vision has not been developed in isolation. We understand that many people live with multiple conditions, and it is often the psychological and social elements, including housing, employment, support from family and friends, and confidence to self-manage, as well as mental and physical illness, which determine what and how much support someone needs.

3.2. The main building blocks

The main building blocks for our strategy include:

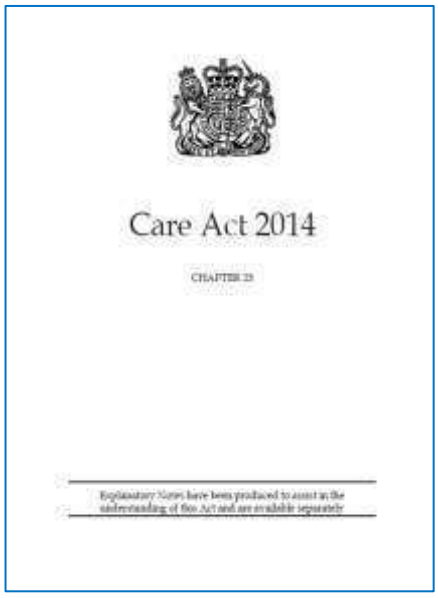
I. The model of care developed by the Sustainability and Transformation Programme



We have developed a model of care which places people at the centre of an integrated, community-focused approach; recognising the importance of the wider environment, prevention and early intervention; and that people frequently live with mental health problems alongside other long term conditions.

The diagram above summarises how integrated health care neighbourhood teams can provide proactive care stratified by different levels of need, as determined by their medical and psychosocial conditions. This brings together work on healthy ageing, long term conditions management and mental health.

II. The Five Year Forward View for Mental Health, and the 2014 Care Act



Our objectives map closely on to those set out in the Five Year Forward View for Mental Health[2] - Prevention, Wellbeing, Delaying Needs, Good Quality Care, Information and Advice, Innovation and Research, Data, Commissioning - Market Shaping, Payments and Incentives, Leadership and Workforce.

NHS England has published its implementation plan for the Five Year Forward View[3] and in Table 2, below, we describe what this means for our local health system.

Table 2: Local implications of the Five Year Forward View for Mental Health

National commitment	Potential local implications
Physical care interventions to cover 30% of population with severe mental illness SMI on the GP register in 2017/18, moving to 60% in 2018/19.	2,100 people with SMI (30%) would have physical care interventions by 2017/18, moving to 4,200 (60%) in 2018/19
By 2020/21 25% of people with common mental health disorders will access services each year.	29,300 people with common mental health disorders would access services a year by 2020/21.
By 2020/21, increase access to specialist perinatal mental health support in all areas in England.	1,250 women would receive additional support for mental health problems during pregnancy and/or the postnatal period by 2020/21, with approximately 420 (or 4%) of this group having severe and complex needs.
At least 35% of CYP with a diagnosable mental health condition receive treatment from an NHS-funded community MH services by 2020/21.	6,755 (35%) children and young people with a diagnosable mental health condition would be receiving treatment from an NHS funded community mental health service a year by 2020/21.
By 2020/21 the number of people taking their own lives will be reduced by 10% nationally compared to 2016/17 levels.	There would be 6 fewer suicides a year (from 2015 levels) by 2020/21.

Please see Annex D for details of how these estimates have been calculated.

[2] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
[3] https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf

The Care Act 2014 is the most significant change to adult social care in over 60 years. It modernises care and support so that the system is built around people's needs and what they want to achieve in their lives. It will give:

- Individuals and carers more control over their care and support.
- Clarification of what individuals and carers can expect from the care system.

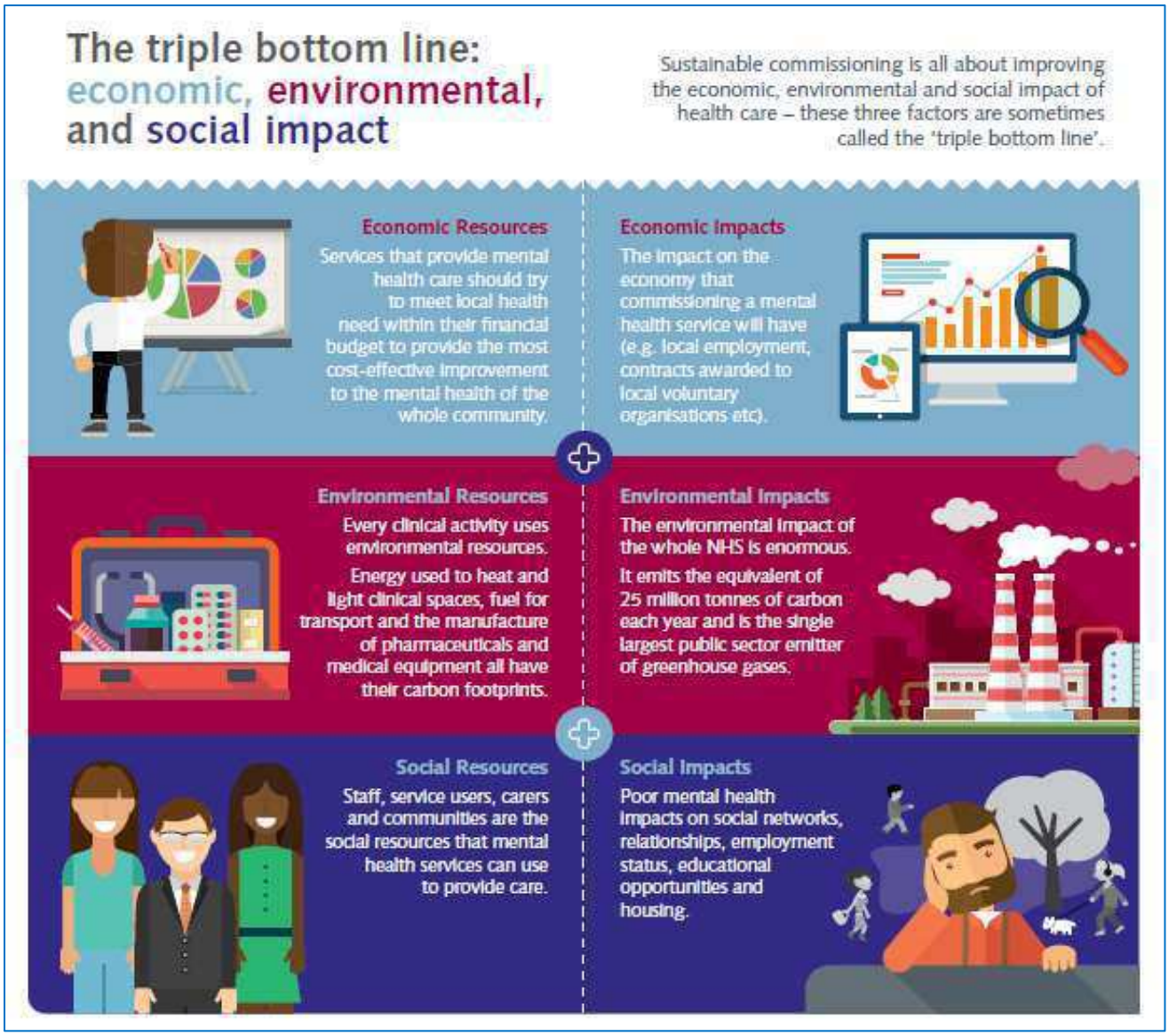
The introduction of the Care Act and its concept of 'Wellbeing' impacts upon how mental health social care services are delivered, because of the duties it places on the council to put more emphasis on responding to the needs of carers, placing more control in the hands of the individual over their care and providing better access to information.

Some of the main features of the Care Act include:

- A change to the way people are assessed – so that decisions about the help they receive will consider their wellbeing, what is important to them and their family, and help to plan for the future.
- New rights for carers and people who pay for their own care (called 'self-funders') to ask for an assessment of their needs and the council's help to access services and support to meet their eligible needs.
- Provision of information and advice to everyone who requires it, not just people using services.

One implication for Mental Health services is a need to realign social work resources away from working solely with secondary care to work across the pathway between secondary and primary care services. This would strengthen the early intervention and prevention capacity of the whole mental health system in line with emphasis on wellbeing

III. A commitment to sustainable commissioning



Our approach to commissioning must be sustainable: not just economically, but also environmentally and socially.[4]

What is sustainable commissioning?

Sustainable commissioning is about 'future-proofing' mental health care. This simply means ensuring better outcomes for patients both now and in the future, despite increasing resource constraints.

Four basic principles for sustainable commissioning decision making

Commissioners are committed to and will take action to ensure that the four basic principles for sustainable commissioning decision making are employed as a framework for decision making.

[4] Source: JCPMH: Guidance for commissioners of financially, environmentally, and socially sustainable mental health services. Available at: http://www.jcpmh.info/resource/guidance-for-commissioners-of-financially-environmentally-and-socially-sustainable-mental-health-services/

I. **Prioritise prevention** – preventing poor mental health can reduce mental health need and therefore ultimately reduce the burden on health services (prevention involves tackling the social and environmental determinants alongside the biological determinants of health).

II. **Empower individuals and communities** – this involves improving awareness of mental health problems, promoting opportunities for self-management and independent living, and ensuring patients and service users are at the centre of decision making. It also requires supporting community projects that improve social networks, build new skills, support employment and ensure appropriate housing.

III. **Improve value** – this involves delivering interventions that provide the maximum patient benefit for the least cost by getting the right intervention at the right time, to the right person, while minimising waste.

IV. **Consider carbon** – this requires working with providers to reduce the carbon impacts of interventions and models of care.

3.3. Our main priorities

Our main priorities, progress to date and next steps are summarised, and mapped against national priorities in Table 3 (page 14). The Executive Summary to this document provides a shortened version of this table highlighting the key priorities (Table 1, page 3).

Our proposed approach focuses on three areas:

I. **Prevention:** promoting mental health and preventing mental illness.

II. **Community-based care:** developing an integrated approach to community-based person-centred care, focused on intervening early.

III. **Specialist care:** timely acute, crisis and inpatient care when it's needed**.** Paying particular attention to admission and discharge processes, the management of interfaces between services, and social services support.

These headings draw together the themes of prevention, integration and capacity and demand alongside many of the other priorities identified both locally by our own service users and partners, and also nationally within the five Year Forward View for Mental Health. Importantly, they also build on and link in with each other, to provide a cohesive person-centred sustainable model of health and care.

This document does not currently encompass Learning Disabilities or Dual Diagnosis. Work on dementia is being developed separately through a dementia strategy, and once available will be incorporated here.

Table 3: Mental Health Five Year Forward View – local requirements split by local priority areas		
Local and national aims: **A. Promoting Mental Health and Preventing Mental Illness**	**Progress to date**	**Next steps**
• Focus on groups at risk of mental illness such as vulnerable children, as well as support for carers. • Access to employment, housing and debt support. • Tackling stigma through campaigns and mental health champions in communities. • Incentives for NHS employers relating to NHS staff health and wellbeing. Measures of staff awareness and confidence in dealing with mental health in staff surveys. • Parenting programmes as part of prevention work, particularly for vulnerable groups. • Improved resilience for children and young people, alongside mental health skills and knowledge of professionals and parents. • Implementation of a whole school approach to mental health and wellbeing. • Individuals and their families are enabled to achieve and sustain their wellbeing through links to strong and resilient communities. • Vulnerable people with mental health needs and their carers find the support and care system easy to navigate. • (Suicide prevention see section C)	• Some focus on at risk groups including vulnerable children. • Access available through commissioned voluntary sector services to employment support, housing and debt advice for some. • Anti-stigma campaigns such as 'stress less', 'one you' and mental health awareness week supported by public health. • School champions (teacher and young people) being piloted. • NHS staff wellbeing programmes, including mental health being developed in large NHS providers. • Parenting programmes considered as part of the mental health service redesign for Children and Young People. • Training for professionals and schools provided, alongside planning for whole school approach. • Development of training packages for employers and setting out standards for workplace health, and support for those with mental illness wanting to remain and/or return to work. • Pilot project on building mentally resilient communities and evaluation with MIND. • Improving the mental health awareness for a broad range of professionals.	• Further work to ensure prevention work is targeting at risk groups. • Further work with voluntary sector to scope potential for delivering improved services on housing, debt and employment services, and the interface with enhanced primary mental health care services, and neighbourhood teams. • Build further joint cross system campaigns for 2017/18. Further development of NHS wellbeing programmes for employees. • Further development of parenting programmes as element of the ithrive model. • Alignment of voluntary sector commissioning. • Further development of 'thrive' element of ithrive model focusing on school support, mental health knowledge and life skills, building resilience, staff and parents, and those most vulnerable to mental health problems. • Continued focus on reducing social isolation, and building community resilience. • Further work on supporting carers including robust assessments and 'what if' plans, as well as defined support pathways for carers.
B. Developing community-based person-centred care focused on intervening early	**Progress to date**	**Next steps**
• By 2020/21 at least 60% of those experiencing a first episode of psychosis access to NICE approved care package within 2 weeks of referral. • Out of area placement for inpatient care eliminated by 2020/21.	• Further investment in Early Intervention Psychosis (EIP) services in line with national guidance. EIP pathway development in place. • Enhanced Primary Care Pilot in place – looking at 'step down/step up' management.	• Establish NICE compliant pathway (Year 3). • Learn from pilot and scale up enhanced primary mental health care. This will support GPs in identifying psychological needs and primary care-led interventions, with support from recovery coaches for those stepping down from secondary care. Integrate and/or develop interface with newly

Table 3: Mental Health Five Year Forward View – local requirements split by local priority areas		
• Reduce Mental Health Act detention through earlier intervention and targeted work to reduce over-representation of BAME and other disadvantaged groups • Prevent avoidable admissions support recovery and 'step down' for SMI and significant risk/safety issues, least restrictive and close to home. Tackle inequalities in detentions and length of stays. • Expansion of 'navigator' roles. • Learning from SI's. • Social care practice is focused on supporting people to gain and retain their independence. • An effective re-ablement service is available in mental health.	• Development of a primary care wellbeing pathway integrating IAPT, the enhanced primary care pilot and recovery coach service (CQUIN). • Fully scoping activity data for Personality Disorder (PD) Pathway (CQUIN). • Clinical Commissioning Group has commissioned 'recovery coaches' to support patients post discharge. Local authorities have piloted a mental health 'navigator' model, based on an existing 'navigator' project. • Recovery College East provided collaborative educational opportunities for Cambridgeshire and Peterborough Foundation Trust (CPFT) service users and staff. • Development of 'what if' plans for carers.	expanded neighbourhood teams, which will support those with deteriorating SMI. Further work to link existing community health/navigators/Peer Support. Workers/Recovery College within these models, and supported self-care. • Consider how enhanced primary mental health care can support those not registered with GPs. • Further modify PD pathway as required (including strengthening involvement and support for friends/families). • Alignment of voluntary sector commissioning. • Improved recognition of depression in patients with LTCs and in old age. • Re-focus social work practice so service users have more engagement with their communities as part of their care plans. • Develop a set of standards for the way in which voluntary sector services enable service users to engage with support existing in their community and build this role into the requirements of all relevant contracts. • Implement and evaluate the re-ablement pilot project in Huntingdon. • Maximise direct payments through staff training and making them more user friendly. • Implementation through strands of work from the Peterborough City Council 'People and Communities' Strategy'.

Table 3: Mental Health Five Year Forward View – local requirements split by local priority areas		
Integrated mental/physical health & access to psychological therapies • Physical health checks for those with SMI. • Improved access to prevention and screening initiatives for those with mental illness. • All mental health inpatient facilities to be smoke free by 2018. • Access to psychological therapies (particularly for LTCs; psychosis, bipolar, PD and common mental health problems) Access to psychological therapies to meet 25% of need, and integrated into physical health pathways. • Improve offender services, including all age liaison and diversion schemes and forensic services.	• Work underway to clarify responsibilities for annual checks with different groups of patients for GPs and CPFT. • Investment made in health trainers working within the enhanced primary care service. • Closer working between stop smoking and mental health services. • IAPT Access and recovery rates as per national targets. • IAPT already focusing on patients with LTCs.	• Clarity built into contracts, and provision monitored. Improve the proportion of SMI patients with a high quality annual health check. • Focused prevention and screening initiatives, and numbers accessing services amongst patients with SMI improved. Smoke-free mental health facilities by 2018. • Improved access to health trainers for those with SMI. Initially investment made in 2016/17. Further work to align with other initiatives supporting self-care for LTCs. • Improve access to psychological therapies where this is of known benefit including for LTCs, MUS, psychosis, mood disorders including bipolar affective disorder and PD (improved). Impact analysed, financial flow adjusted between LTC and MH services. • Plans developed to implement smoke-free inpatient facilities by 2018. • Supporting self-care for those with LTCs to have mental health support embedded within it. • Develop liaison psychiatry skills in primary care to reduce presentations to acute trusts and support them in moving services into the community

Table 3: Mental Health Five Year Forward View – local requirements split by local priority areas		
Perinatal, Children and Young people • Improved access to evidence-based specialist mental health care including psychological therapies and specialist community or inpatient care • One in three children and young people with mental health needs to access Mental Health services by 2020	• Perinatal mental health outcomes built into 0-19 contract for children's services (including health visiting, school nursing and children's centres). • Initial work on Children's mental health redesign to ithrive model underway. Service will: • Increase availability and accessibility of early interventions services through improved signposting, advice, guidance. • Movement of those CYP with mild needs to locality based support. • Effective early MH specific assessment to ensure access to correct interventions and support as early as possible. • Development of wellbeing lead roles to support, advise, guide professionals working with children and young people within the community. • Embedding the use of shared decision making and setting of outcomes and goals from first interaction with services (supported by a programme of training). • Reviewing model of delivery to ensure effective evidence based interventions are delivered and development of innovative workforce models with a range of people skilled to delivery these interventions.	• Continued work to recognise the impact of parental mental health on children and focus practice on responding to the needs of the whole family through whole family assessments and joint visits with other professionals wherever possible. • Improved perinatal access through specialist service provision and community provision in line with NICE stepped provision. 2016/17 further work to baseline current service provision, allocate investment and commission new services. • Continued work on the development and implementation of the ithrive model. New children's mental health service model commissioned, including primary mental health support and counselling in localities. • Focused work to reduce transition issues between child and adult services. • Further development of co-located, jointly commissioned, fully integrated services for children including those with long term conditions. • By December 2016 developing a co-commissioning approach with NHS England focusing on alternatives to admission.

