HEALTH SCRUTINY COMMITTEE

MONDAY 9 MARCH 2020
7.00 PM

Bourges/Viersen Room - Town Hall

AGENDA

Page No

1. Apologies for Absence

2. Declarations of Interest and Whipping Declarations

At this point Members must declare whether they have a disclosable pecuniary interest, or other interest, in any of the items on the agenda, unless it is already entered in the register of members' interests or is a "pending notification " that has been disclosed to the Solicitor to the Council. Members must also declare if they are subject to their party group whip in relation to any items under consideration.

3. Minutes of the Health Scrutiny Committee Meeting Held on 7 January 2020 **3 - 12**

4. Call In of any Cabinet, Cabinet Member or Key Officer Decisions

The decision notice for each decision will bear the date on which it is published and will specify that the decision may then be implemented on the expiry of 3 working days after the publication of the decision (not including the date of publication), unless a request for call-in of the decision is received from any two Members of the relevant Scrutiny Committee. If a request for call-in of a decision is received, implementation of the decision remains suspended for consideration by the relevant Scrutiny Committee.

5. Ambulance Service – Recent changes; Impact of changes; Vision; Performance and challenges **13 - 22**

6. NHS Long Term Plan Response **23 - 90**

7. Cabinet Portfolio Holder For Public Health Performance Report **91 - 106**

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Committee Members:

Councillors: Aitken (Chairman), A Ali, S Barkham, C Burbage, L Coles, S Hemraj, J Howell, S Qayyum, B Rush (Vice Chairman), N Sandford and S Warren

Substitutes: Councillors: G Casey, N Day, D Fower, T Haynes and H Skibsted

Non Statutory Co-opted Members: Parish Councillor June Bull, (Non-voting)

Further information about this meeting can be obtained from Paulina Ford on telephone 01733 452508 or by email – paulina.ford@peterborough.gov.uk

PETERBOROUGH CITY COUNCIL

MINUTES OF A MEETING OF THE HEALTH SCRUTINY COMMITTEE HELD AT 7.00PM ON TUESDAY 7 JANUARY 2020 IN THE BOURGES/VIERSEN ROOM, TOWN HALL, PETERBOROUGH

Committee Members Present:	Councillors K Aitken (Chairman), A Ali, C Burbage, C Harper, L Coles, J Howell, S Qayyum, N Sandford, S Hemraj, S Warren and Co-opted Member Parish Councillor June Bull	
Also present	Jessica Bawden	Director of External Affairs & Policy, Cambridgeshire and Peterborough Clinical Commissioning Group
	David Parke	Head of Primary Care, Cambridgeshire and Peterborough Clinical Commissioning Group
	Dr Mark Sanderson	Medical Director, Cambridgeshire and Peterborough Clinical Commissioning Group
	Caroline Walker	Chief Executive, North West Anglia NHS Foundation Trust
	Fleur Seekins	Clinical Quality Lead Nurse Primary Care at Cambridgeshire
Officers Present:	Dr Liz Robin	Director of Public Health
	Dan Kalley	Senior Democratic Services Officer

24. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Rush and Barkham. Councillor Harper was in attendance as substitute for Councillor Rush. Apologies were also submitted from the representative from Healthwatch Susan Mahmoud.

25. DECLARATIONS OF INTEREST AND WHIPPING DECLARATIONS

Agenda Item 5. North West Anglia NHS Foundation Trust – Preparations for Winter 2019/20

Councillor Hemraj declared a pecuniary interest in Item 5 in that she worked for the North West Anglia NHS Foundation Trust.

Agenda Item 6. North West Anglia NHS Foundation Trust – Financial Update

Councillor Hemraj declared a pecuniary interest in Item 6 in that she worked for the North West Anglia NHS Foundation Trust.

Agenda Item 7. Update on Quality in Care Primary Services

Councillor Qayyum declared a pecuniary interest in Item 7 in that she worked for one of the GP Practices mentioned in the report.

Councillor Sandford declared an interest in Item 7 as he was a patient at a surgery detailed in the report however he stated that this would not affect his ability to discuss the report.

26. MINUTES OF THE HEALTH SCRUTINY COMMITTEE HELD ON 18 SEPTEMBER 2019

The minutes of the meetings held on 18 September 2019 were agreed as a true and accurate record.

27. CALL-IN OF ANY CABINET, CABINET MEMBER OR KEY OFFICER DECISIONS

There were no requests for Call-in to consider.

At this point Cllr Hemraj left the room.

28. NORTH WEST ANGLIA NHS FOUNDATION TRUST – PREPARATIONS FOR WINTER 2019/20

The Chief Executive North West Anglia NHS Foundation Trust (NWAFT) introduced the report. The purpose of the report was to provide an update on the preparations made and subsequent actions taken at Peterborough City Hospital in readiness for Winter 2019-20. The committee were advised that the report had been prepared last Summer for a meeting that did not go ahead on schedule due to the election.

The report covered procedures in place to enable the system to cope with the additional load and surges in demand to ensure patients were directed to the right point of contact. This included preparing staff by increasing the number of staff available and asking staff to have the flu jab to reduce sickness leave.

Additional capacity had been created by opening some facilities for longer and work had been undertaken to improve on social care, nursing home placements and discharge procedures to free up beds. Ambulance offload was not always immediate and if beds and bays were not available, care would be administered in corridors, which whilst not ideal was a better option than leaving patients in ambulances.

The report highlighted that performance targets had not been met and this trend continued to be the case at Peterborough Hospital; in November only 60% of patients were treated within four hours and in December only 56%. The Committee were informed that Hinchingbrooke achieved their targets on most days.

The Health Scrutiny Committee debated the report and in summary, key points raised and responses to questions included:

- Minor attendances, or walk ins, were the largest part of the increased activity. Work was still required to direct these patients to walk-in centres and other alternative care facilities to help ease the congestion in Accident & Emergency (A&E)
- Outflow from the main hospital to free up beds for patients arriving through A&E remained a problem and work continued on discharge matters.
- Most patients attended A & E between 4pm and 10pm, often after work or school by those who should be using other care services. A better provision of same day care was required outside of A&E such as extended GP opening hours and ensuring these services were advertised to raise public awareness.
- Current evaluations included creating an emergency department in the form of a GP or minor injuries service to be integrated within A&E.
- 140 patients per day visited the Minor Injuries Unit in Peterborough rather than A&E.