Table 3: Mental Health Five Year Forward View – local requirements split by local priority areas		
C. Timely acute, crisis and inpatient care when it's needed	**Progress to date**	**Next steps**
• By 2020/21 all acute hospitals to have all-age mental health liaison services in A&E and inpatient wards, and meeting core 24 service standards. • By 2020/21 24/7 community-based mental health crisis response available. Including Crisis Resolution and Home Treatment Teams (CRHTTs) provision of intensive home treatment. • Equivalent model to adult model for children and young people. • Implement new duties to ban use of police cells as a "place of safety" for those under 18 years • Multi-agency suicide prevention plans in place by 2017, contributing to 10% reduction in suicide.	• Implementation of phase 1 of UEC Vanguard for 24/7 mental health crisis in Cambridge. • Pilot of community-based safe place with voluntary sector. • Mental health nurses in police control room as part of UEC Vanguard project provide early input and support to police and provide alternatives to use of Section 136. • Investment of £360k to improve psychiatric liaison services for children and young person including extending assessments to midnight and increasing capacity of Intensive Support Team • S136 Mental Health Based Places of Safety to meet national guidance. • Multi-agency suicide prevention plan and implementation group established. • Successful Stop Suicide Campaign and targeted training programme.	• Plans in place for core/core 24 service standards (by 2020/21) in all acute trusts, subject to staffing limitations. Review Emergency Department Liaison Psychiatry provision, adjust as necessary. • Further implementation of our community-based first response model to the whole CCG, subject to success of pilot and funding, to provide 24/7 self referral for mental health crisis with tele-triage and mental health first responders available to provide urgent assessment when needed. • Develop multidisciplinary paediatric liaison services to acute trusts • Continued implementation of crisis concordat action plan (years 2-5). • Ensure there is a countywide Approved Mental Health Professional (AMHP) service with sufficient capacity and sufficient access to S12 approved medical practitioners. • Improved use and sharing of Crisis/Care Plans. • Develop pathways/processes to ensure ithrive and crisis redesign integration. • Continued implementation of suicide prevention strategy and findings of suicide audit (2016/17).

Sources: STP aide-mémoire: Mental Health and Dementia and Five Year Forward View for Mental Health. All relevant local strategies

3.3.1. Our first local priority: Promoting mental health and preventing mental illness.

Preventing illness, promoting mental health and intervening early and effectively, when people become ill, are the foundations of our strategy.

The Five Year Forward View for Mental Health emphasises the importance of promoting good mental health and preventing poor mental health – helping people lead better lives as equal citizens**,** and recognising that this his is not the remit of the NHS alone – it requires support for parents, good schools, decent housing and supportive communities. Our Public Mental Health Strategy[5] sets out the evidence for such an approach.

Our cross-system prevention work will focus on:

- Building resilience, mental health knowledge and life skills in children and young people.
- Introducing a 'whole school approach' to improving mental health and a similar approach in the early years environment.
- Supporting parents, particularly through evidence-based parenting programmes.
- Engaging with communities to promote mental health and reduce stigma, including through anti-stigma campaigns.
- Mainstreaming mental health promotion within our healthy lifestyles work.
- Developing training packages for employers and setting out standards for workplace health, and support for those with mental illness wanting to remain and/or return to work.
- Improving the mental health awareness for a broad range of professionals who come into contact with those with mental illness but are not mental illness specialists.
- Work to address the factors that increase the risk of mental illness, such as improving access to employment support and debt advice.
- Work to improve the mental health of those with physical illness and the physical health of those with mental illness.
- Continued implementation of the Suicide Prevention Strategy.[6]

As described below much of the challenge with this work is ensuring that it takes place at a sufficient scale to have a significant impact.

3.3.2. Our second local priority: Developing community-based, person-centred care, including intervening early, where possible

At the heart of our vision is an integrated service, community-based, which brings together physical and mental health care, alongside social care, the voluntary sector, and the many resources which exist within our communities.

Considerable work is already underway, much of which is currently being tested in small geographical areas, but this needs further commitment and investment to be expanded across Cambridgeshire and Peterborough.

[5] http://www.cambridgeshireinsight.org.uk/health/healthtopics/mh
[6] http://www.cambridgeshireinsight.org.uk/health/healthtopics/mh/suicide

One key area of activity in this area focuses on improving access to and availability of mental health services, including:

- Significantly more children and young people accessing high quality mental health care, including timely access to inpatient beds as close to home as possible when these are needed, alongside alternatives to admission where this is appropriate.
- Specialist perinatal mental health services available locally for all women who need them.
- Access to psychological therapies to meet 25% of need, integrated into physical health pathways.
- Expansion of rapid access for people experiencing their first episode of psychosis in line with NICE-approved care.
- Multi-agency action to reduce the suicide rate by 10%.

As part of our plan to achieve these goals, we will immediately set up a Cambridgeshire and Peterborough perinatal mental health network group; and we will also consider options for developing more specialist services for perinatal mental health, including exploring the option of establishing a regional Mother and Baby Unit, alongside the development of the whole perinatal pathway.

We will expand our Long Term Conditions IAPT service, and take action to allow our early intervention in psychosis teams to increase their treatment pathways from two years to three, and to expand services for the assessment of individuals with at risk mental states.

Work on children and young people will build on the 'ithrive' work described below.

Box 1: ithrive redesign for children's mental health

We are developing a new model for emotional health and wellbeing services based on the ITHRIVE framework. This will, we hope, reduce the demand we see later on in life for mental health, specialist health, and social care services. Thrive is a conceptual framework for delivering a need based model for CAMHS. Cambridgeshire and Peterborough is one of the national accelerator sites for implementing this approach. More detail on Thrive can be found at http://www.annafreud.org/service-improvement/service-improvement-resources/thrive/

The model supports self-resilience of CYP and families and supports them within their localities and in ways that meets their needs. The model supports the concept of increasing the availability and accessibility of early intervention and preventative activities and therefore ensuring that only children and young people whom would benefit from specialist mental health services need to be referred.

Key points of new model:

- Removal of tiers to a whole system approach.
- Needs based as opposed to diagnosis led.
- Outcome to be defined from beginning of interaction with services.
- Enhance preventative activities to support Thriving and build resilience.
- Increase in early intervention and provide interventions, advice, support earlier and not wait until crisis.
- Use of shared decision making to identify goals and outcomes to be achieved.
- Ensure use of evidence based or best practice interventions.
- Stop treatment if not achieving goals.
- Improvement in access.
- Access to advice and guidance from specialist services earlier through wellbeing lead.
- Improved training and knowledge of mental health across all sectors.

A second area for development focuses on providing people with community-based holistic care, recognising their mental and physical health needs.

We know that we need to do more to bring together and co-ordinate services which can focus on the needs of the individual and understand them in their wider environment and work to address the factors contributing to their mental health problem. This means focusing on wider support such as housing, employment and benefits, alongside supporting family and/or carers.

We also recognise the need to expand support for people who are below the threshold for specialist services but who need more support than can be provided through GPs. Support for self-care and recovery, are central to this. Housing is a crucial part of this and there is a need tor review the sufficiency and spread across the County of specialist accommodation and access to general needs housing for those with severe and enduring mental health problems.

As part of our plan to achieve these goals, by 2017 we will have developed our Recovery Coach model to support discharge from secondary care, and our Enhanced Primary Care service for Mental Health will be developed to allow us to test out approaches to improve the effectiveness of our step up and step down pathways, and help address the 'fear of a cliff edge' which causes many of our service users and carers concern when discharged from secondary Mental Health services.

The Enhanced Primary Care mental health service will, along with all NHS services, support the physical care of patients with mental illness, and identify and address the psychological needs of those with long term conditions and is described in the box below. Our dementia strategy will be developed to continue to meet national targets for early diagnosis; and to improve the support (including crisis and end of life care) for people living with dementia and their carers.

Box 2: Enhanced primary care mental health services

The Model: The service will provide additional mental health resource/capacity within primary care to manage the defined patient group (see above) by supporting the GP with specialist Mental Health staff who have the knowledge, expertise and capacity to support the safe discharge/transfer of stable patients from Secondary to Primary Care and vice versa. Physical health monitoring and where appropriate physical and mental health interventions will be provided in collaboration with the wider MDT team. There will be three teams across the CCG consisting of: Band 6 nurse (mental health interventions and escalations to secondary care where needed); one Health Care Assistant for physical health interventions; and one Peer Support Worker to enable access to community resources.

Who is the service for?
The service will be for patients aged 17-65 years who have mental health problems of moderate to high severity and disability but who are stable, and have risk levels that can be managed in a primary care based service. This should reduce the pressure on primary care and reduce secondary care referrals, creating more capacity within the mental health system.

Next steps
The service specification and model have been agreed, with an initial proof of concept phase in the Fenland and Hunts area to better understand how the model will work in practise. Following an evaluation, the aim is to roll out the model county-wide from Autumn 2016.

3.3.3. Our third local priority: timely acute, crisis and inpatient care when it's needed

The Five Year Forward View for Mental Health emphasises the importance of a seven day NHS which provides the right care at the right time and of the right quality.

Within our local area the Crisis Care Concordat has provided a model of multi-agency collaboration to help develop and improve our crisis services. We will need to build on and develop this work. To make sure that the capacity of our acute and specialist mental health services can sustainably meet demand and achieve the best outcomes for patients, we also need to deliver effectively on our plans for prevention, early intervention and community-based care which we have described previously.

We will continue to work to design integrated pathways between primary and secondary care and the voluntary sector, and to build teams that can respond quickly in a crisis and that will facilitate early discharge, with support from the right services, as soon as this is appropriate and safe. We will work to ensure that children and adolescents have timely access to crisis services that meet their needs in the community, as well as exploring new collaborative approaches to commissioning inpatient services when these are required.

We are developing and piloting a community-based mental health first response service as part of our Urgent and Emergency Care Vanguard programme, and this is described in the box below.

Box 3: Mental Health Vanguard: First Response Service

The mental health Vanguard programme aims to provide a universal, 24/7, mental health crisis care pathway, which can be accessed directly by patients and carers, alongside local NHS, social care and third sector colleagues.

The model: The new services include:

- A first response service run by Cambridgeshire and Peterborough Foundation Trust, supporting patients experiencing a mental health crisis in the community out-of-hours. The team will work alongside the existing crisis teams and will take referrals from emergency services.
- The Sanctuary, a safe place in the community, offering short-term support, run by the third sector, with referrals triaged by the First Response Service. It will provide practical and emotional support for people as an alternative to admission to statutory services. The service will run seven days a week between 6pm and 1am.
- A system-wide co-ordinator supporting calls from emergency services out-of-hours, and referring onto the new Sanctuary and First Response Service.
- Mental health practitioners in the Integrated Police Control Room providing advice to the police. This launched on 29 March 2016 and allows people in mental health crisis to be supported at the earliest opportunity, and provide police officers with advice and referral options. The team was part of the partnership response to the Crisis Care Concordat and is funded by the Cambridgeshire Police and Crime Commissioner and Peterborough City Council.
- The new model will also provide patients with the opportunity to self-refer into the services.

Phase one of the mental health Vanguard programme launched in April in Cambridge, to start to improve how we support people in mental health crisis out-of-hours. Once funding is confirmed the next stage of the programme will launch. We plan to roll out the new model of care in three phases over 2016. The phased rollout will enable us to look at mental health referrals into the emergency system and evaluate the benefits of the new service.

Within acute medical and surgical settings we will build on work which has already been carried out locally to develop liaison psychiatry; interventions for frequent attenders in the Emergency Department and those with medically unexplained symptoms; and building on existing and developed training to facilitate the provision of education and training opportunities for staff to adopt a holistic, integrated approach at the interface of physical and mental health.

3.4. How will we deliver our vision?

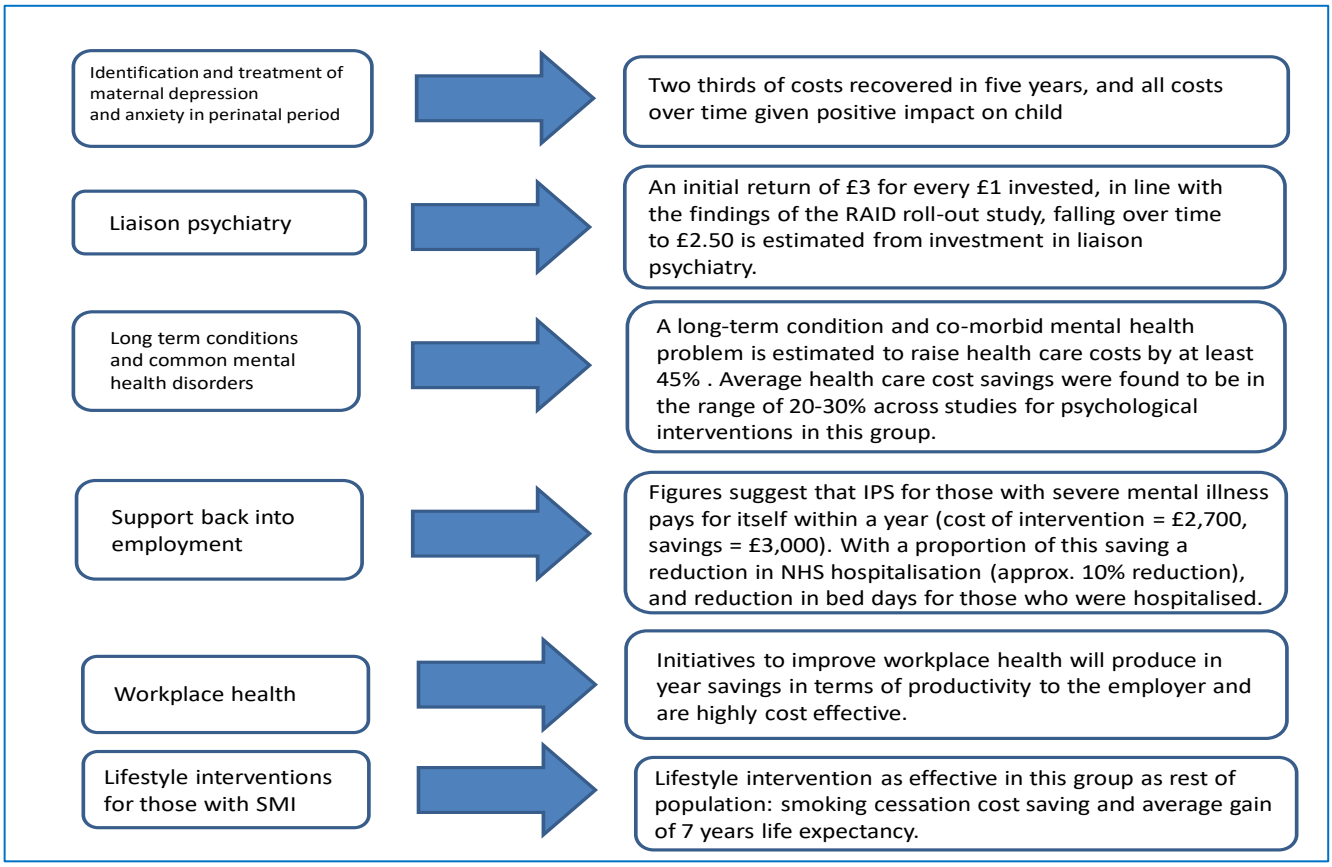
Delivering this strategy will require investment, and a detailed, costed programme plan for each element of implementation. The *Five Year Forward View for Mental Health* makes it clear that mental health services have been chronically underfunded, and estimates a requirement in England for an additional £1 billion investment by 2020/21 to help plug the gaps in the care that the NHS is currently unable to provide. We receive a proportion of this investment locally. We estimate that our share of this additional investment will equate to £12.8m by 2020/21 (based on the funding formula in use in June 2016).

Additional investment is a fundamental requirement if we are to achieve parity of esteem between mental and physical health, but it is important to note that this strategy is not a detailed investment strategy, and there remains much work to be done to develop, cost and plan the key priorities highlighted here. It is clear from our high level costing work that the estimated additional investment of £12.8m is unlikely to be enough to achieve full implementation of the five year forward view or indeed this strategy by 2020/21.

In particular this is the case as we have taken a system wide view of mental health, as we believe this is the best route to improved outcomes for patients, rather than only focusing on the Five year forward view priorities.

Given the financial position of the CCG and both local authorities how we work together to maximise the value of any available investment is critical. We will be seeking to:

- Focus the additional investment to implement the Five Year Forward View for Mental Health on our key priorities.
- Maximise our opportunity to access any nationally available funding for specific mental health initiatives.
- Maximise our ‘invest to save’ opportunities, some of which are highlighted in the diagram below and at Annex D.
- Continue to ensure mental health provision is part of our core STP work on long term conditions, and primary and integrated neighbourhoods.
- Maximising our opportunities to improve quality within current services.
- Working together cross system to the principles of collaborations and logistics set out on the next page.



As we develop our services and pathways, it is essential that we work to a set of principles to demonstrate that our proposals have been developed and implemented on the basis of consensus and collaboration, and with the best available evidence.

To achieve our goals, we will behave with transparency and openness, communicating clearly to develop collaborative consensus-based solutions, engaging widely, working as a system in the interests of the people and communities we serve.

We will work to the following principles and behaviours:

- We will put people and their families and carers at the heart of what we do, and ensure they are engaged in the design and planning of services.
- We will use evidence based solutions where possible, using data to drive and evaluate out progress. We will base our work on the best available knowledge and information.
- We will work to meet the diverse needs of the population, focusing on ensuring equity of access to care and support across our communities.
- We will focus on outcomes that are important for people and their families and carers, not on activity alone, and agree and align these with stakeholders and across agencies.
- We will seek where ever possible to embed consideration of mental health within physical health services.

3.5. Principles of collaboration and logistics

We will work together as partner organisations in Cambridgeshire and Peterborough to improve the system of care and support so that people are helped to help themselves live well, receive help when they need it for their mental health, and are supported in their recovery from mental health problems.

Next steps for our system cannot be delivered without collaboration across many organisations and individuals.

3.5.1. A common language

We will establish a common language that will give us the assurance we are able to work effectively and efficiently as a whole system. This will ensure that our pathways are well defined and can be navigated by any provider or user of the system, that we understand who staff working in our services are and what they do, and that we have a common framework for talking about risk.

3.5.2. Joint outcomes

We will establish a joint outcomes framework for mental health across the health and social care system.

3.5.3. Information and data sharing

Provision of the best quality and most appropriate services to children and adults in need of help and support can only be delivered if agencies have access to the correct information about service users' individual circumstances. Effective cross agency information quality and transparency is also key to ensuring an overall system that works for the population.

3.5.4. Workforce development

Greater integration means new ways of thinking, behaving and working across the whole system; and everyone working in all of our organisations will need to think differently about their role, with a clear expectation about how practice by all professionals will change to support a multi-disciplinary approach. Staff will need to develop new skills and work across traditional boundaries. Common approaches to training and development, as well as a common language across services, will be needed to achieve the full benefits of integration.

3.5.5. Property co-location

Where possible, we want staff from across the system to be co-located or able to share working space in a variety of settings. As partner organisations move towards more mobile working and reduced office space, there will need to be a better join up in relation to planning use of estates to achieve vertical or functional integration. In addition it will be important to make use of existing assets such as libraries and other community buildings to act as a point of information and advice. We will use technology to help us work more closely where we cannot be co-located and for such services as the single point of access this will be essential.

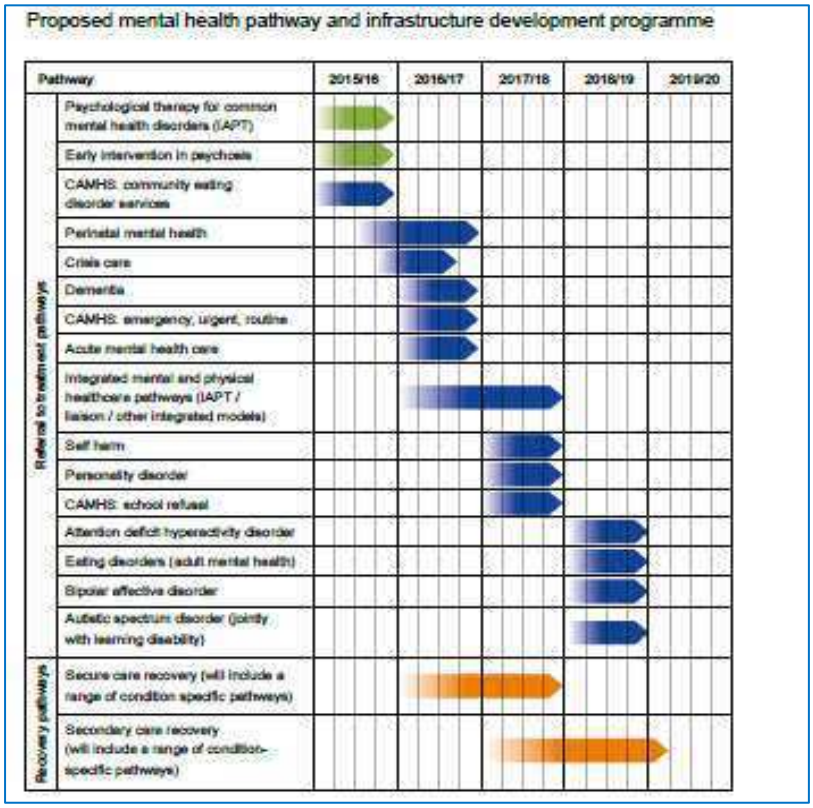
3.5.6. Joint commissioning by health and local councils working together

Service transformation is strengthened when the commissioning of services from both the statutory and voluntary and community sectors can be done jointly by the local NHS and Councils. This enables the commissioning of pathways and the delivery of coordinated services across sectors. This can be achieved through the pooling of commissioning budgets, use of the Better Care Fund pooled budget, and the encouragement of provider consortia and partnerships between the statutory and voluntary sectors. Such partnerships if properly constructed can provide greater security for third sector organisations in a difficult financial climate. The recent

Vanguard First Response development was a jointly commissioned service – from the local NHS Trust with a local voluntary sector provider. All commissioners will be looking to work more closely together, using this strategy as a roadmap, to promote greater coordination of services and to remove duplication to the benefit of the whole health and wellbeing system.

Annex A: Task force priorities (The Five Year Forward View for Mental Health)

Proposed mental health pathway and infrastructure development programme



Annex B: Existing links to local strategies

Cambridgeshire and Peterborough Suicide Prevention Strategy
http://cambridgeshireinsight.org.uk/health/healthtopics/mh

Public Mental Health Strategy 2015-2018
http://cambridgeshireinsight.org.uk/health/healthtopics/mh

Cambridgeshire and Peterborough Crisis Care Concordat
http://www.crisiscareconcordat.org.uk/areas/cambridgeshire/

Social Care Strategy for Adults with Mental Health Needs 2015-18
http://www.cambridgeshire.gov.uk/info/20166/working_together/577/strategies_plans_and_policies

Peterborough People and Communities Strategy
https://www.peterborough.gov.uk/council/strategies-polices-and-plans/communities-strategies/people-and-communities-strategy/

Peterborough draft health and wellbeing strategy 2016-19
https://www.peterborough.gov.uk/healthcare/public-health/health-and-wellbeing-strategy/

Cambridgeshire Health and Wellbeing Strategy 2012-17
http://www.cambridgeshire.gov.uk/info/20004/health_and_keeping_well/548/cambridgeshire_health_and_wellbeing_board

Annex C: Key local data

Mental Health – the current picture

Key points

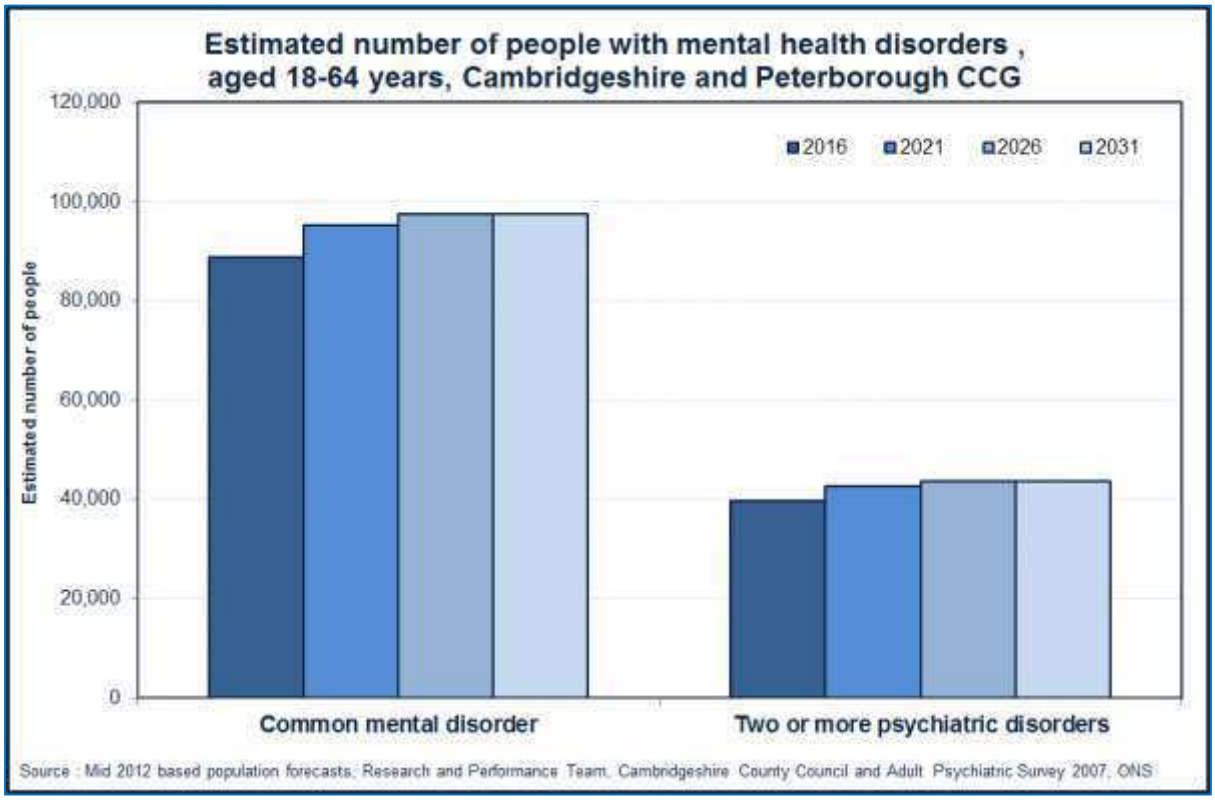
- With a growing population Cambridgeshire and Peterborough has growing numbers of people with mental illness. In 2016 it estimated that over 88,000 adults (aged 18-64 years) in Cambridgeshire and Peterborough have a common mental health disorder – by 2021this figure will be 95,200, and by 2026 it will be 97,500.
- Suicide rates have been consistently higher than England rates in Peterborough (although this was not always statistically significant) until a drop was seen in 2012/14, making Peterborough's rates statistically similar to the England average.
- Hospital admissions rates for self-harm in those aged under 25 years are above the national average in both Cambridgeshire and Peterborough, with Peterborough the highest in the East of England.
- Patterns of service use suggest that acute 'crisis' services are being used more for mental health in Cambridgeshire and Peterborough when we compare with other areas. This is not explained by differences in population need.
- People with two or more long term conditions are seven times more likely to have depression.[7] 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 levels

- It is estimated that over 88,000 adults in Cambridgeshire and Peterborough aged 18-64 years have a common mental health disorder.
- 7% (50,417) of adults in Cambridgeshire and Peterborough were recorded by GP's as having depression in 2014/15.
- There were 775 self-harm hospital admissions in people aged 10-24 years in 2014/15 in Cambridgeshire and Peterborough. Rates are significantly worse than the England average.
- 7,048 patients registered in Cambridgeshire and Peterborough have a serious mental illness.
- In 2016 it estimated that over 88,000 adults (aged 18-64 years) in Cambridgeshire and Peterborough have a common mental health disorder – by 2021 this figure will be 95,200, and by 2026 it will be 97,500.

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

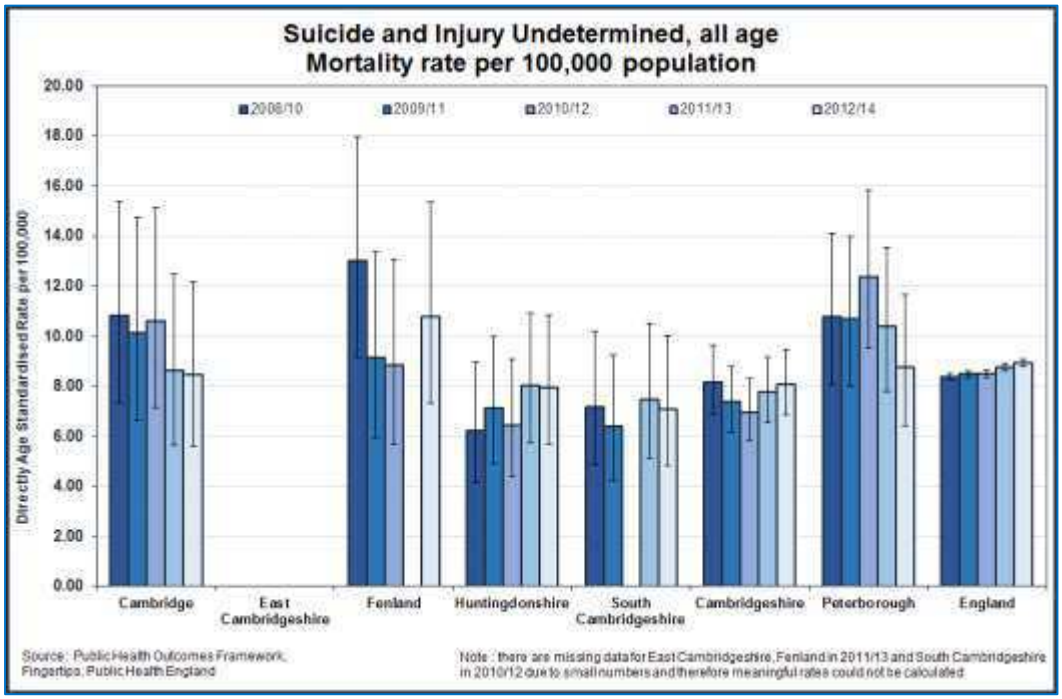
Figure 2: Estimated number of people with mental health disorders, aged 18-64 years, Cambridgeshire and Peterborough CCG



Suicide rates

Suicide rates have been consistently higher than England rates in Peterborough (although this was not always statistically significant) until a drop was seen in 2012/14. This recent improvement means that suicide rates in Peterborough are now statistically similar to the England average. Cambridgeshire rates are consistently below the England rate.

Figure 3: Suicide and Injury Undetermined, all age Mortality rate per 100,000 population

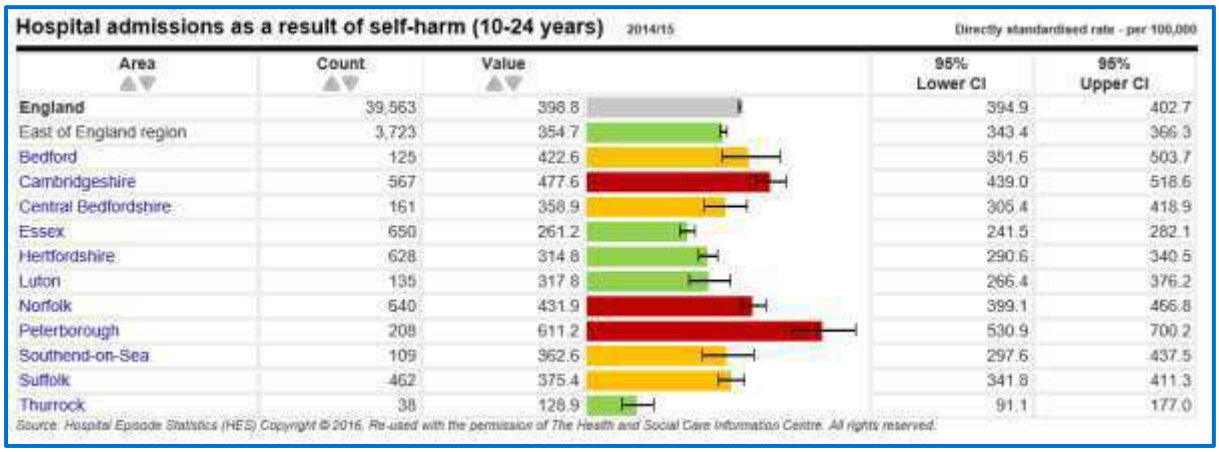


Self-harm in young people

Self-harm is understood as physical injury inflicted as a means to manage an extreme emotional state and is primarily a coping strategy.

In 2014/15 there were 775 admissions to hospital by young people (aged 10-24 years) as a result of self-harm – Cambridgeshire 567 admissions and Peterborough 208 admissions. Hospital admission rates for adult self-harm in 2013/14 for Peterborough (the latest data available) were highest in the East of England, at 40% above the average rate.

Figure 4: Hospital admissions as a result of self-harm (10-24 years)



Hospital admissions as a result of self-harm (10-24 years) 2014/15

Directly standardised rate - per 100,000

Area	Count	Value	95% Lower CI	95% Upper CI
England	39,563	396.8	394.9	402.7
East of England region	3,723	354.7	343.4	366.3
Bedford	125	422.6	351.6	503.7
Cambridgeshire	567	477.6	439.0	518.6
Central Bedfordshire	161	358.9	305.4	418.9
Essex	650	261.2	241.5	282.1
Hertfordshire	628	314.8	290.6	340.5
Luton	135	317.8	266.4	376.2
Norfolk	640	431.9	399.1	466.8
Peterborough	208	611.2	530.9	700.2
Southend-on-Sea	109	362.6	297.6	437.5
Suffolk	462	375.4	341.8	411.3
Thurrock	38	128.9	91.1	177.0

Source: Hospital Episode Statistics (HES) Copyright © 2016. Re-used with the permission of The Health and Social Care Information Centre. All rights reserved.

For the time period 2013-15 in children and young people aged under 18 years around 56% of self-harm admissions in Cambridgeshire and almost a half of admissions in Peterborough had a diagnosis of mental health recorded, with the majority for mood affective disorders (mania, bipolar or depression).

Admissions are higher from the 40% most deprived areas in Cambridgeshire and Peterborough compared to the rest of the areas.

Treatment

Across Cambridgeshire and Peterborough attendances at A&E for psychiatric disorder is higher than the England average and bed days per 100,000 population are lower.

In Peterborough:

- Referral rates to Crisis Resolution Home Treatment are higher than the rest of Cambridgeshire.
- Use of police powers to take a person in mental health crisis to a place of safety (Section 136) occurred at a much higher rate in Peterborough population than in the rest of Cambridgeshire.

This is part explained by Peterborough having a high prevalence of risk factors for mental health, such as, socio-economic deprivation, children in care, violent crime, drugs misuse, homelessness, relationship breakdown, lone parent households, overcrowding and vulnerable populations, such as migrants and asylum seekers. However, the patterns of acute service use in Peterborough are unlikely to be entirely due to additional need within the population.

Peterborough also has lower levels of recorded depression (a common mental health disorder) than would be expected and the depression prevalence data does not correlate with areas of deprivation as we would expect.

Long term conditions and mental health

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 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.[8]

Those with LTCs are at a higher risk of developing a mental illness; the table on the next page 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.

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

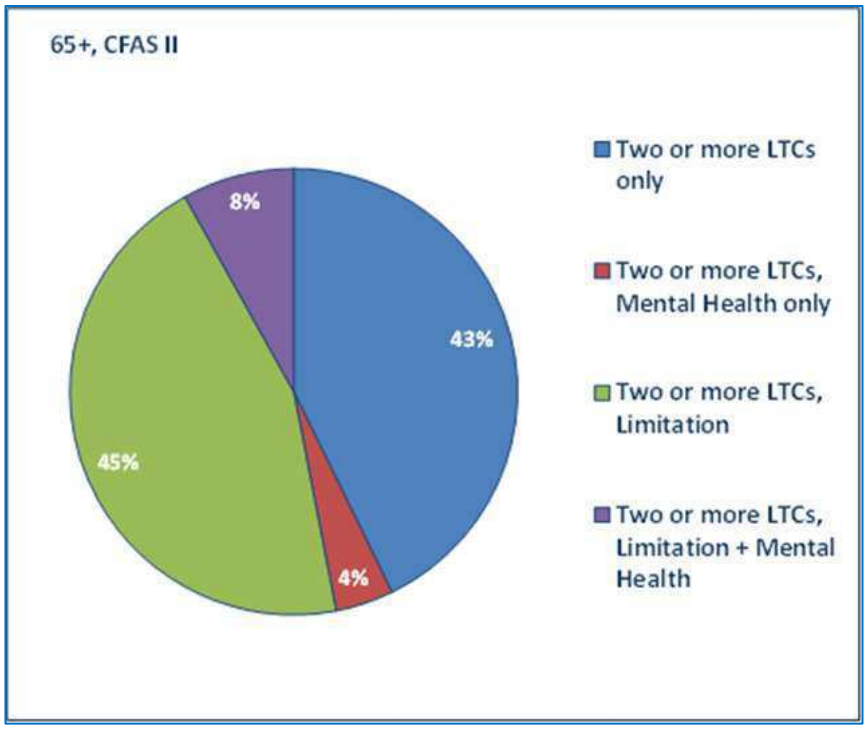
Proportion of people aged 18-64 years with multiple (two or more) long standing illnesses with and without limitation and/or mental ill health (based on GHQ-12 score of four or more)

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 5 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 5: 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.[9] 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.

[9] Psychiatric Morbidity Survey 2010.