- Members were given information by NWAFT on the trial currently in place at Hinchingbrooke Hospital to reduce the number of patients seen in A&E. NWAFT were working with the Herts Urgent Care (HUC) on the pilot which had run for 3 or 4 weeks to date at Hinchingbrooke Hospital, 5 days a week from 3-11pm. It involved intercepting patients as they arrived at A&E and directing them to alternative services such as pharmacies, offering advice with self-help treatments or booking an appointment directly with the GP practice. All GP practices needed to be signed up to the same system and clinical advisors were trained on both GP and hospital systems. GP practices did not set aside appointments solely for the use of the trial. Appointments were made available through HUC who co-ordinated appointments through their out of hours care programme. Initial consultation at Hinchingbrooke was through clinical advisors or nurse practitioners. These were not prescribers and some members felt it would be advantageous if they had this function also, rather than referring to someone who did. The trial at Hinchinbrooke was working well and about 10 patients a day were referred to alternative healthcare appointments. However resources were limited as reliance was on GP availability. The scheme could be introduced in Peterborough once the evaluations were completed.
- Most people who attended hospitals felt this was the most appropriate place to go and it needed to be recognised that either this was due to a structural issue or under resourcing.
- Members were advised that all providers of urgent care had signed up to work on the Urgent and Emergency Care Collaborative. This included minor injury units, extended GP surgeries, urgent treatment centres, the 111 service and a range of other possibilities available which the public were not always aware of. Discussions were taking place on how these organisations could work differently and collaboratively, sharing staff and grants to improve the position for next Winter.
- Members were advised the NHS were considering introducing mandatory flu vaccinations for staff as currently only 68% had taken up the offer. This was partly due to a logistical problem around shift working and pressure of work and partly due to some staff not wanting the vaccination. Concern was expressed that staff could introduce flu into the hospital if they did not have the vaccination.. There was concern that staffing levels, which were already tight, could be adversly affected if receipt of the flu vaccine became mandatory. Peterborough hospital did not perform well in comparison with other hospitals in similar areas and had recently been placed 116 out of 158 hospitals on performance. This was mainly due to above average increase in attendances and below average performance.
- The hospital design was a major issue in respect of ambulance admissions as all ambulances accessed the hospital via the same route. Most hospitals had different ambulance receiving points dependant on the referral route which avoided some patients passing through the Emergency Department.
- Members discussed how patients responded when surgeries were unexpectedly closed. They were advised that communications were issued signposting patients through alternative routes and providing advice on treating the symptons of flu, with most GP practices in Peterborough being able to provide alternative cover. The Clinical Commissioning Group (CCG) could provide information to councillors to assist re-directing patients should the situation occur again.
- The NWAFT had no statistics available on the number of patients received in A&E who didn't need to be there however regular audits had shown that although the number was not high, redirecting these patients would have enabled the department to manage better.
- GPs could phone professionals at the hospital for advice and to confirm if a patient should be referred to hospital.
- Members were advised that parking continued to be a problem at the hospital and building was currently underway to provide 106 additional parking spaces and future

capital funding would be available towards a multi storey car park to provide additional parking spaces for staff and patients. A green travel plan was being formulated for staff. 48% of staff lived within 3km of the hospital and it was being proposed that these people would not be allowed to bring a car onto the site. It was, however, recognised that those working shifts or with care responsibilities would need their car at work. Local bus companies had offered discounts to hospital staff using the bus service for travel to work. Patient parking was made more difficult when staff parked in patient car parks.

- The NWAFT noted that an additional exit road from the site would be beneficial as there was considerable congestion caused on both entering and leaving the car park. This had caused problems in recruiting and retaining staff, due to the time taken to leave the site being unacceptable.

AGREED ACTIONS

The Health Scrutiny Committee considered the report and **RESOLVED:**

1. To note the preparations and subsequent actions taken at Peterborough City Hospital in readiness for Winter 2019-20.
2. That the NHS North West Anglia Trust Foundation bring a report to the next meeting on how the emergency collaborative framework and working smarter programme had been working and ways forward for Peterborough City Hospital.

RECOMMENDATION

The Health Scrutiny Committee **RECOMMENDED** that the pilot scheme currently being used at Hinchingbrooke Hospital was progressed further and implemented at Peterborough City Hospital.

29. NORTH WEST ANGLIA NHS FOUNDATION TRUST – FINANCIAL UPDATE

The Chief Executive North West Anglia NHS Foundation Trust introduced the report. The purpose of the report was to provide an update on key issues relating to the financial performance of North West Anglia NHS Trust Foundation (NWAFT) mid-way through the financial year 2019-20. The report also provided an overview on other items of trust news which could have an impact on patients, staff and visitors.

The Health Scrutiny Committee debated the report and in summary, key points raised and responses to questions included:

- Members expressed concern that consideration was being given to building a multi storey car park rather than encouraging employees to use public transport or cycles which would also help address the city's obesity and climate challenge.
- Members requested further engagement with council officers regarding the entrance and exit to the hospital site.
- Stagecoach had reported that congestion at the hospital site caused delays and was a major concern. They had agreed to trial some alternative routes on the implementation of the travel plan and it was suggested that the council could support this through bus subsidies.
- The incentive funding available this year was back end loaded to the second half of the year and there would be significantly more income in the second half of the year. Combined expenditure reductions linked to cost improvements and increased funding indicated the budget remained on target.

- The NWAFT confirmed that of the £490million income the trust received less than £1million from overseas visitors
- Members advised that car parking in residential areas near the hospital continued to be a problem and discussions were due to commence with patients and members of the public from February onwards. National guidance was expected from the government on the expectations of free facilities to patients and staff. The NWAFT asked that council committees supported future proposals for another car park exit and green travel plan.
- Members asked for specific examples of failings highlighted within in the Care Quality Commission (CQC) report and were advised this included access to the maternity helpline which triaged in anticipation of admission to hospital. These patients who then arrived at hospital were kept waiting many hours to be seen due to heavy workloads and the escalation plan to combat this was not implemented. Staff were reminded immediately of the policies in place and how to implement them.
- Another area requiring improvement on the CQC report included drug storage. Drugs had been stored in cupboards locked by keypad doors since the hospital opened. The CQC advised on this inspection that this was inadequate as drugs should be stored in locked cupboards behind keypad locked doors. Alterations were now underway to change the storage facilities across the hospital and staff were not allowed in drug cupboards unescorted and records were being maintained on access to the cupboards.

AGREED ACTIONS

The Health Scrutiny Committee considered the report and **RESOLVED:**

1. To note the latest financial performance update from North West Anglia NHS Foundation trust and the part it played in the financial performance of the Cambridgeshire and Peterborough Sustainability and Transformation programme.
2. To note the actions being taken to address the growing demand for car parking spaces on the Peterborough City Hospital site.
3. To note the Trust's Care Quality Commission inspection rating, following the Trust-wide inspection which took place in July 2019.

RECOMMENDATION

The Health Scrutiny Committee **RECOMMENDED** that a report be presented to the Committee in the next Municipal Year on public transport access at the hospital and the progress made on the green transport plan.

Councillor Hemraj re-joined the committee at this point.

Councillor Qayyum left the meeting at this point.

30. UPDATE ON QUALITY IN PRIMARY CARE SERVICES

The Director of External Affairs & Policy, Cambridgeshire and Peterborough Clinical Commissioning Group accompanied by the Clinical Quality Lead Nurse for Primary Care, the Clinical Commissioning Group Medical Director and the Head of Primary Care, Cambridgeshire and Peterborough Clinical Commissioning Group. presented the report in Primary Care Services.