Annex D: Potential local implications of the Five Year Forward View for Mental Health: calculations and assumptions

National commitment	Potential local implication
By 2020/21 A reduction in premature mortality of people living with severe mental illness (SMI). Physical care interventions to cover 30% of population with SMI on the GP register in 2017/18, moving to 60% in 2018/19.	Cambridge and Peterborough CCG in 2014/15 has 7,048 people with SMI (QOF data) on GP registers. Assuming levels remain the same as in 2017/18, this would mean 2,100 people with SMI (30%) will have physical care interventions, moving to 4,200 (60%) in 2018/19.
By 2020/21 25% of people with common mental health disorders will access services each year.	The Cambridgeshire and Peterborough CCG adult population (18+) is estimated to be 723,145 by 2021 (ONS population forecasts based on mid 2014). The prevalence of common mental health disorders is estimated to be 16.2% in the adult population (2007 Adult Psychiatric Morbidity Survey) or 117,150 people by 2021. 25% of this group is roughly 29,300 people with common mental health disorders.
By 2020/21, increase access to specialist perinatal mental health support in all areas in England, in the community or inpatient mother and baby units, allowing at least an additional 30,000 women each year to receive evidence based treatment.	In Cambridgeshire and Peterborough in 2014 there were 10,431 still and live births. The estimated number of women who may require additional support and/or appropriate onward referral for mental health problems during pregnancy and and/or the postnatal period is based on the NICE benchmark rate of 12% of deliveries or 120 per 1000 deliveries. This includes 4% of deliveries to women with severe and/or complex needs and 8% of women who require and take up psychological therapies. https://www.nice.org.uk/guidance/cg192 This suggests that locally annually 1,250 women will need additional support for mental health problems during pregnancy and/or the postnatal period, with approximately 420 (or 4%) of this group having severe and complex needs.
By 2020/21 at least 70,000 additional children and young people each year will receive evidence-based treatment. At least 35% of CYP with a diagnosable mental health condition receive treatment from an NHS-funded community MH services.	By 2021 it is estimated that there will be 201,000 children and Young people aged under 18 in Cambridgeshire and Peterborough. Prevalence estimates (Mental health of children and young people in Great Britain, 2004, ONS) suggest approximately 9.6% of children aged 5-16 years will have a diagnosable mental health disorder. Applying these estimates to all those under the age of 18 this suggests there would be 19,300 children and young people in Cambridgeshire and Peterborough under age of 18 by 2021 with a diagnosable mental health condition. Therefore, 6,755 (35%) of these children and young people would be receiving treatment a year by 2021*.
By 2020/21 the number of people taking their own lives will be reduced by 10% nationally compared to 2016/17 levels.'	Using 2015 as the baseline year, by 2020/21 this would mean the number of people taking their own lives will be reduced by 10% to 54 deaths from 2015 levels. **

*This is based on the 2004 psychiatric morbidity study and this is current being revised.
**A three year rolling average is a more reliable measure of progress given the small numbers.

Annex E: Further information on 'invest to save' priorities

The Priorities for Mental Health: Economic report for the NHS England mental health taskforce highlighted nine areas for investment as follows. Further detail from this report and other relevant reports is in the table below.

Prevention and early intervention

- Identification and treatment of maternal depression and anxiety during the perinatal period, including as a preventive measure against the development of mental health problems in children.
- Treatment of conduct disorder in children up to age 10.
- Early intervention services for first-episode psychosis.

Physical health conditions

- Expanded provision of liaison psychiatry services in acute hospitals, particularly in support of elderly inpatients.
- Integrated physical and mental health care in the community for people with long-term conditions and co-morbid mental health problems.
- Improved management of people with medically unexplained symptoms and related complex needs.

Improved services for people with severe mental illness

- Expanded provision of evidence-based supported employment services.
- Community-based alternatives to acute inpatient care at times of crisis.
- Interventions to improve the physical health of people with severe mental illness.

Initiative	**Evidence***
Perinatal mental health	Some 15-20% of women suffer from depression or anxiety during pregnancy or in the first year after childbirth, but about half of all these cases go undetected and untreated. This is damaging and costly, not only because of the adverse impact on the mother but also because maternal mental illness roughly doubles the risk of subsequent mental health problems in the child. According to one estimate, the long-term cost to society of a single case of perinatal depression is around £74,000, mostly because of adverse impacts on the child. The effective treatment of mothers offers the genuine prospect of primary prevention in relation to the development of mental health problems in children. The available evidence strongly supports the provision of psychological therapy as the most effective intervention, but this is currently available to only a small minority. Improving the identification of perinatal depression and anxiety (via more screening and assessment) and providing psychological therapy to all who would benefit in line with NICE waiting time standards it is estimate would lead to subsequent reductions in health service use by both mothers and children would more than cover this cost over time, with about two-thirds of costs being recovered within five years.
Liaison psychiatry	An initial return of £3 for every £1 invested, in line with the findings of the RAID roll-out study, falling over time to £2.50 is estimated from investment in liaison psychiatry.

Initiative	Evidence*
	It is important that new - and indeed existing - services are targeted at those areas of activity which the evidence suggests will yield the greatest benefits. In terms of support for inpatients, this is particularly likely to mean a strong focus on elderly people. Similarly, in emergency departments, services should seek to work with those who make heavy use of A&E, keeping a register of frequent attenders combined with regular review of these patients and proactive case management. All the financial benefits of liaison support take the form of cost savings in those acute hospitals where liaison psychiatry is provided.
Early intervention psychosis	There is a strong case for in year savings. At a unit cost of £6,000 a year early intervention for psychosis has net cost savings of £2,510 per patient in year one and £6,728 per patient over three years. However, we have a good existing service, as Rightcare benchmarking information shows, that is already compliant to year 2 of NICE pathways.
Psychological interventions for those with Long Term Conditions	Common mental disorders (CMDs), which include depression and anxiety, are highly prevalent with long term conditions. Evidence consistently demonstrates that people with long term physical health conditions (LTCs) 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. 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. 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.[10] 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.
Parenting programmes for conduct disorder	Estimated public expenditure savings over the seven-year appraisal period amount to £3,758 per child, to be set against an intervention cost of £1,282. In other words, every £1 invested in the programme generates savings in public spending of £2.83. The breakdown of these savings is: NHS and social care £1,207 Education £2,215 Criminal justice £336

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

Initiative	Evidence*
	The largest savings thus accrue to the education sector, though the savings within health and social care are also almost enough to cover the full costs of the intervention on their own. Savings in the criminal justice system are small mainly because of the short time horizon of the appraisal, and over a longer period these would become the largest single item. Public sector savings over a five-year period, confined to health/social care and education, are roughly twice the cost of the intervention.
Medically Unexplained Symptoms (MUS)	The most costly 5% of patients with MUS cost the NHS around £3,500 a year, or £10,500 over three years. This compares with an intervention cost of around £1,350 per patient, again based on the PCPCS model. If the service reduces the use of health care by just 15% a year for three years, this would more than cover the full costs of intervention. Proportionate cost savings of this magnitude are well within the range suggested by the available literature.
Employment support **Individual Placement Support (IPS)**	Individual Placement and Support (for those with severe enduring mental health problems) participants are twice as likely to gain employment compared with traditional vocational rehabilitation alternatives. Figures suggest (from Centre for Mental Health) that IPS pays for itself within a year (cost of intervention = £2,700, savings = £3,000). With a proportion of this saving a reduction in NHS hospitalisation (approx. 10% reduction), and reduction in bed days for those who were hospitalised. Current CCG IPS provision supports only a small proportion of those suitable (current investment of approx. £0.5m). The commissioning for value packs show poor CCG performance in this area compared to others.
Debt advice	Debt advice – medium level evidence, debt management intervention has better outcomes and lower costs over a two-year period compared to no action. The investment in debt advice can reduce the risk of developing mental health problems, the vast majority of the savings are in reductions in lost productivity. Debt advice services are patchy across the CCG.
Suicide prevention	It is estimated that the average cost per completed suicide for those of working age only in England is £1.67m (at 2009 prices).This includes intangible costs (loss of life to the individual and the pain and suffering of relatives), as well as lost output (both waged and unwaged), police time and funerals. The model looks at the economic case over 10 years for investing in GP suicide prevention education aimed at reducing suicide among the cohort of working age adults. Based on an earlier study, GPs who go on the suicide prevention training course will have a 20% greater chance of identifying those at risk of suicidal behaviour in the year following training.[vi] The model indicates that 603, 706 or 669 suicides would be avoided over the 1, 5and 10year time horizons, respectively. The analysis of costs/savings includes expenditure on health care, police/coroner activities, funerals, productivity and intangible costs. The additional treatment and support costs for individuals who do not complete suicide are to some extent offset by a reduction in the costs to the health care system of completed suicides and serious self harm events, but the intervention has significant net costs to the health care system of up to £19m over 10 years nationally. However, if the reductions in productivity losses are also included then the intervention is cost saving by a very large margin), and remains so even if the

Initiative	Evidence*
	estimated impact on productivity is reduced to just 5% of the baseline case. Overall, net savings of £1.27bn arise over 10 years if intangible costs are also included. All results are sensitive to assumptions about the future risk of suicide.
Workforce health	The evidence shows that initiatives to improve workplace health will produce in year savings in terms of productivity to the employer. Some studies suggest that there is a return on investment of approximately £9 for every £1 spent in terms of improved productivity to the employer. • 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.
Lifestyle interventions to improve the health of those with severe mental illness (SMI)	The prevalence of smoking is particularly high among mental health service users and interventions are just as effective in this group as in the rest of the population. Smoking cessation has been shown to be perhaps the single most effective and cost-effective intervention in the whole field of public health. Estimated savings are £100.8 million, spread over a number of years, due to reduced smoking-related NHS costs. More profoundly, those successfully quitting would on average gain an increase in life expectancy of around seven years.
Community-based alternatives to acute psychiatric inpatient care for people with severe mental health illness at times of crisis	There is growing evidence that when implemented as intended Crisis home resolution teams are effective in reducing admissions and reducing length of stay in hospital without any adverse impact on clinical outcomes. They are also preferred by patients. Initiatives, such as the mental health first response Vanguard service locally anticipate an impact on reducing attendances and admissions at A&E (10% -30% reduction in avoidances overall in year as shown in other areas), aiming for 2-3 years to break even financially.

*adapted from Health System Prevention Strategy for Cambridgeshire and Peterborough (Jan 2016), and Priorities for Mental Health: Economic report for the NHS England mental health taskforce. Centre for Mental Health (Jan 2016). Mental health promotion and mental health prevention: the economic case. LSE/PRSSU April 2011.

Annex F: Additional key references

Health System Prevention Strategy for Cambridgeshire and Peterborough January 2016
http://cambridgeshireinsight.org.uk/health/healthcare/prevention

Peterborough Mental Health and Mental Illness of Adults of Working Age
https://www.peterborough.gov.uk/healthcare/public-health/JSNA/

Suicide Audit
http://cambridgeshireinsight.org.uk/health/healthtopics/mh

The Mental health of Children and Young People in Cambridgeshire 2013
http://cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/mental-health-children-and-young-people

Fingertips
http://fingertips.phe.org.uk/

Public Health Outcomes Framework
http://cambridgeshireinsight.org.uk/health/phof

Annex G: Jargon Buster

2014 Care Act	The Care Act 2014 sets out carers' legal rights to assessment and support. It came into force in April 2015. The Care Act relates mostly to adult carers – people aged 18 and over who are caring for another adult. This is because young carers (aged under 18) and adults who care for disabled children can be assessed and supported under children's law.
Approved Mental Health Professional (AMHP)	AMHPs exercise functions under the Mental Health Act 1983. Those functions relate to decisions made about individuals with mental disorders, including the decision to apply for compulsory admission to hospital.
BAME	Black, Asian, and minority ethnic.
Better Care Fund	The Better Care Fund (BCF) is a programme spanning both the NHS and local government. It has been created to improve the lives of some of the most vulnerable people in our society, placing them at the centre of their care and support, and providing them with 'wraparound' fully integrated health and social care, resulting in an improved experience and better quality of life.
Child and Adolescent Mental Health Services (CAMHS)	CAMHS stands for Child and Adolescent Mental Health Services. CAMHS is a specialist NHS services. It offers assessment and treatment when children and young people have emotional, behavioural or mental health difficulties.
Common mental disorders (CMDs)	Common mental disorders (CMDs) comprise different types of depression and anxiety. They cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition. Although usually less disabling than major psychiatric disorders, their higher prevalence means the cumulative cost of CMDs to society is great.
Core 24 service	Core 24 Liaison Psychiatry services provide the minimum that is suggested by evidence to be beneficial to patients, in sites where demand for Liaison Psychiatry is constant enough for 24 hour care, seven days a week. These sites will most likely be situated in urban areas. Most commonly these services will see emergencies and urgent care patients.
CQUIN	The Commissioning for Quality and Innovation (CQUINs) payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare.
Crisis Care Concordat	The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.
Crisis Resolution and Home Treatment Teams (CRHTTs)	A 24-hour / seven-day-a-week community-based team providing assessment and home treatment as appropriate for people experiencing a mental health crisis.
Crisis Resolution Home Treatment	Crisis Resolution and Home Treatment teams have been introduced throughout England as part of a transformation of the community mental healthcare system. They aim to assess all patients being considered for acute hospital admission, to offer intensive home treatment rather than hospital admission if feasible, and to facilitate early discharge from hospital.
Dual Diagnosis	Dual Diagnosis is the term used to describe patients with both severe mental illness (mainly psychotic disorders) and problematic drug and/or alcohol use.

Early intervention in psychosis (EIP)	Early intervention in psychosis (EIP) promotes early detection and engagement to reduce the duration of untreated psychosis to less than three months. Specialist staff provide a range of interventions, including psychosocial interventions and anti-psychotic medications, tailored to the needs of young people with a view to facilitating recovery.
Five Year Forward View for Mental Health	'Implementing the Five Year Forward View for Mental Health', outlines the changes people will see on the ground over the coming years in response to the Mental Health Taskforce's recommendations to improve care.
Improving Access to Psychological Therapies (IAPT)	Improving access to psychological therapies is a national programme to increase the availability of 'talking therapies' on the NHS. IAPT is primarily for people who have mild to moderate mental health difficulties, such as depression, anxiety, phobias and post traumatic stress disorder.
Individual Placement and Support (IPS)	Individual Placement and Support (IPS) is a vocational rehabilitation intervention for people with severe mental disabilities. IPS draws from components and philosophies of several other models.
iTHRIVE	iTHRIVE focuses on children and young people's needs and preferences for care; prevention and promotion of mental health and emotional wellbeing; and active participation in decisions regarding care. It clearly defines treatment and support, self-management and intervention, shared decision making and collection of reference data.
Joint Strategic Needs Assessment (JSNA)	A Joint Strategic Needs Assessment (JSNA) looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning (buying) of health, wellbeing and social care services within a local authority area.
Liaison psychiatry	Liaison psychiatry, also known as psychological medicine, is the medical specialty concerned with the care of people presenting with both mental and physical health symptoms regardless of presumed cause.
Long term conditions (LTC)	A long term condition is defined as a condition that cannot, at present be cured; but can be controlled by medication and other therapies. Examples of long term conditions are diabetes, heart disease and chronic obstructive pulmonary disease.
Medically Unexplained Symptoms (MUS)	Many people have persistent physical complaints, such as dizziness or pain, that don't appear to be symptoms of a medical condition. These type of symptoms are sometimes known as 'medically unexplained symptoms' or 'functional symptoms' when they last for more than a few weeks, but doctors can't find a problem with the body that may be the cause. This doesn't mean the symptoms are faked or 'all in the head' – they're real and can affect your ability to function properly. Not understanding the cause can make them even more distressing and difficult to cope with. Medically unexplained symptoms are common, accounting for up to a fifth of all GP consultations in the UK.
Medication management	Medicines management supports better and more cost effective prescribing in primary care, as well as helping patients to manage medications better. Good medicines management can help to reduce the likelihood of medication errors and hence patient harm.
NICE	The National Institute for Health and Care Excellence provides national guidance and advice to improve health and social care.
NICE compliant pathway	This guideline covers care for people aged 18 and over with common mental health problems, with a focus on primary care. It aims to improve access to services for adults and how mental health problems are identified and assessed, and makes recommendations on local care pathways.
Perinatal mental health	Perinatal mental health refers to a woman's mental health during pregnancy and the first year after birth. This includes mental illness

	existing before pregnancy, as well as illnesses that develop for the first time, or are greatly exacerbated in the perinatal period.
Personality disorder (PD)	Personality disorders are conditions in which an individual differs significantly from an average person, in terms of how they think, perceive, feel or relate to others.
RAID	Rapid Assessment, Interface and Discharge (RAID) is a specialist mental health service, based in various hospitals, for anyone aged over 16. It aims to follow the patient's journey through rapid assessment, interface and discharge from start to finish.
S136 Mental Health Based Places of Safety	Section 136 of the Mental Health Act allows for someone believed by the police to have a mental disorder, and who may cause harm to themselves or another, to be detained in a public place and taken to a safe place where a mental health assessment can be carried out. A place of safety could be a hospital, care home, or any other suitable place where the occupier is willing to receive the person while the assessment is completed. Police stations should be only be used in exceptional circumstances.
Severe mental illness (SMI)	Serious mental illness includes diagnoses which typically involve psychosis (losing touch with reality or experiencing delusions) or high levels of care, and which may require hospital treatment.
Social prescribing	Social prescribing is a way of linking patients in primary care with sources of support within the community. It provides GPs with a non-medical referral option that can operate alongside existing treatments to improve health and wellbeing.
Socio-economic deprivation	The term socio-economic deprivation refers to the lack of material benefits considered to be basic necessities in a society.
Stop Suicide Campaign	The campaign, which is funded by NHS England and led by the charities Mind in Cambridgeshire, Peterborough and Fenland Mind and Lifecraft, is a suicide prevention campaign that seeks to empower communities and individuals across Cambridgeshire and Peterborough to help stop suicides by being alert to the warning signs, asking directly about suicide and helping those who are feeling suicidal to stay safe.
Sustainability and Transformation Programme	Sustainability and Transformation Plans (STPs) were announced in NHS planning guidance published in December 2015. NHS organisations and local authorities in different parts of England have come together to develop 'place-based plans' for the future of health and care services in their area. Draft plans were produced by June 2016 and revised plans were submitted in October. These plans now need to go through a process of assessment, engagement and further development.
Vanguard	Between January and September 2015, 50 vanguards were selected to take a lead on the development of new care models which will act as the blueprints for the NHS moving forward and the inspiration to the rest of the health and care system.

Agenda Item No: 12

PRIMARY CARE STRATEGY – FOCUS ON GP RECRUITMENT AND RETENTION IN CAMBRIDGESHIRE

To: Health and Wellbeing Board

Date: 19 January 2017

From: Jessica Bawden, Director of Corporate Affairs, Cambridgeshire and Peterborough CCG

1.0 PURPOSE

1.1 The Health Committee requested information from the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) on the General Practice Forward View (GPFV), with a focus on GP recruitment and retention in Cambridgeshire. Information provided in this report is for the whole of Cambridgeshire and Peterborough as moving forward it is essential to work as a whole system, however, where appropriate, specific data or information on Cambridgeshire has been included.

2.0 BACKGROUND

2.1 General Practice Forward View (GPFV)

Called 'the most significant announcement for general practice since the 1960's'[1], the GPFV was published in April 2016 as a response to the pressures facing general practice and outlines how the government plans to act. It contains specific, practical and funded steps on five areas: investment, workforce, workload, infrastructure and care redesign[2]. A brief overview of these areas can be seen in Appendix A.

The GPFV sets ambitious workforce aspirations to address the gaps and issues relating to the aging workforce. As well as aiming to recruit GPs, the GPFV also supports the development of new roles in General Practice to improve skill mix and to maximise the GP resource available.

The following paragraphs provide further information about some of the investment areas for which more detail is becoming increasingly available:

- *General Practice Resilience Programme - Nationally investing £40 million over 4 years, £16m identified for 16/17*

This programme is about buying direct support for practices who are defined as "good but challenged", and for whom support from a menu of interventions should support sustainability. It is managed by NHS England local teams with the commitment that it will be deployed as flexibly as possible. Practices have indicated whether they wish to be

[1] RCGP (2016) Maureen Baker, Chair comment on release of General Practice Forward View
[2] NHS England (2016) General Practice Forward View

considered for this fund and the CCG and NHS England locally are working closely to maximise the support available.

- *General practice national development programme - £30million nationally over 3 years.*

This investment is about managing workload differently and supporting groups of practices to implement the published 10 High Impact Actions. This is for less-challenged practices and will be wider in its application.
Practices or their CCG can submit an expression of interest form any time until summer 2018. They will be allocated an expert development advisor, who will help them plan their own Time for Care programme. It is expected that over the course of a typical 9-12 month programme, most practices could expect to release about 10% of GP time.
NHS England is also providing a new £45m fund over the next five years to support training for reception and clerical staff – it was stated that this would be devolved to CCGs and therefore sourced locally.

- *GP Access Fund*

This funding is being targeted at those areas of England which had successful pilot sites in 2015/16, known as the "Prime Minister's Challenge Fund" or "General Practice Access Fund" sites. Peterborough has been such an area and investment continues in 2016/17. The CCG is planning to receive additional funding in 17/18 and 18/19 to commission the associated additional access across the rest of Cambridgeshire.

- *Estates and Technology Transformation Fund*

This fund supports improvements in estate and technology. The schemes which have been supported in principle have now been confirmed by NHS England. Schemes supported for cohort 1 funding will need to complete by end of March 2017 rather than the previous expectation that resource will more closely reflect the length of time that premises improvement and technology developments take to implement. The CCG is working with practices to maximise the utilisation of confirmed resource across this and the subsequent two cohorts of funding.

The CCG is working closely with NHS England locally to ensure that the funding opportunities and support that the General Practice Forward View offers are accessed and used to their full potential for primary care in Cambridgeshire and Peterborough.

2.2 General Practice in Cambridgeshire and Peterborough

The CCG covers a diverse patient population of over 900,000. In common with other areas we have an aging population with significant inequalities and a mix of urban and rural districts.

The CCG has 105 member practices, making it one of the biggest CCGs in the country – it is also one of the most financially challenged. The local population is growing with people migrating to new developments in Huntingdonshire and established cities such as Cambridge and Peterborough. The population is also aging, resulting in patients increasingly developing complex and longer term conditions. The local workforce is not growing at the rate required to support demand and there is recognition from the system that the current model for the delivery of primary care needs to change from a GP delivered system to a multi-professional GP led system.

The CCG has been supporting local general practices to consider and develop organisational structures and models of care that enable them to work more closely and at scale. Three GP Federations are now operating across the county, including the Cambridge GP Network Ltd which consists of 32 member practices and 282,000 patients. The recent development of the local Sustainability and Transformation Plan (STP) builds on this and recognises the requirement to ensure the sustainability of Primary Care as the foundation of a strong and resilient health system. Integration with acute and community health services, social care and voluntary sector provision are an essential factor of future care models.

A Sustainable Primary Care Strategy Development Group has been meeting regularly to identify the wider strategy as well as shorter term steps that need to be taken to develop a sustainable future for primary care across Cambridgeshire and Peterborough. Key to delivery is implementation of the General Practice Forward View (GPFV), maximising the resource available through the committed investment and ensuring the engagement of local practices in the processes.

2.3 Workforce Development

Working in collaboration with the CCG, the Cambridgeshire and Peterborough Workforce Partnership (part of Health Education England, HEE) implemented a workforce development programme in 2015 to address some of the pressing workforce issues across the local system. In its first year it saw 54 per cent of the nursing workforce accessing Continuing Professional Development and 13 Practice Nurses commence an Advanced Nursing Practice Masters (MSc) at Anglia Ruskin University. The programme also saw 66 new apprenticeships starts across primary care; with 73 percent (n=48) of those being in general practice. A GP Fellowship programme was developed, supported by two of our provider Trusts, recruiting (over 2 years) 8 GPs to the local system (5 to Cambridge). The programme received recognition by the Health Service Journal by being shortlisted for its work in the 2016 HSJ Value in Healthcare Awards. A Workforce and Organisational Development plan for general practice forms part of the Sustainability and Transformation Plan for Cambridgeshire and Peterborough.

3.0 MAIN ISSUES

3.1 Pressures in General Practice

The challenges facing general practice are widely reported. Practices across Cambridgeshire and Peterborough are not immune to these pressures. As part of the work to understand the current issues and improve the sustainability, the CCG held two workshops in the summer of 2016 for member practice representatives to attend. In addition to the workforce challenges that this report covers, issues relating to increased demand and complexity of caseload; demanding practice administration and bureaucracy, navigating patients between the different health and social care provision; and having the space and time to plan for future service delivery, were identified as impacting on current capacity and ongoing sustainability. Perceived and actual pressures in general practice are a deterrent to recruitment. Local management to support new care models and

implementation of the aspirations of the GPFV are key to addressing these service delivery and small business pressures.

3.2 Workforce Profile

(See appendix C for Cambridge practice data)

The profiles for Cambridgeshire versus Peterborough differ significantly with the cost of living and local demographics among key factors having a noticeable impact on the workforce profile in each area.

The General Practice workforce across Cambridgeshire and Peterborough has a relatively young GP profile with only 18% of GPs over the age of 54. The age profile for GPs under the age of 35 in Cambridgeshire is below national average, at 13%, however Peterborough is in a more precarious position with just 6%. The general practice workforce in Cambridgeshire is GP dominated with 53% of the workforce being GPs. There are 0.51 nurses for every GP, which is in stark contrast to Peterborough where there are 0.9 nurses for every GP.

The aging General Practice Nurse (GPN) profile for Cambridgeshire is significantly higher than for Cambridgeshire and Peterborough, and nationally, with 44% aged over 54 years old. Here there are more GPNs aged over 60 than there are aged under 40. Just 5% of GPNs are aged under 35 years old. It is worth considering that there is likely a cycle of experienced nurses moving into General Practice after years in NHS Trusts, particularly Addenbrooke's, therefore the retiring workforce is being replaced with experienced and older nurses rather than recently qualified nurses. This does require further exploration but would explain why GP nurses are much older in Cambridgeshire – again, the price of living will also factor.

The percentage of the workforce that are classed as direct patient care (DPC) staff (e.g. Health Care Assistants, pharmacists, therapists, phlebotomists, administration) is in proportion to the rest of the country. Cambridgeshire and Peterborough has 39% of DPC staff in Health Care Assistant roles, which provide opportunities for staff development into professional roles, to address issues with an aging GPN population.

Patient demographics are positive, with lists being around 5% smaller per whole time equivalent GP than the national average.

3.3 Workforce Demand and Supply

The GPFV has set a national target of 5,000 more GPs by 2020 which equates to approximately 600 GPs in the east of England (using a population share of 10.6%). Assuming good retention, the supply pipeline has the potential to make good progress towards this requirement. It is important to note however, that to become a GP requires 5 years at medical school, 2 years in foundation training and then at least 3 years in GP specialty training. Therefore achieving the increase of 5,000 doctors in primary care cannot be achieved through increasing training places alone. There is work being undertaken nationally to attract UK-trained GPs working abroad back to UK practice. This work

encourages retention of current GPs and the return of those who have stopped clinical practice.

In Cambridgeshire and Peterborough, 54 GP specialty training posts have been allocated and filled in 2016. This is a 3 year programme (4 years for the 3 academic posts available in Cambridgeshire). The Cambridgeshire training scheme has an allocation of 22 posts which have all been filled.

It is more difficult to provide a supply forecast for general practice nurses as general practice isn't a defined branch of nursing, meaning that it is not possible to track university starters through training to completion. However, as suggested earlier, general practice nurses tend to have trained in the adult branch of nursing and generally move to general practice after they have spent time working in secondary or community care and are seeking a more traditional 9-5 work life.

3.4 Recruitment and retention

There are around 137 current GP vacancies across Cambridgeshire and Peterborough, with a high proportion of these in Peterborough, not Cambridgeshire.

Retention of GP specialist trainees (GPSTs) post completion of training in Cambridgeshire doesn't tend to be an issue with around 84% remaining taking employment opportunities here post completion of training (CCT). For the nursing workforce, historically practices have sought to employ experienced practice nurses rather than newly qualified; however with the aging GPN workforce profile this is changing. More practices are becoming open to the idea of recruiting newly qualified nurses and supporting them to develop general practice specific competencies as part of their induction or preceptorship. The high cost of living may have a negative impact on retention of newly qualified nurses in the local system, as would the draw from Addenbrooke's.

When compared to Peterborough, Cambridgeshire has a lower percentage of Advanced, Specialist or Extended nurses, at just 19%. This might suggest that the need to employ advanced, specialist or extended scope nurses hasn't been required as the Cambridgeshire system doesn't face the same challenges as Peterborough in plugging the gap left by GP recruitment challenges. However, with the aging GPN workforce; offering more opportunities linked to a career pathway would enhance the systems offer for career development which should contribute to increased recruitment of retention of a younger workforce. In addition, the future of general practice will look very different with an emphasis on a wider skill mix in teams – so considering the opportunities for expanding the multi professional and speciality team, not just in nursing, but in pharmacy, therapies and wider community care roles, is something that must be considered now as part of the recruitment and retention strategy.

3.5 Training

This year saw a significant reduction in Continuing Professional Development (CPD) for the non-medical workforce across both primary and secondary care nationally. Practices recognise the value in developing their staff; however pressures on small practice teams

often prevent staff being released from practice as they are unable to cover patient appointments. Practice nurse forums have been well established in the past and provided opportunities for group learning; however these have become less frequent recently. Moving forward, delivering primary care at scale and developing federations, there should be more opportunities to enable staff to be released for training.

The Peterborough and Huntingdon GP Federations secured funding from HEE to establish Community Education Provider Networks (CPENs). CEPNs are a mechanism for local systems to take ownership for a number of local workforce issues including workforce planning, education commissioning, new role development, and staff development. It is understood that should funding become available again, the Cambridgeshire system will apply for funding to establish their own CEPN. At the start of the year, the Cambridgeshire system surveyed their GPN workforce to understand the skills, competencies and training needs of their system. This information was feedback into the wider Cambridgeshire and Peterborough system, and helped to shape CPD training options for the whole area. Going forward, the assumption is that the Cambridge GP Network will use this information to shape the direction of their CEPN if established.

There is also insufficient change management and leadership capability across the system to manage the successful delivery of primary care at scale. In Cambridgeshire, the Cambridge GP Network has utilised external consultancy expertise to establish themselves as an entity but it is unknown if that support will continue.

3.6 Workload

Increasing patient demand and a reduced workforce has resulted in significant administration activities for GPs, many of whom spend a considerable amount of time responding to referral letters and the review and management of patient medications. The worried well, those undiagnosed but with rising risk, also contribute to the workload for both GPs and advanced nurses as more time is required to support these patients. Different types of appointments are increasingly offered, including telephone and online consultations. From a management perspective, back office functions are localised to practices and require time to manage effectively. GP Federations are exploring solutions that can be delivered at scale to address some of the local duplications of effort.

4.0 SOLUTIONS

4.1 Primary Care Strategy

The development of a local primary care strategy will combine the requirements of the national GPFV and the context of the local STP to set a sustainable direction for general practice in Cambridgeshire and Peterborough. The workforce challenges are just one illustration of the need for primary care to embrace new models of care, to maximise the resource that is available to meet the growing and more complex needs of the population. Solutions that see greater integration between practices and across health care providers will result in new roles and utilisation of the primary care workforce. The emphasis will be on creating efficient ways of working and directing clinical staff to clinical functions and away from administration and bureaucracy.

4.2 A workforce plan is being developed and will be finalised once the outcomes of the primary care strategy are published. The following are interventions which have been implemented since the start of this work in 2015 or areas being considered as key to the final plan:

- Understanding our supply pipeline. Develop a greater understanding of what newly qualified clinicians want and expect from careers which will allow the system to better tailor career opportunities
- Growing Our Own. Development routes which support unregistered staff into registrant roles should increase retention rates and improve the clinical competence of the local workforce. Apprenticeships, foundation degrees and flexible nursing pathways are some of the options already being utilised within the system.
- Retention of organisational knowledge. Ways to retain mature GPs and GPNs within the local system are being considered, for example flexible working, support with indemnity costs and new roles in education, mentoring, and commissioning
- Integration. Proving opportunities for portfolio working which will enable clinicians to work across settings to deliver care will not only provide varied career options for GPs but also enable GPs to enhance competencies in specific areas e.g. dermatology, palliative care etc., and improve relationships between primary and secondary care
- Centralisation of back office functions – for example outsourcing payroll, HR, and other activities would release practice workload and drive down costs if a number of practices shared a contract.
- Establishing true integrated care across the system is a key component of the STP plan to ensure patients are most efficiently supported along their pathway. The integration of both health and social care, and between general practice and wider neighbourhood, community teams, and secondary care should improve working relationships and the patient pathway.

Reviewing skill mix will be a key part of the strategy. Emerging clinical models must consider whether clinicians are being used to their fullest potential; and if the workforce has the required skills, knowledge and competencies to address our population's needs. We will be working with practices, taking direction from the General Practice Forward View and local initiatives, to consider how expansion of the multi-professional workforce and new roles will support appropriate delegation of tasks. Nationally, the General Practice Forward View, Health Education England and NHS England have committed to place and train: 1,000 Physician's Associates (PAs), an extra 1,500 Clinical Pharmacists, and 3,000 Mental Health therapists.

- To date, Cambridgeshire and Peterborough have supported clinical placements for three PAs in two of our practices.
- Practices chose not to engage in the first Clinical Pharmacy pilot; however we have 6 clinical pharmacists employed in practice at present, with more practices keen to understand the cost and quality benefits.
- Mental health therapists can work across a number of areas in primary care and it is important for general practice to work with the wider system, to understand how these roles can best be grown. Expansion of the traditional GP team may also bring opportunities to attract clinicians into primary care roles from other specialities which may be over supplied at present.

5.0 IMPLICATIONS

5.1 This paper is linked to and informed by the GP Forward View as referenced.

5.2 As noted, our member practices and local stakeholders have been included in the design and delivery of workforce interventions to date. We are working with our local system to shape and design the STP Sustainable Primary Care Strategy which is due for submission on 23 December 2016.

6.0 RECOMMENDATION/DECISION REQUIRED

6.1 The Health and Wellbeing Board is required to comment upon and note this report.

Authors:
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02 December 2016

7.0 SOURCE DOCUMENTS

Source Documents	Location
General Practice Forward View	NHS England (2016) https://www.england.nhs.uk/ourwork/gpfv/

Appendix A – General Practice Forward View on a page
See attached PDF

Appendix B – Primary Care Workforce Development Programme leaflet
See attached PDF

Appendix C – Workforce Minimum Data set information for Cambridge practices only – September 2015 collection
See next page

Appendix C

Workforce Minimum Data set information for Cambridge practices only – September 2015 collection

Data taken from the Workforce Minimum Data set - a national bi-annual collection exercise.

We are unable to extract data from the March 2016 WMDs for just Cambridge practices at this time, however there will not be a big variation from the Sep 2015 data shown

Exclusion Criteria
This Benchmarking tool uses submitted data only; no estimates are included for missing data:
- Sep 2015 = 100% return (for 36 Cambridge practices)
- There are known errors in Registrar and Retainer data therefore these have been excluded.
- Locums have also been excluded as NHS Digital provided no breakdown which excludes Registrars and Retainers only.

Cambridge Practices - WMDs Sep 2015 return Cambridge and Cam Health LCGs				
Submission rate = 100%				
Counts				
Headcount: Total GPs excluding Retainers, Registrars and Locums	220			
Headcount: Total Nurses	132			
Headcount: of which Advanced, Specialist and Extended Nurse Roles	23			
Headcount: of which District Nurses	0			
Headcount: Total DPC	108			
Headcount: of which Therapists (DPC)	1			
Headcount: of which Pharmacists (DPC)	5			
Headcount: of which Physician Associates (DPC)	0			
Headcount: Total Admin and Management	445			
FTE count: Total GPs excluding Retainers, Registrars and Locums	175			
FTE count: Total Nurses	90			
FTE count: of which Advanced, Specialist and Extended Nurse Roles	17			
FTE count: of which District Nurses	0			
FTE count: Total DPC	68			
FTE count: of which Therapists (DPC)	0			
FTE count: of which Pharmacists (DPC)	3			
FTE count: of which Physician Associates (DPC)	0			
FTE count: Total Admin and Management	311			
Patients: Total Patients	323134	Averages		
Ratios		**C&P**	**EoE**	**National**
Patients: % of Patients aged over 74	7%	7%	8%	8%
Patients: % of Dispensing Patients in Total Patients	17%	16%	12%	6%
GP demographics: % of GPs aged under 35 (Headcount)	12%	13%	13%	19%
GP demographics: % of GPs aged over 54 (Headcount)	18%	18%	22%	20%
GP demographics: % of Partnered GPs (FTE)	79%	75%	79%	69%
Nurse demographics: % of Nurses aged under 35 (Headcount)	5%	7%	7%	7%
Nurse demographics: % of Nurses aged over 54 (Headcount)	42%	33%	32%	31%
Nurse demographics: % of Trainee Nurses (Headcount)	0.0%	0.5%	0.4%	0.5%
DPC demographics: % of DPC aged under 35 (Headcount)	18%	22%	17%	17%
DPC demographics: % of DPC aged over 54 (Headcount)	35%	29%	28%	26%
Capacity to population: Patients per GP (FTE)	1845	1923	2022	1954
Capacity to population: Patients per Nurse (FTE)	3600	2951	3671	3804
Capacity to population: Patients per DPC (FTE)	4740	3873	5039	6223
Skill mix: Ratio of Nurses to GPs (FTE)	0.51	0.65	0.55	0.51
Skill mix: % of Advanced, Specialist and Extended Nurses (FTE)	19%	25%	27%	23%
Skill mix: % of HCA in Total DPC (FTE)	39%	52%	50%	63%
Skill mix: Ratio of DPC to Nurses (FTE)	0.76	0.76	0.73	0.61

General Practice Forward View: On A Page

Maureen Baker (RCGP President) called this **"the most significant announcement for general practice since the 1960s."**

CHAPTER 1: £

- Investing a further **£2.4 billion by 2020/21 into general practice services**.
- This means that investment will rise from **£9.6 billion a year in 2015/16 to over £12 billion a year by 2020/21**.
- This includes recurrent and transformational funding
- Additionally a review on Carr-Hill formula in progress to ensure it reflects derivation and workload etc.