The Head of Primary Care, Cambridgeshire and Peterborough Clinical Commissioning Group (CPCCG) introduced the report which provided an update on the quality objectives and strategy systems in place to ensure and improve quality in General Practice. This was following a request from the committee for assurance that the CPCCG was introducing measures to improve and support practices who were struggling to maintain high standards.

The CPCCG had a formal governance framework to ensure the quality of care and had recently approved a scheme of support to all practices and a structured approach to the management of concerns raised that supports openness, transparency and learning. Primary Care was overseen by the Primary Care Commissioning Committee, which was made up of Lay Members, NHS England, Executives, the Local Medical Committee and Healthwatch.

There were a number of practices that had been rated by the CQC as requiring improvement or inadequate although some practices had been rated good or outstanding..

The Quality Surveillance Group met monthly for feedback and intelligence was gathered from patient groups, Healthwatch, stakeholders and the media. Practice visits would commence in January with priority being given to those rated inadequate or requiring improvement and support offered in specific areas of need such as IT systems or coding involving stakeholders where appropriate.

A hub had been set up to support surgeries including training, coaching and mentoring and GP retention schemes. The hub would also include Leadership Training Awards and a buddy system for newly qualified GPs to share good practices.

The Health Scrutiny Committee debated the report and in summary, key points raised and responses to questions included:

- Members were advised that measures were in place to support practices on a weekly basis to improve their CPCQC rating, reducing to monthly support as improvements were made. Focus was on practices who were struggling most where an action plan would be prepared for progress to be monitored.
- Surgeries were encouraged to share good practices. Member practices of each Primary Care Network (PCN) would be sharing contracts and delivering on services to a shared patient population and would want to support each other in terms of quality output.
- There was a requirement for a notice of special measures to be displayed at the surgery and on the website once the report had been published however this could take several weeks. Members responded to this saying whilst understanding practices were under a lot of pressure, they felt that, for the purpose of transparency, the visibility of how the practice was rated would provide an incentive for improvement. Members also pointed out that there was inconsistency in the displaying of results as there was no mention of the CPCQC results on the website for the Octagen Practice however the Welland Practice details were available clearly.
- Patients were always free to register with a different practice should their own be rated inadequate although the majority of patients would remain as most care was generally good.
- The monitoring dashboard included public health data, work force data, identifying vulnerabilities, health prevention and prescribing information. Patient experience data and feedback from ward councillors and community groups would also be included.
- Some information was collected for information purposes only. Information was weighted 40% quality, 40% performance and 20% patient experience – the rating for patient experience was less as less data was available. The data dashboard had been

applied across the Eastern Region to ensure consistency with similar scoring to other CCGs,

- The CPCCG advised that the work force age, nearness to retirement and the ratios of patients, GPs and nurses was of specific interest. Members expressed concern and wanted to know what action was being taken to address pending retirements.
- The CPCCG explained that GP retention was a national issue. The new Primary Care Network were hoping to increase the workforce generally by looking at the 5Ps and recruiting paramedics, physiotherapists, social prescribers, clinical pharmacists, and physician associates to overcome the national shortage of GPs which would leave GPs available to attend the most severe cases.
- The report indicated that Westwood Clinic had not received assurance visits as often as required as the practice had not provided suitable dates. This was as a result of changes in practice management and staff sickness rather than a refusal to co-operate.
- A Workforce Plan had been compiled to study capacity for the new management team taking on the running of the new Nightingale Practice. to ensure that there was enough capacity to carry out current commitments across the various surgeries together with the new practice. Additional reception staff and nurses had been recruited to cover the opening of the new practice and conversations were taking place with GPs to increase the workforce.
- There was a rigorous process for closing a practice and a formal application for closure would be required. A decision to close a practice was based on the current strategy and the need of the patients within that geographic area.
- Appointment availability continued to be an issue and some surgeries required patients to call at a specified time to book a same day appointment. Members wanted to know why, in these surgeries, additional staff were not available to take the calls and avoid the long call waiting times. Members felt that if patients could access GP appointments more easily there would be a positive outcome on the visits to A&E. Members were advised that work within the Primary Care Networks aimed to address these issues, looking into other ways of working and making it easier for patients to access health professionals.
- Some patients preferred to consult with a GP however over time most would become familiar with alternative practitioners and be more accepting as they became more regular.
- The Thistlemoor Practice had received an outstanding CQC rating. Members wanted to know what Thistlemoor was doing differently and how this could be implemented in other practices to improve their results. Members were advised practices were run by GPs as partnerships. Thistlemoor had outstanding leadership and vision and those practices which were underachieving had less impressive leadership and the CPCQC had reported this was a key reason why some practices underperformed.
- Whilst GPs were good doctors, their medical training had not always included leadership and management skills. The patient population around Thistlemoor was based largely around those with English as a second language and the practice had responded to patient needs and re-modelled accordingly. The practice was enthusiastic and keen to show anyone around and were often used as an example to other surgeries. Members advised that the triage system they had experienced at Thistlemoor often lead to patients being referred to other health professionals more appropriate rather than GPs.
- Members were provided with some background information on two failing practices where leadership had been reported by the CQC as quite poor. This was as a result of the original partners leaving the practice and, in both cases, leaving only one doctor who became doctor, business manager and employer, running the practice alone and whilst good GPs, they were not natural leaders.
- Members repeated their frustration over the appointment allocation system in operation in most GP practices which was not associated with demographics or resources but a

result of poor customer service and asked when the CCG would insist that certain processes were not acceptable. The committee had previously made a recommendation regarding this to the CPCQC. Members were advised that there was no easy answer. The government, via NHS England negotiated the General Medical Services contract with the BMA across the UK which governed how practices provided services and set out their obligations. The contract was quite vague and did not set out clear standards or ways of working and contractually there were no enforcement actions available. There were different methods in use across the various surgeries to allocate appointments and the system was not standardised. Attempts were being made to promote booking appointments online which some patients found more acceptable and online consultations were being rolled out across all practices. All practices would receive new software for processing patient results more efficiently and new additional NHS funding would be available for the digital agenda.

AGREED ACTIONS

The Health Scrutiny Committee **RESOLVED** to note the report.

RECOMMENDATIONS

The Health Scrutiny Committee **RECOMMENDED** that letters be sent to the Health Secretary and the local MP's regarding a standardised approach and outlining concerns that the national contract for GP surgeries was not specific enough and did not permit continuity of standards. The letter would include specific examples of inconstancies within the system.

31. HEALTH SCRUTINY COMMITTEE MEETING START TIME 2020-21

The Senior Democratic Services Officer introduced the report. The purpose of the report was to seek the Committee's agreement on the meeting start time for the municipal year 2020-21.

The Health Scrutiny Committee debated the report and in summary, key points raised and responses to questions included:

- Some members would prefer an earlier start time however those in employment would have difficulty making a pre meeting at 5pm.
- Meetings held in the morning or afternoon would restrict access to members of the public who may want to attend.
- Some members could not arrive before 6pm however members were reminded that the decision was being taken for the next committee and the membership could change.

AGREED ACTIONS

The Health Scrutiny Committee **RESOLVED** to agree the start time for the meetings in the municipal year 2020-21 to be 7pm.

32. MONITORING SCRUTINY RECOMMENDATIONS

The Senior Democratic Services Officer introduced the report which provided the Committee with a record of recommendations made at previous meetings and the outcome of those recommendations to consider if further monitoring was required.

The Committee were informed that the letter to the two local MP's asking them to lobby the Secretary of State for Health for an increase in the Public Health Grant for Peterborough had been sent.

The Chair advised that the briefing note had not been received from Cambridgeshire and Peterborough Clinical Commissioning Group on the practice in place by some GP practices where patients were required to phone at 8am to book an appointment and this item remained outstanding.

AGREED ACTIONS

The Health Scrutiny Committee **RESOLVED** to note the contents of the report and note the actions outstanding.

33. FORWARD PLAN OF EXECUTIVE DECISIONS

The Senior Democratic Services Officer introduced a report, being the latest version of the Council's Forward Plan of Executive Decisions containing key decisions that the Leader of the Council, the Cabinet or individual Cabinet Members would make during the forthcoming month. Members were invited to comment on the plan and where appropriate, identify any relevant areas for inclusion in the Committee's Work Programme.

AGREED ACTIONS

The Health Scrutiny Committee **RESOLVED** to note the report and considered the current Forward Plan of Executive Decisions.

34. WORK PROGRAMME 2019/2020

Members considered the Committee's Work Programme for 2019/20 and agreed to note the items as included.

AGREED ACTIONS:

The Health Scrutiny Committee **RESOLVED** to note the work programme for 2019/20.

35. DATE OF NEXT MEETING

The next meeting would be held on Tuesday 9 March 2020.

CHAIRMAN
7.00pm – 8.55pm

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HEALTH SCRUTINY COMMITTEE	AGENDA ITEM No. 5
9 MARCH 2020	PUBLIC REPORT

Report of:	East of England Ambulance Service NHS Trust	
Contact Officer(s):	Luke Squibb (Head of Operations – Cambridgeshire and Peterborough) Jessica Watts (Head of Improvement Programmes)	Tel. 07850 648575

AMBULANCE SERVICE – Recent changes; Impact of changes; Vision; Performance and challenges

R E C O M M E N D A T I O N S
It is recommended that the Health Scrutiny Committee note the contents of the report.

1. ORIGIN OF REPORT

1.1 The report is being presented at the request of the Health Scrutiny Committee.

2. PURPOSE AND REASON FOR REPORT

2.1 This report has been produced at the request of the Health Scrutiny Committee to update the Committee on recent changes put in place since the appointment of Dorothy Hosein, Chief Executive, the impact of these changes, the current vision for the ambulance service, performance and challenges in delivering the service.

2.2 This report is for the Health Scrutiny Committee to consider under its Terms of Reference Part 3, Section 4 - Overview and Scrutiny Functions, paragraph No. 2.1 Functions determined by Council - Scrutiny of the NHS and NHS providers.

3. BACKGROUND AND KEY ISSUES

3.1 **Changes and impact**

A new Chair, Nicola Scrivings, was appointed to the EEAST Board in October and took up post in November. Nicola joined EEAST from Cambridgeshire Community Services Trust, where she had been the Trust's chair since January 2015, and a non-executive with the Trust prior to that. Nicola brings more than 20 years' experience with the Royal Mail including Director level roles including, from 2009 until 201, Regional Operations Director (Anglia). Nicola is also currently Group Chair of Cambridge Housing Society. This new appointment comes at an important time for the Trust as we launch our new corporate strategy, which sets out an ambitious and exciting vision for improvement over the next five years for providing safe, high quality patient care.

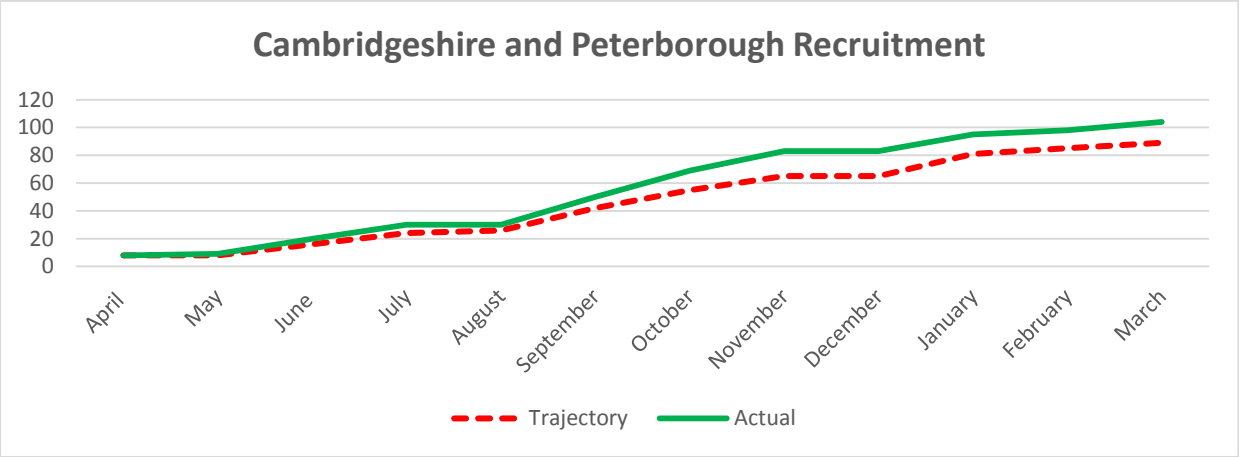
Dorothy Hosein joined the East of England Ambulance Service Trust (EEAST) as Interim Chief Executive on 1st November 2018. Dorothy brought with her a wealth of experience at partner trusts within the region and outside. At the time of Dorothy joining EEAST, we were facing many difficulties, many of which had been highlighted in the Deloittes Independent Service Review, including a significant capacity gap and staff retention issue, an aging fleet, and low morale which all contributed to a performance that needed improving.

On joining EEAST, Dorothy identified the need to change the culture and ethos of the Trust to one which is supportive and accountable from the top down. The recent CQC report recognised the outstanding care we are giving to our patients but also highlighted the work we need to undertake to change the culture and engage with our staff across the Trust. As part of these changes we have had a change at executive level, bringing in the experience we need to effect the changes required. Dorothy has subsequently been appointed as permanent CEO, in December 2019, following a competitive external process.

This cultural and organisational change is being achieved through organisational autonomy, giving senior managers the autonomy to make decisions and drive the change in their areas and giving them the tools to achieve that through support from the executive board, whilst maintaining the focus on key areas to improve our response to patients.