CHAPTER 2: WORKFORCE

- Create an extra **5,000 additional doctors working in general practice by 2020**
- Attract an extra 500 GPs from abroad and targeted £20,000 bursaries that have found it hardest to recruit.
- **A minimum of 5,000 other staff working in general practice by 2020/21**
  - ❖ *3,000 mental health therapists*
  - ❖ *1,500 pharmacists*
- **£206 million in support for the workforce through:**
  - ❖ ***£112 million (in addition to £31m already committed)*** *for the clinical pharmacist programme to enable a* ***pharmacist per 30,000 population***
  - ❖ ***£15 million national investment for nurse development support*** *including improving training capacity in general practice, increases in the number of pre-registration nurse placements and measures to improve retention of the existing nursing workforce and support for return to work.*
  - ❖ ***£45 million*** *benefitting every practice to support the training of current reception and clerical staff to play a greater role in navigation.*
  - ❖ *Investment by HEE in the training of* ***1,000 physician associates to support general practice.*** *Introduction of pilots of new medical assistant roles that help support doctors.*
  - ❖ ***£6 million investment*** *in practice manager development, alongside access for practice managers to the new national development programme.*

CHAPTER 3: WORKLOAD

Support for GPs to manage demand, unnecessary work, bureaucracy and integration with wider system

- **£16 million extra investment** in specialist mental health services to support GPs with burn out and stress.
- **£30 million** 'Releasing Time for Patients' development programme
- new standard contract measures for hospitals to stop work
- new four year **£40 million** practice resilience programme (plus an **additional £16m in 2016/17**)
- move to five yearly CQC inspections for good/outstanding practices
- introduction of a simplified system across NHS E, CQC and GMC, streamlining of payment for practices,& automation of common tasks.

CHAPTER 4: INFRA-STRUCTURE

- **£900m for premises and IT** (this is the continuation of the Primary Care Transformation Fund, now renamed)
- **£45m** for e-consultation support
- New rules to allow up to **100% reimbursement of premises developments**
- Over **18% increase in allocations to CCGs** for provision of IT services and technology for general practice

CHAPTER 5: CARE REDESIGN

- **Support to strengthen & redesign general practice by c**ommissioning and funding of services to provide extra primary care capacity across every part of England, backed by over **£500 million of funding by 2020/21** incl.**£171 million one-off investment** by CCGs starting in 2017/18, for practice transformational support, introduction of new Enhanced Multi-speciality Community Provider contract from April 2017.
- **New national three year 'Releasing Time for Patients' programme to reach every practice in the country to free up to 10 percent of GPs' time (£30m),** building on recent NHS England and BMA roadshows.

Cambridgeshire and Peterborough Clinical Commissioning Group

Health Education England

2016 and beyond

Focus on

Practice Nurse Supply

- Placement capacity
  - Mentoring
- Flexible pathways
- Preceptorship

Skill mix

- Pharmacy
  - ANP
- GP Fellowships
- Apprenticeships

System transformation

- Sustainable Transformation Programme
- Community Education Provider Networks'

Reach your potential in Cambridgeshire and Peterborough

Cambridgeshire and Peterborough Clinical Commissioning Group

Health Education England

Primary Care Workforce Development Programme – helping people reach their potential in Cambridgeshire and Peterborough

A collaborative programme between Cambridgeshire and Peterborough Workforce Partnership (Health Education England) and Cambridgeshire and Peterborough Clinical Commissioning Group.

"The PCWDP has had a great first year. Working in collaboration, the Workforce Partnership and the Clinical Commissioning Group have engaged stakeholders to design a programme to support and develop a sustainable Primary Care workforce capable of delivering new models of quality patient care. The solution was to design a multi-faceted programme of workforce transformation interventions which enables the local system to be in a position to deliver its new models of quality patient care whilst ensuring the sustainability of its workforce. The PCWDP has had a successful first year and is now working towards enhanced delivery and moving to a system owned programme."

Dr David Roberts
Chair, Primary Care Board
Cambridgeshire and Peterborough Clinical Commissioning Group

Our area

Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) has 105 GP practices as members across Cambridgeshire, Peterborough and parts of Hertfordshire and Northamptonshire.

We are the third largest CCG in England, responsible for providing NHS services to our 922,857 patient population.
The CCG is organised into six local groups (known as Local Commissioning Groups or LCGs). The six LCGs are part of the wider Clinical Commissioning Group

Programme enablers

- Collaborative working
  has enabled us to pool expertise from commissioners and providers
- Engagement
  our workforce have informed the strategic direction of the programme
- Whole workforce
  The programme recognises value of multi-disciplinary teams and skill mix

Reach your potential in Cambridgeshire and Peterborough

NHS Cambridgeshire and Peterborough Clinical Commissioning Group

NHS Health Education England

2015/16 Outcomes

Focus on supply and sustainability

Increasing competency

Increasing competency levels of our support workforce; developing skill mix within practice teams to enhance patient care, enhancing and promoting the development of skill mix within practice teams:

- **3 'Super HCA' programmes**
  "It has made me excited to learn again"
  A package combining an apprenticeship with 5 days of competency based training, and the care certificate for new staff. 26 HCAs on programme to date.

- 

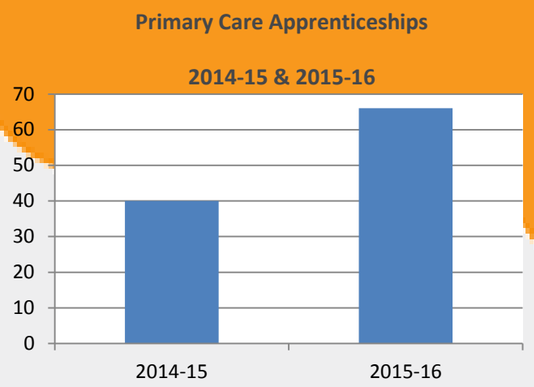
  Recruitment of Widening Participation Officer.
  Sallyann is the point of contact for support staff and Practices.
  She works closely with primary care, training providers and schools to encourage young people into roles in healthcare

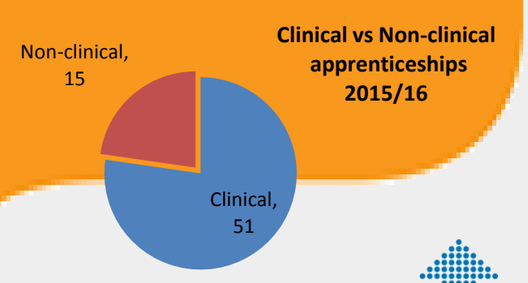
- **Modernising pharmacy roles**
  Practices are realising the impact on service and resource savings employing Pharmacists in Practice can provide. We have supported education of staff on local non-medical prescribing programmes and we are developing apprenticeship routes in to provide immediate support to teams and a new development pathway for support staff.

Infrastructure

Developing the infrastructure to increase the supply of future workforce:

- We have increased apprenticeships by 30% with the majority being clinical posts
- We have developed a streamlined process to engage practices with supporting pre-registration students and increased active placements. Work continues to provide great placement period to pre-reg nursing students.
- Development of GP Fellowship programme with links to secondary care.
  3 GPs employed in 15/16 with 10 applications received so far for 16/17.
- We established baseline data of our workforce by enhancing the results of the nWMDs with a qualitative survey





Reach your potential in Cambridgeshire and Peterborough

NHS Cambridgeshire and Peterborough Clinical Commissioning Group

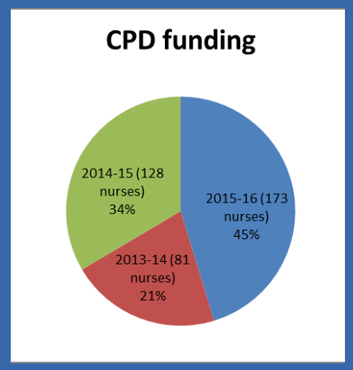
NHS Health Education England

Mechanisms

Increasing the mechanisms available to Practice Nurses for accessing education, training and career development to enhance the provision of patient care and lead to increased levels of workforce competency and satisfaction:

- Recruitment of Nurse Tutors

- Full utilisation of £180k CPD fund
  Significant increases in access to CPD from nurses can be attributed in part to tour Nurse Tutors actively promoting and supporting people to develop



- Successful delivery of educational programmes to support recruitment retention and returners in both GPN and GP – Fundamentals, ANP MSc and GP Fellowship
- Promotion of career development opportunities
  Our activities have been locally welcomed and nationally adopted with support from @WeGPNs, HEE nationally and Health Careers featuring our work on their careers pages.

"Being a General Practice Nurse" Film link

System engagement

To increase system engagement, enabling stakeholders contribute and benefit from the design, delivery and outcomes of the PCWDP

- PCWDP sub group – meets bi monthly and provides a multi professional forum to develop the programme
- Quantitative survey – a 44% return was received, very good for a survey of this type. This enhanced the national Minimum Data Set (nWMDs) and provided local intelligence about system issues and solutions which could then be shared.
- Team presence – significant presence and engagement at local nurse, GP, Practice manager and stakeholder forums
- Stakeholder support

Anglia Ruskin University

annie barr associates

Cambridgeshire LMC

Agenda Item No. 13

QUALITY PREMIUM

To: Health and Wellbeing Board

Date: 19 January 2017

From: Catherine Boaden
Head of Planning Cambridgeshire and Peterborough CCG

1.0 PURPOSE

1.1 This report informs the Health and Wellbeing Board on the construction of the Quality Premium that is available to CCGs for the financial years 2017/18 and 2018/19.

2.0 BACKGROUND

2.1 The Quality Premium scheme is run by NHS England and rewards Clinical Commissioning Groups (CCGs) for improving the quality of the services that they commission, improving health outcomes and reducing inequalities.

2.2 Under the Quality Premium scheme a CCG can receive up to £5 per head of population for achieving the indicators in the scheme. For Cambridgeshire and Peterborough CCG this is up to £4.7 m per annum.

2.3 In line with operational planning the scheme is being set up as a two year scheme for 2017/18 and 2018/19.

3.0 SUPPORTING PARAGRAPHS

3.1 The Quality Premium is allocated on the basis of passing a Quality Gateway, a Financial Gateway, a NHS Constitution Gateway and then achieving 6 indicators
Five of these indicators are set nationally and the sixth is set by the CCG in conjunction with the NHS Regional Team.

3.2 The Quality Gateway that must be passed to receive the Quality Premium is that there are no serious quality failures in the CCG. A serious quality failure is defined as:

- a local provider has been subject to enforcement action by the Care Quality Commission;
  or
- a local provider has been flagged as a quality compliance risk and/or have requirements in place around breaches of provider licence conditions; or a local provider has been subject to enforcement action based on a quality risk;
  and

- it has been identified through NHS England's assessment of the CCG, in respect of the quality and governance elements of the Improvement and Assessment Framework, that the CCG is not considered to be making an appropriate, proportionate response with its partners to resolve the above quality failure; and
- this continues to be the position for the CCG at the end of year assessment.

3.3 The Financial Gateway means that a CCG will not receive the Quality Premium if

- in the view of NHS England, during the relevant financial year the CCG has not operated in a manner that is consistent with the obligations and principles set out in Managing Public Money1;
  or
- the CCG ends the relevant financial year with an adverse variance against the planned surplus, breakeven or deficit financial position2, or requires unplanned financial support to avoid being in this position;
  or
- it receives a qualified audit report in respect of the relevant financial year.

3.4 The NHS Constitution Gateway means that the amount payable under the Quality Premium will be reduced by 25% for each of the following 4 NHS constitution targets that are not achieved:

- Maximum 18 weeks from referral to treatment
- Maximum 4 hour wait in Accident and Emergency Department
- Maximum 62 day wait from urgent GP referral to first definitive treatment for cancer
- Maximum 8 minute response time for Category A (Red 1) ambulance calls

3.5 If the CCG meets the above criteria it receives 17% of its calculated Quality Premium amount for achieving each of the following

- An improvement in the proportion of cancers diagnosed at an early stage
- Improvement in the overall experience of making a GP appointment
- Use of the continuing healthcare checklist and ensuring most assessments take place out of hospital
- Reducing the number of out of area placements for mental health patients, improving equity of access and outcomes in the IAPT service and access to children's and young people s mental health services
- Reducing the number of blood stream infections and in appropriate antibiotic prescribing

3.6 The final 15% of the possible Quality Premium amount is awarded for achieving a local indicator which is selected from the RightCare suite of indicators and is agreed with the NHS England Regional Team. At the time of writing this indicator is still being decided by the CCG in conjunction with NHS England.

4.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

The Quality Premium links to the following Health and Wellbeing strategy areas:

- Ensure a positive start to life for children, young people and their families
- Support older people to be independent, safe and well

- Encourage healthy lifestyles and behaviours in all actions and activities while respecting people's personal choices

5.0 IMPLICATIONS

5.1 Achieving the Quality Premium increases the resources available to the Health System. Achievement is linked to performance standards. There are no legal implications, equality and diversity implications, or specific engagement or consultation issues.

6.0 RECOMMENDATION/DECISION REQUIRED

6.1 The Health and Wellbeing Board is asked to comment upon and note the above information about the CCG Quality Premium scheme for 2017/2018 and 2018/2019.

7.0 SOURCE DOCUMENTS

Source Documents	Location
Annex to NHS England Planning Guidance Technical Guidance B Information on the Quality Premium	https://www.england.nhs.uk/wp-content/uploads/2015/12/ann-b-qual-prem.pdf

Author
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Improving Outcomes Team
Cambridgeshire and Peterborough CCG

Technical Guidance Annex B
Information on Quality Premium

Contents

1 Background

The Quality Premium (QP) scheme is about rewarding Clinical Commissioning Groups (CCGs) for improvements in the quality of the services they commission. The scheme also incentivises CCGs to improve patient health outcomes and reduce inequalities in health outcomes and improve access to services.

As in previous years, it is important that we retain a focus on the fundamentals of everyday commissioning. These include delivery of the NHS Constitution commitments on Referral to Treatment (RTT) Times, A&E, ambulance and cancer waiting times; adhering to quality regulatory standards, and delivering financial balance. The QP scheme will view CCG performance in the planning submissions round on the national and local priorities as well as on the fundamentals of commissioning to recognised standards.

2 Value

Under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), NHS England has the power to make payments to CCGs to reflect the quality of services that they commission, the associated health outcomes and reductions in inequalities.

In keeping with previous years, the maximum QP payment for a CCG is expressed as £5 per head of population, calculated using the same methodology as for CCG running costs, and made as a programme allocation. (This is in addition to a CCG's main financial allocation and in addition to its running costs allowance.)

3 Composition of the Quality Premium Scheme

This is a two year Quality Premium scheme. The QP paid to CCGs in 2018/19 and 2019/20 reflects the quality of the health services commissioned by them in 2017/18 and 2018/19. The QP award will be based on measures that cover a combination of national and local priorities, and on delivery of the gateway tests, as described below.

3.1 National and Local Indicators

There are five national measures and in total these are worth 85% of the QP (full details are set out in Appendix 1):

#	Indicator Name	Weighting
1	Early Cancer Diagnosis	17%
2	GP Access and Experience	17%
3	Continuing Healthcare	17%
4	Mental Health	17%
5	Bloodstream Infections	17%

CCGs can select one local indicator which will be worth 15% of the QP. The indicator should be selected from the RightCare suite of indicators – as set out in the Commissioning for Value packs, focussing on an area of unwarranted variation locally which offers the potential for CCGs to drive improvement.

The level of improvement needed to trigger the reward will be agreed locally between the CCG and NHS England regional team, ensuring that this is robust and offers a stretching ambition.

CCGs will be required to submit their locally agreed indicator definition and level of improvement (as agreed with the Regional Team) early in 2017 via UNIFY.

3.2 Quality Gateway

CCGs are responsible for the quality of the care and treatment that they commission on behalf of their population. NHS England reserves the right not to make any quality premium payments to a CCG in cases of serious quality failure, i.e. where it is identified that:

- a local provider has been subject to enforcement action by the Care Quality Commission; or
- a local provider has been flagged as a quality compliance risk and/or have requirements in place around breaches of provider licence conditions; or
- a local provider has been subject to enforcement action based on a quality risk; and
- it has been identified through NHS England's assessment of the CCG, in respect of the quality and governance elements of the Improvement and Assessment Framework, that the CCG is not considered to be making an appropriate, proportionate response with its partners to resolve the above quality failure; and
- this continues to be the position for the CCG at the end of year assessment.

As an alternative to withholding the Quality Premium in the circumstances above, NHS England may, at its discretion, make the quality premium available to the relevant CCG if the CCG agrees to use the quality premium payment to help resolve the serious quality failure.

It is important that the quality premium and assessment processes are well aligned. Should the assessment process criteria with respect to quality failure change during the two-year period, NHS England may amend the above criteria in order to maintain alignment with it, including if assessment criteria are introduced to identify quality failures within CCGs.

3.3 Financial Gateway

Effective use of public resources should be seen as an integral part of securing high-quality services. A CCG will not receive a quality premium if:

- in the view of NHS England, during the relevant financial year the CCG has not operated in a manner that is consistent with the obligations and principles set out in Managing Public Money[1]; or
- the CCG ends the relevant financial year with an adverse variance against the planned surplus, breakeven or deficit financial position[2], or requires unplanned financial support to avoid being in this position; or
- it receives a qualified audit report in respect of the relevant financial year.

[1] https://www.gov.uk/government/publications/managing-public-money
[2] CCGs are measured against all delegated budgets

3.4 NHS Constitution Gateway

As in previous years, a CCG may have its quality premium award reduced via the NHS Constitution gateway. In 2017/18, some providers will continue to have agreed bespoke trajectories, as part of the operation of the Sustainability and Transformation Fund, for delivery of RTT, four hour A&E, 62 day cancer waits and Red 1 ambulance response times. On this basis, the CCG gateway test in respect of these measures will be adjusted to reflect these differential requirements.