This included changing the process of centralised recruitment and allowing Managers to drive the recruitment locally. For Cambridgeshire this meant we had a target this financial year to recruit 116 new members of staff to bridge the capacity gap and allow for leavers. I can report we have achieved above the trajectory this year (Fig 1)

Fig 1



The remaining new joiners for A&E are booked in for courses starting during this financial year with the PTS vacancies being interviewed for by the end February. Through this robust local recruitment planning Peterborough station will be at full establishment of frontline emergency ambulance staff by the end of the financial year.

Month	A-EMT	ECSW	DE Para / EMT
October	10	6	4
November	9	0	6
December			
January	12	0	0
February	1	1	0
March	5	1	2
PTS			
Vacancies remaining		8	

The impact of this change is; improved performance, shorter patient waits, improved staff morale, as the increase in recruitment in Cambridgeshire will result in being fully staffed by year end this has enabled us to set a clear recruitment plan for next year focussing on staff turnover and retention.

As part of the change in culture we have introduced ‘Huddles’ across the Trust. This is

engagement and briefing from a manager to all members of staff at the beginning of their shift. Most importantly it provides staff with the opportunity to raise concerns and issues, and Managers to offer support. It allows for improved communications and sharing of pertinent information to all staff. Huddles are becoming embedded across EEAST at all levels of management.

In Cambridgeshire the local managers rota themselves on the front line with their staff members, which improves the staff engagement and is an opportunity to lead by example, improve relationships, understand the issues and concerns, and work with staff to improve the moral. This has been well received by both staff and managers.

Dorothy is kept appraised of the local performance, issues and concerns, for patients and staff, through accountability meetings every month. Senior Managers are challenged at these meetings but also supported where there is a need for other directorates to assist.

3.2 Vision

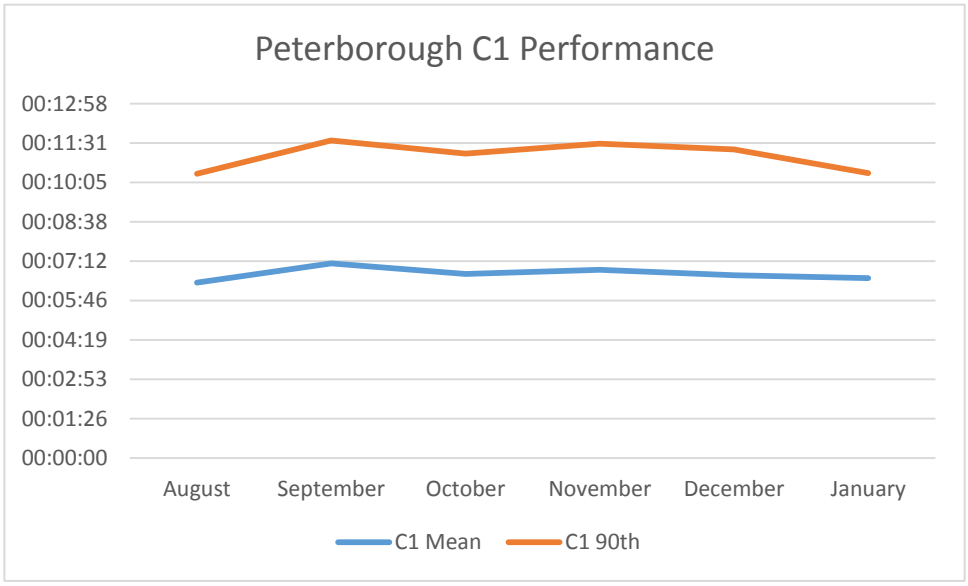
Nicola Scrivings, the new Trust chair, is working with the board to update the Trust vision. The Trust draft goals are:

- To be an exceptional place to work, volunteer and learn
- To provide outstanding quality of care and performance
- To be excellent collaborators and innovators as system partners
- To become an environmentally, socially and financially sustainable organisation.

3.3 Performance

Performance covers two main areas, how quickly we respond to patients waiting for an ambulance and the quality of the care we give to the patients once we arrive.

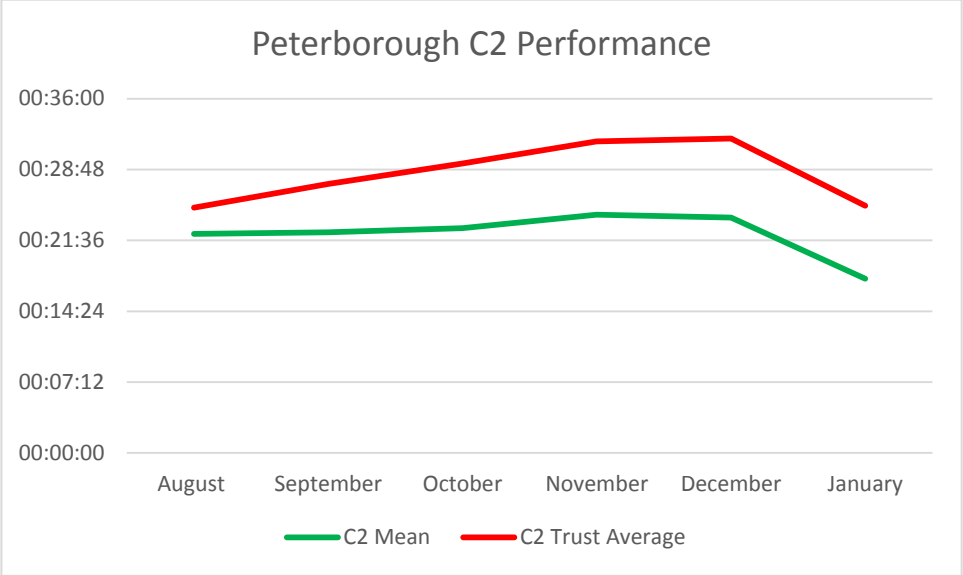
Response to patients
Two years ago, in this committee, we discussed the introduction of the Ambulance Response Program, a national change to the way we operate; this had just been embedded into the Trust. This allows us to get the right resource to the patient first time, the majority of the time, and for our sickest patients, those classified as being immediately life threatening, this is measured against a mean target of 7 minutes and a 90th percentile target of 15 minutes.



As can be seen in the above chart, in the Peterborough area we are delivering very well against

the national standard for both the mean and the 90th percentile. This means we are getting to those patients with life threatening conditions within the national standard the majority of the time.

The second category of patients, C2, are patients that can be seriously unwell but are not thought to be life threatening. The national standard for a response time to these patients is a mean average of 18 minutes.



The chart demonstrates we are not achieving the national target for the C2 patients but are reporting improved performance against the Trust average. As part of the 'building better rotas' project we have seen a number of new rotas go live in Peterborough from 6th January 2020 which has started to have an impact on our C2 performance. Following on from the independent service review recommendations we have an improved level of resources available on shift to meet our demand profile.

Quality of Care
The recent CQC report rated the East of England Ambulance Service for caring as outstanding; "staff continued to deliver compassionate care and treated patients and their loved ones with respect and dignity. Patients that we spoke with told us that staff had been caring and treated them with kindness"

This is a great accolade for our staff who demonstrate their kindness and compassion everyday they put on their uniform, but what this doesn't capture is the clinical aspect of the care we provide. On the last report on the Ambulance Quality Indicators, in Cambridgeshire and Peterborough:

- We delivered 100% (81 patients) of Stroke care bundles, this means we gave all 81 patients suspected of suffering a stroke the care they needed. 32 of these patients were from the Peterborough area (December 2019)
- We delivered 100% (10 patients) of STEMI care bundles, this means we gave all 10 patients suffering from an ST Elevated Myocardial Infarction, the care they need. 5 of these patients were from the Peterborough area.
- We achieved 100% post ROSC (13 patients) care bundle which means we did everything right for those patients we achieved a ROSC with. 8 of these patients were from the Peterborough area.
- Cardiac arrest survival to discharge rates were 12% against a Trust average of 8.3% and outperforming the national average of 10.3%.

3.4 **Challenges**

Two years ago, in this committee, we discussed some of the challenges that faced the Ambulance service;

- performance,
- recruitment and retention,
- capacity,
- late finishes for staff and the impact,
- loss of ambulance capacity with delayed handover at hospitals locally and regionally. This displaces resources, introduces long distance travelling and longer waiting times
- Demand increases on 999.

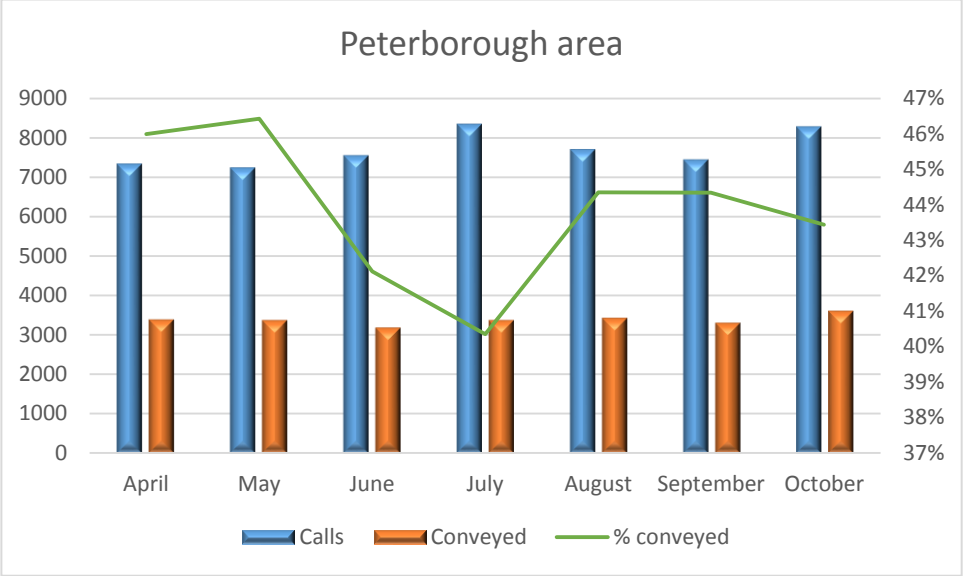
Performance has improved, our capacity with staff and resources is improving and more staff are finishing their shifts on time, and those that are late off are not late off by the amount of time they were. Although there is a concern for recruitment challenges in the future due to the new Primary Care Network (PCN) contracts and their approach to our Paramedics. EEAST are fully engaged with system partners and actively exploring the opportunities available within the STP for rotational paramedic roles.

Handover delays

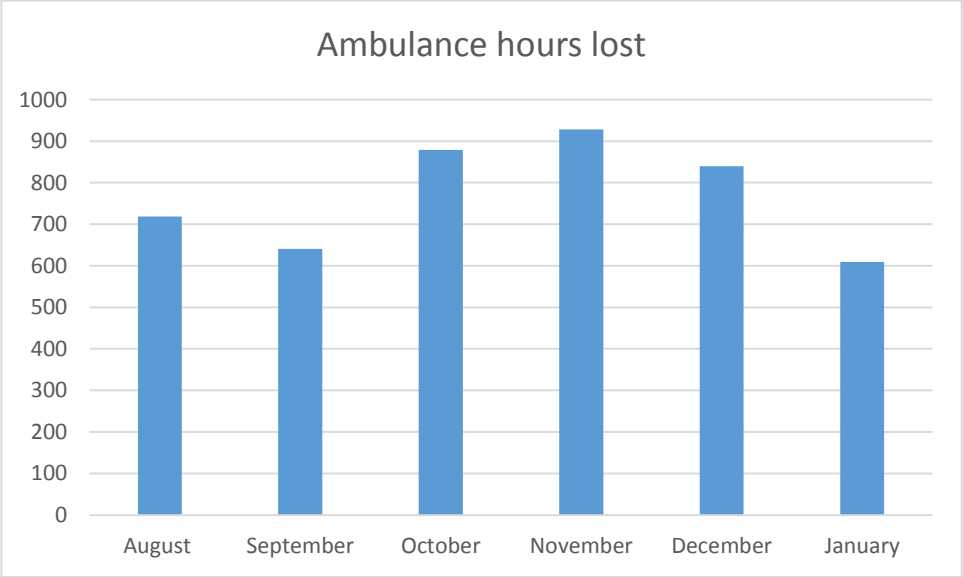
Whilst still in the grip of winter pressure for the NHS, the trend for patient handovers at hospital being worse than last year is extremely worrying. December saw the highest recorded handover delays ever seen throughout EEAST with this issue not being unique to Cambridgeshire and Peterborough. EEAST continues to experience the highest number of lost ambulance hours from hospital handover delays in England. This means that we are forced to 'stack' 999 callers who we are waiting to send ambulances to because we are waiting to offload our patients at hospitals. These patients in the community are recognised as being a higher risk as they have not got a clinician with them.

Caroline Walker has actively been involved in discussions around improving the handover delays at Peterborough City Hospital and we held a CEO to CEO meeting between Caroline and Dorothy where the issues were discussed and some actions agreed. One of the actions was a review of system processes where we saw the completion of building work for a dedicated ambulance handover area completed over the festive period enabling the handover process at Peterborough City Hospital to follow the same process as we have observed and shared from Addenbrookes Hospital. Peterborough City Hospital Chief Operating Officer, Graham Wilde, has set up a senior group within his Emergency Department to focus on the concerns at PCH, however the hospital have challenges of their own which are contributing towards the issue. We are starting to see some improvement in handover times at PCH which is allowing EEAST to meet the needs of our patients in the community in a more timely manner.

We are trying to reduce the conveyances to aid the hospital and are regularly conveying less than 45% of our calls to hospital and are actively trying to find alternate pathways for patients.