NHS Constitution requirement	Reduction to Quality Premium
Maximum 18 weeks from referral to treatment - incomplete standard	25%
Maximum four hour waits in A&E departments standard	25%
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	25%
Maximum 8 minute response for Category A (Red 1) ambulance calls	25%

In keeping with the need to keep the quality premium and CCG assessment processes well aligned, it is important to ensure alignment between the payment of the quality premium and the NHS Constitution Gateway. Should the measures in the NHS Constitution be updated, as occurred with RTT, or expectations around the operation of the Sustainability and Transformation Fund change, NHS England may amend the above criteria in order to maintain alignment.

4 Calculation and use of Quality Premium payments

The maximum QP payment for a CCG will be expressed as £5 per head of population, calculated using the same methodology as for CCG running costs. (This is in addition to a CCG's main financial allocation and in addition to its running costs allowance.)

For each measure where the identified quality threshold is achieved, the CCG will be eligible for the indicated percentage of the overall funding available to it. Where a CCG has failed to meet the requirements of the quality or financial gateways set out above, it will not receive a QP payment except where NHS England exercises its discretion with respect to the quality gateway.

Where a CCG does not deliver the identified patient rights and pledges on waiting times, or any bespoke trajectories towards these (in the case of CCGs who commission from providers in receipt of the Sustainability and Transformation Fund (STF)), a reduction for each relevant NHS Constitution measure will be made to the QP payment.

It is planned that CCGs will be advised of the level of their QP award in quarter 3 of the following financial year. In order to maximise its ability to make the most effective

use of the payment within 2018/19 and 2019/20, each CCG should consider making plans for use of the payment in advance of this date, so that these plans can be implemented as soon as the level of award is confirmed.

QP payments can only be used for the purposes set out in regulations[3]. These state that QP payments should be used by CCGs to secure improvement in:

- the quality of health services; or
- the outcomes achieved from the provision of health services; or
- reducing inequalities between patients in terms of their ability to access health services or the outcomes achieved.

CCGs may utilise the QP payment with other organisations to deliver the improvements above where appropriate wider powers are available for the use of the funding in this manner.

Each CCG is required[4] to publish an explanation of how it has spent a QP payment.

[3] The National Health Service (Clinical Commissioning Groups-Payments in Respect of Quality) Regulations 2013 (S.I. 2013/474)
[4] Section 223K(7) of the NHS Act 2006

Appendix 1: Quality Premium measures

Quality premium measure	Cancers diagnosed at early stage
Threshold	To earn this portion of the quality premium, CCGs will need to either: 1. Demonstrate a 4 percentage point improvement in the proportion of cancers (specific cancer sites, morphologies and behaviour*) that are diagnosed at stages 1 and 2 in the 2017 calendar year compared to the 2016 calendar year. For year 2 (2018/19) this will be the 2018 calendar year compared to the 2017 calendar year. Or 2. Achieve greater than 60% of all cancers (specific cancer sites, morphologies and behaviour*) that are diagnosed at stages 1 and 2 in the 2017 calendar year. For year 2 (2018/19) this will be the 2018 calendar year. Note: In year 2 the denominator may be amended to exclude cancer of unknown stage, this will require an amendment to the thresholds.
Value	17% of quality premium.
Rationale	Cancer survival rates in England have never been higher, but we know that we often lag behind the highest performing countries in the world in international comparisons. We also know that the earlier cancer is diagnosed, the more likely it is to be successfully treated, and survival rates can be dramatically improved. The independent cancer taskforce, in their report *Achieving World-Class Cancer Outcomes*, published in July 2015, set an ambition for the NHS that 62% of all cancers with known stage at diagnosis would be diagnosed at stages 1 and 2 by 2020. Achieving this target will require every CCG to focus on and make significant improvement in early stage diagnoses. Specific public health interventions, such as screening programmes and public information campaigns can aim to improve rates of early diagnosis. Supporting clinicians to spot cancers earlier and greater GP access to diagnostic and specialist advice were outlined in the Five Year Forward View as key planks of improving our diagnostic strategies. In addition, NICE published new guidance on appropriate referral for suspected cancer in 2015, which lowered the threshold of risk for symptoms suggestive of cancer to trigger an urgent referral for suspected cancer to 3%, with the aim of diagnosing more cancers at an early stage. An indicator on the proportion of cancers diagnosed at an early stage is therefore a useful measure for assessing improvement in early diagnosis and ultimately cancer survival. Improving cancer survival is one of the three key ambitions outline in *Achieving World-*

	Class Cancer Outcomes. Thresholds have been set based on levels of improvement previously seen amongst high-performing CCGs and felt to be achievable for the majority of CCGs.
Technical definition	New cases of cancer diagnosed at stage 1 and 2 as a proportion of new cases of cancer diagnosed (specific cancer sites, morphologies and behaviour*) **Numerator:** Cases of cancer diagnosed at stage 1 or 2, for the specific cancer sites, morphologies and behaviour* **Denominator:** All new cases of cancer diagnosed at any stage or unknown stage, for the specific cancer sites, morphologies and behaviour* *invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary, uterus, non-Hodgkin lymphomas, and invasive melanomas of skin.
Data source	Cancer Analysis System, National Cancer Registry, Public Health England
Published Frequency & Timeliness	Data will be a rolling window of one year's worth of data. The data will be lagged by 12 months.

Quality Premium measure	Overall experience of making a GP appointment
Threshold	To earn this portion of the quality premium, CCGs will need to demonstrate in the July 2018 publication, either: • Achieve a level of 85% of respondents who said they had a good experience of making an appointment, or; • A 3 percentage point increase from July 2017 publication on the percentage of respondents who said they had a good experience of making an appointment.
Value	17% of quality premium.
Rationale	The GP Patient Survey (GPPS) seeks the views of 2.4 million people every year about their experience of GP services and results are published at GP practice level. The survey gives patients the opportunity to provide feedback on a number of aspects of their experience of their GP practice, and provides a rich source of quantitative data on patients' experiences of the access and quality of care they receive. Access to GP services, and, in particular, the ease of making an appointment is a key measure of patient experience, and affects the wider healthcare system as patients who find it difficult to access GP services may seek care through emergency services inappropriately. Q18 ("Overall, how would you describe your experience of making an appointment?") of the GP Patient Survey (GPPS) is the "litmus test" indicator in this regard. Attaching a quality premium payment will also ensure that the profile and importance of insight about patient experience is underlined and it will incentivise the wider system to review and learn from the findings of the GPPS.

Technical definition	Question 18: Overall, how would you describe your experience of making an appointment? • Very good • Fairly good • Neither good nor poor • Fairly poor • Very poor **Numerator:** the weighted number of people answering 'very good' or 'fairly good' to question 18 of the GP Patient Survey. This is expressed as $\Sigma_k(wt\_new_k)$ where k = 1, …, p which are all respondents who answer question 18 with either answering 'very good' or 'fairly good' . **Denominator**: the total weighted number of people who answer question 18 of the GP Patient Survey. This is expressed as $\Sigma_j(wt\_newj)$ where j = 1, …, q which are all respondents who answer question 18 **Weighting** A weight is applied to construct the indicator. The GP Patient Survey includes a weight for non-response bias (wt_new). This adjusts the data to account for potential differences between the demographic profile of all eligible patients in a practice and the patients who actually complete the questionnaire. The non-response weighting scheme has been developed by Ipsos MORI, incorporating elements such as age and gender of the survey respondent as well as factors from the area where the respondent lives such as level of deprivation, ethnicity profile, ACORN classification and so on, which have been shown to impact on non-response bias within the GP Patient Survey. Further information on the current weighting scheme can be found in the survey's technical annex.
Data source	Data for this indicator is from the GP Patient Survey. This survey is commissioned by NHS England and is conducted by the independent survey organisation Ipsos MORI.
Published Frequency & Timeliness	Publication will be in July representing data collection from January to March.

Quality Premium measure	NHS Continuing Healthcare
Threshold	This is a two part indicator: Part a) worth 50% To achieve the Quality Premium for this part, CCGs must ensure that in more than 80% of cases with a positive NHS CHC Checklist, the NHS CHC eligibility decision is made by the CCG within 28 days from receipt of the Checklist (or other notification of potential eligibility) Part b) worth 50% To achieve the Quality Premium for this part, CCGs must ensure that less than 15% of all full NHS CHC assessments take place in an acute hospital setting.
Value	17% of quality premium.

Rationale	Part a) The time that elapses between the Checklist (or, where no Checklist is used, other notification of potential eligibility) being received by the CCG and the funding decision being made should, in most cases, not exceed 28 days. CCGs should make all reasonable efforts to ensure the required information or participation is made available within 28 days. This should include developing protocols with services likely to be regularly involved in NHS Continuing Healthcare eligibility processes that reflect the need for information or participation within 28 days. Where the CCG commissions the service from which information or participation is regularly required, it may be appropriate to consider placing such expectations within the specification for the relevant service. Part b) It is preferable for eligibility for NHS Continuing Healthcare to be considered after discharge from hospital when the person's long-term needs are clearer, and for NHS-funded services to be provided in the interim. This might include therapy and/or rehabilitation, if that could make a difference to the potential further recovery of the individual in the following few months. It might also include intermediate care or an interim package of support in an individual's own home or in a care home. It should always be borne in mind that assessment of eligibility that takes place in an acute hospital may not always reflect an individual's capacity to maximise their potential. This could be because, with appropriate support, that individual has the potential to recover further in the near future. It could also be because it is difficult to make an accurate assessment of an individual's needs while they are in an acute services environment. Anyone who carries out an assessment of eligibility for NHS continuing healthcare should always consider whether there is further potential for rehabilitation and for independence to be regained, and how the outcome of any treatment or medication may affect ongoing needs. In order to address this issue and ensure that unnecessary stays on acute wards are avoided, there should be consideration of whether the provision of further NHS-funded services is appropriate. This might include therapy and/or rehabilitation, if that could make a difference to the potential of the individual in the following few months. It might also include intermediate care or an interim package of support in an individual's own home or in a care home. In such situations, assessment of eligibility for NHS Continuing Healthcare should usually be deferred until an accurate assessment of future needs can be made. The interim services (or appropriate alternative interim services if needs change) should continue in place until the determination of eligibility for NHS continuing healthcare has taken place. There must be no gap in the provision of appropriate support to meet the individual's needs.

Technical definition	Part a) In 80% of cases with a positive NHS CHC Checklist, the NHS CHC eligibility decision is made by the CCG within 28 days from receipt of the Checklist (or other notification of potential eligibility) This applies to new referrals and not reviews of existing NHS CHC cases or Previously Unassessed Periods of Care cases. **Elapsed time calculation:** **Clock starts:** 28 days referral time starts from the date the CCG receives any type of recorded decision that full consideration for NHS CHC is required i.e. a positive checklist or other notification of potential eligibility **Clock stops:** At the date the CCG makes a decision on eligibility. **Numerator:** Number of NHS CHC eligibility decisions where the CCG makes a decision within 28 days of receiving any type of recorded decision that full consideration for NHS CHC is required i.e. a positive checklist or other notification of potential eligibility (N.B. will always be a subset of the denominator figure) **Denominator:** Total number of NHS CHC eligibility decisions made within the financial year (sum of quarterly data) This will then provide a percentage of NHS CHC referrals that have been completed within 28 days The collection method uses both in-built data validations at point of entry and data quality checking post collection. The data collection is accompanied by guidance and definitions Part b) **Numerator:** Number of full comprehensive NHS CHC assessments completed whilst the individual was in an acute hospital in the relevant financial year (sum of quarterly data) **Denominator:** Total number of full NHS CHC assessments completed in the financial year (sum of quarterly data) This will then provide a percentage of full NHS CHC assessments that were completed in an acute hospital in the relevant financial year (sum of quarterly data). The collection method uses both in-built data validations at point of entry and data quality checking post collection. The data collection is accompanied by guidance and definitions.
Data source	NHS England NHS CHC report (the collection is presently covered by BAAS approval until 30th June 2018).

Published Frequency & Timeliness	Quarterly data collection to begin Q1 1718 Not currently published. Data available 55 working days after quarter end e.g. quarter 1 data will be available in quarter 2.

Quality premium measure	**Mental Health** This Quality Premium measure consists of three discrete indicators from which one will be chosen based upon the inequality most pertinent to a given CCG a) Out of area placements (OAPs) b) Equity of Access and outcomes in to IAPT services c) Improve inequitable rates of access to Children & Young People's Mental Health Services The CCG and NHSE Regional Team will agree the indicator most pertinent to the CCG. Only one element will be applied to a given CCG and so each element will be worth 100% of the Quality Premium payment available for this indicator.
Threshold	Each element of the quality premium has specific thresholds as follows: **Part a) OAPs:** a reduction in the number of inappropriate adult OAPs for non-specialist adult acute care. Total number of bed days relating to out of area placements to have reduced by 33% of the baseline number as at 1 April 2017. *NB – during 2017/18 this measure refers to adult acute, older adult acute and PICU beds only. In future years there is likely to be an expectation to reduce OAPs for all CCG-commissioned beds (e.g. Rehabilitation).* *A national definition of OAPs is included in guidance.* **Part b) Equity of Access and outcomes in IAPT services** 1. Recovery rate of people accessing IAPT services identified as BAME; improvement of at least 5 percentage points or to same level as white British, whichever is smaller. And 2. Proportion of people accessing IAPT services aged 65+; to increase to at least 50% of the proportion of adults aged 65+ in the local population or by at least 33%, whichever is greater in 2017/18; to increase to at least 70% of the proportion of adults aged 65+ in the local population, or by an additional 33% in 2018/19, whichever is greater. It is required that both elements must be met in order to meet this

	indicator. **Part c) Improved Access to Children & Young People's Mental Health Services** The required performance in 2017/18 is whichever is the greater of: 1. at least a 14% increase in the number of individual children and young people aged 0-18 with a diagnosable Mental Health condition starting treatment in NHS funded community services when they need it in 2017/18 based on 2016/17 baseline 2. the increase in activity necessary to enable 32% of children and young people aged 0-18 with a diagnosable Mental Health condition starting treatment in NHS funded community services when they need it in 2017/18 Similar tests will apply in 2018/19.
Value	17% of the Quality Premium CCGs and their NHS England Regional Teams will agree the indicator to be applied to that CCG, based upon the inequality most pertinent to that CCG.
Rationale	*The Five Year Forward View for Mental Health* placed a particular focus on tackling inequalities. Addressing this, a mandatory Mental Health element of the Quality Premium will focus on a number of key inequalities, allowing for the targeting of particular needs pertinent to local health economies and enabling CCGs to draw together resources in order to address local priorities. The quality premium will provide significant incentive for CCGs and their local partners to collaborate in pursuit of improvements in the quality of mental health outcomes. Based on NHS England's interpretation of a CCG's most pertinent needs in this area, this element of QP will be addressed against one of the following inequalities: **a) OAPs** People requiring acute mental health care should always receive evidence based treatment, close to home and in the least restrictive setting. Unfortunately we know that too many acutely unwell people, who require inpatient care, are sent far away from their friends and families at this time when they are particularly vulnerable. Evidence shows that people receiving care out of area have far worse outcomes than those receiving care locally and have a far higher

	incidence of suicide. Furthermore, OAPs are far more costly to provide which means that public funding is not being used to best effect. This is, of course, unacceptable, and *Implementing the Five Year Forward View for Mental Health* agreed to the Mental Health Taskforce recommendation that inappropriate OAPs for non-specialist acute mental health care should be eliminated. Some areas have already achieved this ambition, but there are still high levels of variation across the country. This is why OAPs are being included as a measure in the Quality Premium. **b) Equity of Access and outcomes in IAPT services** Improving access is a priority in the Five Year Forward View for Mental Health: by 2020/21 at least 25% of people with common mental health conditions should access services each year. In parallel, quality should be maintained and developed; including meeting existing waiting times and recovery standards, and improving access and outcomes for all adults. We know that people from Black, Asian and minority ethnic (BAME) communities can experience poorer outcomes from services than people who identify themselves as White British. In the most recently available national data (Quarter 4 2015/16) the recovery rates for people from Black Asian and minority ethnic groups were as much as 13.6 percentage points lower than the rate for people identified as White British. In addition, older people are under-represented in services, not accessing them as readily as people who are under 65 years of age. The percentage of over 65s completing a course of treatment is around 7% nationally, which is lower than the equivalent proportion of the adult population at approximately 13%. Service providers and commissioners should be taking action to ensure equity of access to and outcomes from IAPT services to people irrespective of any protected characteristics (as defined under the Equalities Act 2010) in line with their Public Sector Equalities Duties (PSED). They must also pay due regard to the need to reduce health inequalities between patients in access to and outcomes from IAPT services. There are examples of good practice in making IAPT services serve their whole population equally, and improving access for older people and outcomes for people from Black and Minority Ethnic groups is a

	good step towards this goal. **c) Improved rates of access to Children & Young People's Mental Health services** Children and young people are a priority group for mental health promotion and prevention, and *the Five Year Forward View for Mental Health* calls for *the Future in Mind* recommendations to be implemented in full. Early intervention and quick access to good quality care is vital – especially for children and young people. Waiting times should be substantially reduced, significant inequalities in access should be addressed and support should be offered while people are waiting for care. One in ten children has a diagnosable mental health disorder. This can range from short spells of depression or anxiety through to severe and persistent conditions that can isolate, disrupt and frighten those who experience them. Mental health problems in young people can result in lower educational attainment (for example, children with conduct disorder are twice as likely as other children to leave school with no qualifications) and are strongly associated with behaviours that pose a risk to their health, such as smoking, drug and alcohol abuse and risky sexual behaviour. Despite recognition that early intervention can be highly cost effective, a significant treatment gap persists. The last UK epidemiological study suggested that, at that time, less than 25% – 35% of those with a diagnosable mental health condition accessed support. Compounding this, data from the NHS benchmarking network and recent audits year on year reveal increases in referrals and waiting times, with providers reporting increased complexity and severity of presenting problems. This indicator seeks to address this inequitable treatment gap by improving access. Addressing the difficulties in accessing the help they need NHSE has committed to helping at least 70,000 more children and young people each year to access high-quality, evidence based mental health care when they need it by 2020/21. An increase of 14% accessing treatment is consistent with the national real terms improvement required to move 12 months ahead of the national trajectory, set out in *Implementing the Five Year Forward View for Mental Health*.
Technical definition	**a) OAPs –** a 33% or greater reduction in OAPS is required to receive the QP

	Numerator: Total number of bed days people sent inappropriately out of area as at year end 31 March 2018 **Denominator**: Total number of bed days people sent inappropriately out of area as at baseline defined by CCGs at year end **Source**: CAP collection on OAPs, due to be reporting from December 2016, MHSDS, Unify **b) IAPT Access** – satisfactory performance against both components required to receive the QP There are two components of the IAPT indicator, which is applicable in both 2017/18 and 2018/19, enabling both short and medium term improvement activity: **i.** **BAME Access:** Recovery rate of people accessing IAPT services identified as BAME; improvement of at least 5 percentage points or to same level as white British, whichever is smaller. **Numerator:** Number of people from BAME groups reaching recovery **Denominator:** Number of people from BAME groups completing treatment. **Source:** IAPT MDS, aggregated information necessary for this calculation to be available quarterly from December 2016. **ii.** **Older People's Access**: For 17/18 the proportion of people accessing IAPT services aged 65+ to increase to at least 50% of the proportion of adults aged 65+ in the local population, or by at least 33%, whichever is greater; for 18/19 the proportion of people accessing IAPT services aged 65+ to increase to at least 70% of the proportion of adults aged 65+ in the local population, or by an additional 33%, whichever is greater. **Numerator:** number of people entering treatment to IAPT Services aged 65+ as a proportion of total number of people entering treatment to IAPT Services **Denominator:** Total number of people aged 65+ in the local population. **Source:** IAPT MDS, aggregated information necessary for this calculation to be available quarterly from December 2016.