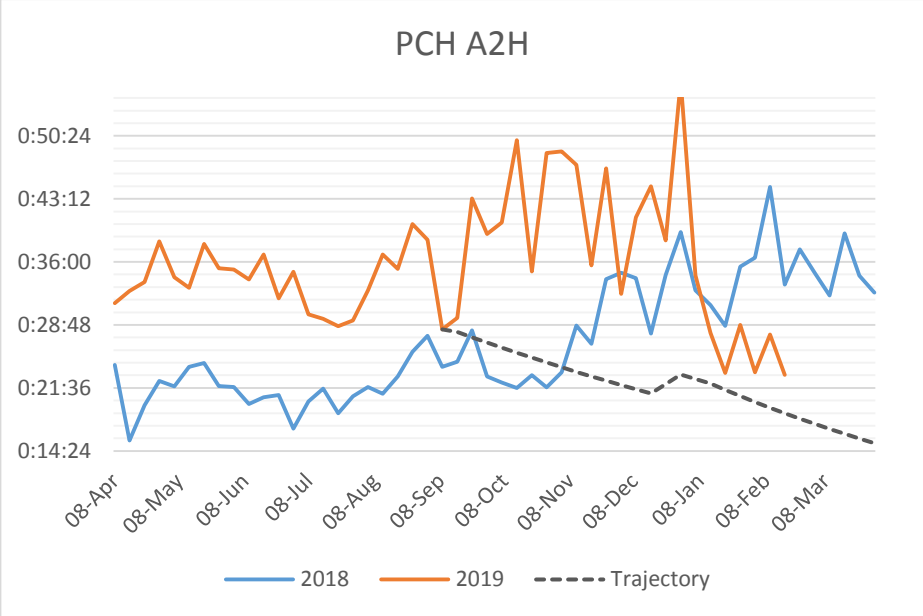
We see a considerable amount of ambulance hours lost each month as a result of handover delays at PCH. The loss of these hours has a direct impact on the Trusts ability to respond to patients in the community where it is agreed there is the biggest risk across the system.



The below chart shows the hospitals in Cambridgeshire and across the East of England and as can be seen we are challenged at many. Our patients from Wisbech area are more often than not, conveyed to the Queen Elizabeth Hospital in Kings Lynn, a main hospital where we experience patient delays. We have seen some improvement in the arrival to handover times at PCH in 2020 although they are still considered an outlier across the East of England and remain above the national target of 15 minutes.

Average Arrival To Handover Time in HH:mm:ss						Up to 23.02.20	
Acutes	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20
Addenbrookes Hospital	00:15:16	00:15:50	00:17:11	00:17:21	00:18:10	00:21:35	00:16:35
Barnet General Hospital	00:24:06	00:28:02	00:29:11	00:32:58	00:31:46	00:32:53	00:31:42
Basildon & Thurrock Hospital	00:16:59	00:16:31	00:16:27	00:17:11	00:19:55	00:18:19	00:17:20
Bedford Hospital South Wing	00:13:19	00:13:03	00:13:47	00:15:51	00:19:08	00:20:28	00:16:48
Broomfield Hospital	00:21:35	00:21:08	00:25:31	00:27:16	00:29:30	00:34:46	00:24:55
Colchester General Hospital	00:18:28	00:18:31	00:19:07	00:19:11	00:20:24	00:22:11	00:18:45
Hinchingbrooke Hospital	00:21:51	00:21:14	00:20:04	00:21:58	00:28:49	00:28:16	00:22:58
Ipswich Hospital	00:17:48	00:19:31	00:24:05	00:19:22	00:24:14	00:23:18	00:22:27
James Paget Hospital	00:19:03	00:21:31	00:21:33	00:23:52	00:21:16	00:21:27	00:19:20
Lister Hospital	00:17:17	00:19:02	00:18:03	00:21:56	00:25:00	00:27:16	00:20:47
Luton And Dunstable Hospital	00:22:07	00:23:01	00:24:30	00:25:45	00:27:06	00:22:36	00:17:55
Norfolk & Norwich University Hospital	00:22:00	00:24:37	00:32:46	00:39:29	00:38:10	00:31:40	00:30:40
Peterborough City Hospital	00:37:15	00:35:17	00:40:30	00:46:25	00:40:56	00:32:30	00:24:46
Princess Alexandra Hospital	00:19:09	00:21:06	00:21:50	00:25:39	00:34:16	00:29:35	00:25:59
Queen Elizabeth Hospital	00:37:22	00:38:29	00:37:52	00:37:04	00:45:51	00:36:28	00:25:28
Southend University Hospital	00:20:23	00:22:13	00:21:52	00:26:25	00:27:49	00:31:07	00:24:39
Watford General Hospital	00:29:15	00:25:29	00:23:48	00:23:20	00:29:01	00:27:43	00:27:53
West Suffolk Hospital	00:19:25	00:20:48	00:22:48	00:21:25	00:22:50	00:24:08	00:20:31
Grand Total	00:21:26	00:22:04	00:23:59	00:25:38	00:27:48	00:26:42	00:22:35

We are working closely with Peterborough City Hospital to try and alleviate these delays and have recently agreed a trajectory to target the national standard (15 minutes). The trajectory below has been agreed with the Chief Operating Officer, Graham Wilde, and is monitored weekly and reported on at the monthly North Alliance System Resilience Group meeting.



4. CONSULTATION

4.1 N/A

5. ANTICIPATED OUTCOMES OR IMPACT

5.1 Benefit to Peterborough patients

We continually look to improve patient care and patient outcomes, often through innovative schemes or pathways.

Currently in Cambridgeshire:

- We are providing Hospital Ambulance Liaison Officers at both Addenbrookes and Peterborough City Hospital – currently only funded until the end of March 2020.
- Our Managers undertake approx. 30% of their shifts on the front line with their staff
- We are looking to providing an Urgent Vehicle; a dedicated response for the lower acuity patients
- Our Community First Responder (CFR) Liaison officer has been working with CFR groups to support them and increase their numbers
- We have started to trial a new response to elderly fallers in Peterborough.

EEAST continually work with system partners through external groups and meetings such as:

- Health & Care Executive
- Cambridgeshire and Peterborough Systemwide A&E Delivery Board
- North Alliance System Resilience Group
- South Alliance System Resilience Group
- Strategic Interoperability Board
- Cambridgeshire NEPTS systemwide meeting
- Clinical Advisory Group
- Joint Strategic Operability Board
- Urgent Care Programme Board
- Greater Peterborough IDB
- Cambridgeshire & Peterborough Local Resilience Forum
- Cambridgeshire & Peterborough Local Health Resilience Forum

To provide a collaborative approach to delivering the best possible health and care to the communities of Cambridgeshire and Peterborough.