	ONS population data. Compliance is defined as achieving both components. **c) CYP- MH Access** – in order to achieve the QP, the required performance in 2017/18 is whichever is the greater of: 1. at least 14% increase in the number of individual children and young people aged 0-18 with a diagnosable Mental Health condition starting treatment in NHS funded community services when they need it in 2017/18 based on 2016/17 baseline, Or; 2. the increase in activity necessary to enable 32% of children and young people aged 0-18 with a diagnosable MH condition starting treatment in NHS funded community services when they need it in 2017/18 Similar tests will apply in 2018/19 **Numerator:** The number of children and young people aged 0-18 with a diagnosable MH condition starting treatment in NHS funded community services in the reporting period. **Denominator:** Baseline figure for total number of new, individual children and young people 0-18 with a diagnosable MH condition treated by NHS funded community services. **Source:** MHSDS. The expectation is that Q2 MHSDS data for 2016/17 will be multiplied by 4 and included in the planning template to provide an estimated baseline. You will have the opportunity in the data collection template to amend this baseline based Q4 data or local data if it is higher than the Q4 reported baseline.

Quality Premium Measure	**Reducing Gram Negative Bloodstream Infections (GNBSIs) and inappropriate antibiotic prescribing in at risk groups** This Quality Premium measure consists of three parts: Part a) reducing gram negative blood stream infections (BSI) across the whole health economy Part b) reduction of inappropriate antibiotic prescribing for urinary tract infections (UTI) in primary care Part c) sustained reduction of inappropriate prescribing in primary care The weighting for the 3 measures is as follows: Part A = 45% Part B= 45% Part C= 10%: Part A i) will be worth 35%. Part A ii) will be worth 10%; Part B i) will be worth 22.5% and part B ii) will be worth 22.5%; Part C will be worth 10%. Payment must be considered individually for each component of the QP as each part supports improvement within different areas which individually and collectively support the overarching ambition. This proposal outlines the details for the QP during 2017/18 however the main components of the QP should be maintained during 2018/19 to support a 2 year QP scheme. As outlined below, targets associated with each element will be reviewed so that more specific and ambitious targets can be set for 18/19.
Threshold	**Part a) reduction in the number of gram negative blood stream infections across the whole health economy. The required performance in 2017/18 must be:** i. a 10% reduction (or greater) in all *E coli* BSI reported at CCG level based on 2016 performance data (indicative and final targets will be made available in a following publication). In 2018/19 reduction thresholds will be reviewed against the latest activity to ensure the QP supports the maximum appropriate reduction gains. ii. collection and reporting of a core primary care data set for all E *coli* BSI in Q2-4 2017/18. This will require completion of requisite data through the existing PHE DCS reporting system for E coli BSI and the refined data collection for primary care related aspects. Further details will be available in following publications. Collection and reporting of a core primary care data set for all E coli BSI will continue during 2018/19.

	Part b) reduction of inappropriate antibiotic prescribing for UTI in primary care. The required performance in 2017/18 must be: iii. a 10% reduction (or greater) in the Trimethoprim: Nitrofurantoin prescribing ratio based on CCG baseline data (June15-May16) for 2017/18. In 2018/19 reduction thresholds will be reviewed to ensure targets reflect latest activity and maximise appropriate reduction gains. iv. a 10% reduction (or greater) in the number of trimethoprim items prescribed to patients aged 70 years or greater on baseline data (June15-May16) for 2017/18. In 2018/19 reduction thresholds will be reviewed to ensure targets reflect latest activity and maximise appropriate reduction gains. **Part C) sustained reduction of inappropriate prescribing in primary care** i. items per STAR-PU must be equal to or below England 2013/14 mean performance value of 1.161 items per STAR-PU. This threshold will remain during 2018/19.
Value	17% of quality premium
Rationale	Work to develop and deliver this Quality Premium directly responds to the ambitions set by Government following the O'Neill Review on Antimicrobial Resistance (May, 2016). These ambitions include a: • 50% reduction of Gram Negative Bloodstream Infections (GNBSIs) by 2020 • 50% reduction of the number of inappropriate antibiotic prescriptions by 2020 It also enables work (across the ALBs) to support the UK 5 Year AMR Strategy (2013-2018), which states that there are few public health issues of greater importance than antimicrobial resistance (AMR) in terms of impact on society. Infections are increasingly developing that cannot be treated and the rapid spread of multi-drug resistant bacteria means that we could be close to reaching a point where it is not possible to prevent or treat everyday infections or diseases. This work will support the other clinical priority areas, across NHS England and NHS Improvement, particularly through supporting the Sepsis agenda and by informing improvements in community care. It will assist Sustainability and Transformation Planning footprints to develop and deliver Sustainability and Transformation Plans - for which patient safety, and AMR specifically, are included as key priority areas – and local AMR plans (which are being lead and supported by PHE). **Part a) reducing gram negative blood stream infections across the whole health economy** Healthcare-associated Gram-negative bacteraemias (bloodstream

	infections) pose a significant health risk and threat to patient safety. They include infections caused by *Escherichia coli*, and *Pseudomonas aeruginosa.* Rates of bacteraemia caused by GNB vary depending on the bacterial species: • Mandatory surveillance of *Escherichia coli* (*E.coli)* has indicated an alarming rise in rates of *E. coli* bacteraemia (60.4 to 66.2 per 100,000 population from 2012- 2015). • Rates of *Pseudomonas spp*. and *Stenotrophomonas spp*. bacteraemia have decreased steadily. (6.9 to 6.2 per 100,000 and 1.3 to 0.8 per 100,000, respectively, from 2007-2014). • Rates of carbapenemase-producing enterobacteriaceae (CPE) are also increasing within the UK. • Health care acquired infections (HCAIs) associated with multi-drug resistant (MDR) Gram-negative species are of utmost importance due to the difficulties in treatment associated with the limited number of effective antibiotics. E.coli bacteraemia is the largest most prevalent group of GNBSI which supports the QP's focus on these bacteraemia over the next 2 years. The reporting of E.coli BSI is already mandatory (via the PHE DCS system) and this provides data on which to establish a baseline and set reduction targets for 2017/18. Reduction targets should be revised for 2018/19 when (through the work done as part of the 17/18 QP) we will understand where and how greater improvements can be supported. Reduction in other GNBSI should be considered in future years when systems should have been established to capture baseline data. **Part b) reduction of inappropriate antibiotic prescribing for UTI in primary care** The age group with the highest rates of E. coli bacteraemia in England were observed amongst the elderly (75 years and over) with 402.9 and 313.5 reports per 100,000 population for males and females respectively. The PHE enhanced data set reported to ARHAI 24-14 (01) for *E coli* BSI (including 3 months of data from 38 acute trusts Nov 2012-Jan 2013, reporting on 891 cases) stated that 50% of cases related to the urogenital tract, and in these 72% occurred in patients >65years, and 64% of patients had reported at least one UTI in the previous 12 months. This supports the focus of this element of the QP. The report states that: *is it clear that a significant proportion of the rise may be due to patients being prescribed inappropriate antibiotics, resulting in relapsing infections. It is important that antimicrobial prescribing is appropriate and effective. However, there remains a difficult balance between the clinical management of UTIs and the empiric prescribing of broad-spectrum antimicrobials due to increasing resistance to narrow spectrum antibiotics which limits available treatment options*. On-going mandatory surveillance continues to identify previous UTIs as a

	key risk factor. This indicator would work to increase the appropriate use of nitrofurantoin as 1st line choice for the empirical management of UTI in primary care settings, and support a reduction in inappropriate prescribing of trimethoprim which is reported to have a significantly higher rate of non-susceptibility in 'at risk' groups; these are defined in PHE Management of Infection Guidelines. Prescribing data also demonstrates the variation in prescribing practice across CCGs and further supports the view that this is an area that requires and is amendable to improvement. **Part C) sustained reduction of inappropriate prescribing in primary** This QP also aims to sustain improvements enabled by the previous QP which successfully delivered a reduction in the prescribing of antibiotics (by 7.3%, 2.6 million prescriptions), including board spectrum antibiotics (which reduced from 3.9m prescriptions in 2014-15 to 3.3m the following year) within primary care. CCGs will be expected to ensure items per STAR-PU are equal to or below England 2013/14 mean performance value of 1.161 items per STAR-PU.
Technical definition	**Part a) Reducing gram negative blood stream infections across the whole health economy** i. **A reduction target of 10% in all *E.coli* BSI reported at CCG level - independent of the time of onset of BSI**. Baseline rates will be set using 2016 performance data currently captured via the DCS system and published online. Indicative targets will be made available following publication of 2015/16 infection rates in October 2016. Final targets will be made available following the publication of 2016 data in early 2017. Performance will be measured using FY 2017/18 data. Thresholds will be reviewed for 2018/19 as highlighted above. To support the health economy to achieve this reduction CCGs will need to; ii. **Collect and report a core primary care data set for all *E.coli* BSI in Q2-4 2017/18.** This will require completion of requisite data through the existing PHE DCS reporting system for E.coli BSI and the refined data collection for primary care related aspects. Further details will be available in a following publication. CCGs are expected to use Q1 2017/18 to establish a local approach to capture the core primary care data. **Part b) reduction of inappropriate antibiotic prescribing for UTI in primary care.** Individual practice reduction to be decided by the CCG. **i. a 10% reduction (or greater) in the Trimethoprim: Nitrofurantoin prescribing ratio based on CCG baseline data (June15-May16). This threshold will be reviewed for 2018/19 as highlighted above.**

	Numerator: Number of prescription items for trimethoprim within the CCG **Denominator:** Number of prescription items for nitrofurantoin within the CCG **Prescribing Data** This information can be obtained from the electronic Prescribing Analysis and CosT tool (ePACT) provided by NHS Business Services Authority which cover prescriptions prescribed by GPs, nurses, pharmacists and others in England and dispensed in the community in the UK. Further information is available on the Information Services Portal. *(NB: this system will be moved to a new platform in January 2017 that will include an Antimicrobial dashboard to support this Quality Premium at CCG level)* For data at CCG level, prescriptions written by a prescriber located in a particular CCG but dispensed outside that CCG will be included in the CCG in which the prescriber is based. Prescriptions written in England but dispensed outside England are included. Prescriptions dispensed in hospitals, dental prescribing and private prescriptions are not included in the data. The data is to include prescribing by Out of Hours and Urgent Care services where relevant prescribing data is captured within the CCG data set. Cost centres that support Vanguard Integrated Urgent Care Hub prescribing may be excluded from the CCG data set (this can be agreed individually with NHS Improvement) **ii. a 10% reduction (or greater) in the number of trimethoprim items prescribed to patients aged 70 years or greater on baseline data (June15-May16) . This threshold will be reviewed for 2018/19 as highlighted above.** **Numerator:** Number of prescription items for trimethoprim with identifiable NHS number and age 70 years or greater within the CCG **Prescribing Data** This information will be obtained from the electronic Prescribing Analysis and CosT tool (ePACT) provided by NHS Business Services Authority which cover prescriptions prescribed by GPs, nurses, pharmacists and others in England and dispensed in the community in the UK. Further information is available on the Information Services Portal. *(NB. this system will be moved to a new platform in January 2017 that will include an Antimicrobial dashboard to support this Quality Premium at CCG level)* For data at CCG level, prescriptions written by a prescriber located in a particular CCG but dispensed outside that CCG will be included in the CCG in which the prescriber is based. Prescriptions written in England but dispensed outside England are included. Prescriptions dispensed in hospitals, dental prescribing and private prescriptions are not included in the data. The data is to include prescribing by Out of Hours and Urgent Care services where relevant prescribing data is captured within the CCG data set. Cost

	centres that support Vanguard Integrated Urgent Care Hub prescribing may be excluded from the CCG data set (this can be agreed individually with NHS Improvement). **Part C) sustained reduction of inappropriate prescribing in primary care** i. items/STAR-PU must be equal to or below England 2013/14 mean performance value of 1.161 items per STAR-PU. This threshold will remain during 2018/19 Numerator: Number of prescription items for antibacterial drugs (BNF 5.1) within the CCG **Denominator:** Total number of Oral antibacterials (BNF 5.1 sub-set) ITEM based Specific Therapeutic group Age-Sex Related Prescribing Unit (STAR-PUs) **Prescribing Data** This information can be obtained from the Information Services Portal (ISP) or the electronic Prescribing Analysis and CosT tool (ePACT) provided by NHS Business Services Authority which cover prescriptions prescribed by GPs, nurses, pharmacists and others in England and dispensed in the community in the UK. Further information is available on the Information Services Portal. For data at CCG level, prescriptions written by a prescriber located in a particular CCG but dispensed outside that CCG will be included in the CCG in which the prescriber is based. Prescriptions written in England but dispensed outside England are included. Prescriptions dispensed in hospitals, dental prescribing and private prescriptions are not included in the data. The data is to include prescribing by Out of Hours and Urgent Care services where relevant prescribing data is captured within ISP. Cost centres that support Vanguard Integrated Urgent Care Hub prescribing may be excluded from the CCG data set (this can be agreed individually with NHS Improvement).
Data source	**Part a) reducing gram negative blood stream infections across the whole health economy** For this part of the QP, data will be taken from PHE DCS system to both collect data for GNBSI and monitor progress on E coli BSI. This will be on the Fingertips AMR Portal **Part b) reduction of inappropriate antibiotic prescribing for UTI in primary care** The NHSBSA ePACT is moving to a new platform, and this will support reporting of prescription patient age data. The AMS dashboard will be

	developed and this will be pre-populated with relevant information for the CCG. Prescribing data for all elements of this part of the QP will be reported by NHS BSA on a monthly basis as a rolling 12 monthly value.
Published Frequency & Timeliness	**Part A:** The number E.coli BSIs are reported at a CCG level by PHE and published quarterly. Information will be available via the Fingertips AMR Portal. **Part B and C:** Prescribing data is reported monthly at a CCG level by NHSBSA Prescription Services. To support GNBSI QP performance monitoring both GNBSI QP antibiotic indicators will be reported monthly (with existing 3 month lag), as a rolling 12 monthly data set at CCG level. This will be presented in the antibiotic monitoring dashboard published on the NHS England QP web page. This follows the existing system to support the current QP activity. In addition the new ePACT platform on Oracle will allow the development of a dashboard to support CCGs to deliver these elements of the QP. This dashboard will also support the CCG IAF AMR indicators in the current AMR QP which will help support sustained QP activity into 2017-19.

HEALTH AND WELLBEING BOARD
FORWARD AGENDA PLAN

MEETING DATE	ITEM	REPORT AUTHOR	TO DEMOCRATIC SERVICES (R Greenhill) By:
19 January 2017 10.00am (Shire Hall)	**Health and Wellbeing Board**		
	Apologies and Declarations of Interest	Oral	**Thursday 5 January 2017**
	Minutes of the Meeting on 17 November 2016	Richenda Greenhill	
	Action Log Update	Richenda Greenhill	
	Person's story	Meredith Teasdale	
	Update on the HWB Development Session on 17 November 2016	Liz Robin/ Kate Parker	
	Developing the Better Care Fund Plan 2017-18	Geoff Hinkins	
	Priority 1 report from Children's Trust Executive Partnership	Meredith Teasdale	
	Update on actions arising from the New Communities Joint Strategic Needs Assessment (JSNA)	Iain Green	
	Pharmaceutical Needs Assessment	Kirsteen Watson	
	Cambridgeshire and Peterborough Health and Care System Sustainability and Transformation (STP) Programme	Tracy Dowling	
	Sustainability and Transformation (STP) Programme Memorandum of Understanding: Update	Liz Robin	
	Mental Health Strategy Framework	CCG	
	Primary Care Strategy	CCG	

MEETING DATE	ITEM	REPORT AUTHOR	TO DEMOCRATIC SERVICES (R Greenhill) By:
	Working Force Strategy	CCG	
	CCG Choice of Local Indicators	Sue Last	
	Forward agenda plan	Richenda Greenhill	
	Date of Next Meeting		
30 March 2017 10.00am (S.Cambs Hall, Cambourne)	**Health and Wellbeing Board**		
	Apologies and Declarations of Interest	Oral	**Thursday 16 March 2017**
	Minutes of the Meeting on 19 January 2017	Richenda Greenhill	
	Action Log Update	Richenda Greenhill	
	Person's story	TBC	
	Cambridgeshire and Peterborough Health and Care System Sustainability and Transformation Programme	Tracy Dowling	
	Developing the Better Care Fund Plan 2017-18	Geoff Hinkins	
	Dual Diagnosis of Mental Health and Substance Misuse Issues	Val Thomas	
	Report from the Public Health Reference Group	Liz Robin	
	Forward agenda plan	Richenda Greenhill	
	Date of Next Meeting		
1 June 2017 10.00am (Shire Hall)	**Health and Wellbeing Board** *(First meeting of municipal year)*		
	Election of Vice-Chairman/woman	Oral	**Wednesday 17 May**
	Apologies and Declarations of Interest	Oral	
	Minutes of the Meeting on 30 March 2017	Richenda Greenhill	
	Action Log Update	Richenda Greenhill	

MEETING DATE	ITEM	REPORT AUTHOR	TO DEMOCRATIC SERVICES (R Greenhill) By:
	Person's story	TBC	
	Better Care Fund Plan 2017-18	Geoff Hinkins	
	Cambridgeshire and Peterborough Health and Care System Sustainability and Transformation Programme	Tracy Dowling	
	Forward agenda plan	Richenda Greenhill	
	Date of Next Meeting		

To be included in the programme:

- Safeguarding Adults Board Annual Report for 2016-17: September 2017 tbc

Updated: 10.01.17