6. REASON FOR THE RECOMMENDATION

6.1 N/A

7. ALTERNATIVE OPTIONS CONSIDERED

7.1 N/A

8. IMPLICATIONS

Financial Implications

8.1 N/A

Legal Implications

8.2 N/A

Equalities Implications

8.3 N/A

Rural Implications

8.4 N/A

9. BACKGROUND DOCUMENTS

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

9.1 None

10. APPENDICES

10.1 None

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HEALTH SCRUTINY COMMITTEE	AGENDA ITEM No. 6
9 MARCH 2020	PUBLIC REPORT

Report of:	Claire Stoneham, Executive Programme Director, Sustainability and Transformation Partnership	
Contact Officer(s):	Catherine Boaden, Head of System Strategy	Tel. 07980784245

NHS LONG TERM PLAN RESPONSE

RECOMMENDATIONS

It is recommended that the Health Scrutiny Committee members note the update provided on the Cambridgeshire and Peterborough Sustainability and Transformation Partnership's response to the national NHS Long Term Plan and the work currently in progress

1. ORIGIN OF REPORT

1.1 The local response to the NHS Long-term Plan will determine the direction for NHS services for the next five years. This draft is being shared with key stakeholders. The finance sections will be updated following agreement with NHSE.

2. PURPOSE AND REASON FOR REPORT

2.1 The response to the national Long Term Plan (LTP) is one of the key priorities on which the Cambridgeshire and Peterborough (C&P) Sustainability and Transformation Partnership (STP) needs to focus. This paper provides an update on the C&P STP response to the LTP and on the work currently in progress.

2.2 This report is for the Health Scrutiny Committee to consider under its Terms of Reference Part 3, Section 4 - Overview Scrutiny Functions, paragraph No. 2.1 Functions determined by Council:

3. Scrutiny of the NHS and NHS providers.

3. BACKGROUND AND KEY ISSUES

3.1 The *NHS Long Term Plan (LTP)*, published in January 2019, set out a number of ambitions to ensure the NHS is equipped for the future and to consolidate the expectation that local partners should continue to work collaboratively, plan together and co-create strategic plans. The *NHS Long Term Plan Implementation Framework* was published in June 2019 and underpinned the LTP, focusing on what the NHS needed to deliver locally over a five-year period to 2023/24 and setting out an integrated approach that systems should use.

The national LTP set out a series of 'must-dos' for service transformation:

- Transform out of hospital care and fully integrate community-based care.
- Reduce pressure on emergency hospital services.
- Give people more control over their own health and more personalised care.
- Digitally-enable primary care and outpatients.

- Improve care for major health conditions.

It also included must-dos for system development:

- Set out how the STP will develop to become an ICS by April 2021.

It included a series of expectations on how we would support our workforce, deliver digitally enabled care, and improve productivity.

And additionally, there were areas we were expected to include, but where there was greater scope for local prioritisation and phasing:

- Prevention.
- Children and young people, including maternity and neonatal.
- Learning disability and autism.
- Cardiovascular disease; stroke; diabetes; respiratory disease.
- Research and innovation; genomics.
- Volunteering; wider societal impact.

This paper focuses on the system's response to the LTP to date, building on STP Board discussions which took place from September through to December 2019. It covers the expectations of the C&P STP system and provides an update on the work in progress to deliver results in 2020/21 and beyond.

3.2 **Cambridgeshire and Peterborough STP Long Term Plan**

The Cambridgeshire and Peterborough STP Board have led a process to draft an LTP for our system covering the next five years. Our draft plan proposes a very significant programme of transformation that will start to deliver results from April 2020. As a system, we have previously demonstrated the ability to make real and rapid progress together (for example, by reducing delayed transfers of care) and we remain committed to making changes that will improve health and care for our population. We are already establishing and mobilising our workstreams to implement our plan.

We face severe financial challenges in 2019/20 and beyond and our plan focuses on how, despite these challenges, we will deliver high quality and sustainable services in the medium-term and how we will address our financial position in the longer term. To achieve this, we need to secure external support and buy-in for our plan.

We can be proud of the fantastic care provided to our patients and population by organisations within Cambridgeshire and Peterborough. Much of this care is excellent, and in some cases world-leading. However, there is significant variation in outcomes, and we have large health inequalities associated with areas of deprivation. These inequalities are described in detail in our draft LTP (in chapter 1). It is imperative that as we develop our delivery plans, we consider what we can do ‘up-stream’ to identify those at risk of developing ill-health and what we can do preventatively to reduce this risk and we know there is more we need to do develop our plans in this area.

A key component of our LTP is our ambition to develop integrated out-of-hospital care built on the foundation of stable general practice and resourced appropriately. We need to care for people better in the community to avoid unnecessary non-elective admissions and reduce inappropriate lengths of stay in hospital, and we need to make the best use of our workforce to enable these changes to happen. Alongside better out-of-hospital care, our plan envisages efficient, high-quality care in hospital (where necessary).

We have already established system working and governance, and an emerging new operating model based around north and south 'Alliances' and Primary Care Networks (PCNs). Some of our more established PCNs have developed into 'Integrated Neighbourhoods' and begun to implement new services and ways of working, for example in physiotherapy and neurology. We have a number of programmes in place at Alliance level focused on innovation, engagement and support.

We have a huge opportunity to begin to realise the leveraging of our wider system assets, including research and innovation, industry collaboration with the biomedical campus, a new children's hospital and partnership working with the universities. In addition, we have considered where we have opportunities locally to go further and faster, for example through realising a unique set of collaborations between research, industry and digital partners.

Our ambition is high: we want to transform, making very significant changes to how we use our resources and how we care for our population. Using a wide range of data, alongside the Health and Wellbeing Strategy and as well as the results of a prioritisation exercise undertaken by our clinicians and the result of in-depth analysis of our financial spending, we have picked a small number of areas to focus on, around which we will align our resources. We have agreed a set of 4+1 transformational priorities (described in chapter 3 of our LTP) as follows:

4+1 transformational priorities

- **Integrated out of hospital care**
  Focusing on population needs, we will join up out-of-hospital services more effectively, building on the foundations of strong primary care and providing additional support where necessary.
- **Outpatient transformation**
  We will change the way we deliver our outpatient services to ensure that our patients are seen by the right professionals in the right places.
- **Redesigning care pathways to improve efficiency and reduce unwarranted variation**
  We will improve the quality of the care we provide by reducing variations in the way services are delivered, adopting best practice.
- **Making the most of our assets**
  We will identify opportunities to make the best use of our high fixed cost assets, including estates and digital infrastructure.
  +
- **Research and innovation**
  We will ensure that our system derives maximum benefits from links with research to deliver improvements for our population and for our staff.

Taken together, with our existing collaborative work on Urgent and Emergency Care and on digital infrastructure, workforce and system development, we have set out a huge programme of transformational change which will impact on every part of the health and care system in Cambridgeshire and Peterborough. We are seeking to improve care both in and out of hospital, using resources much more efficiently. We know this will be difficult to achieve, and we can only be successful if all system partners fully buy in and commit to the ambition.

Our draft LTP also describes, in a series of annexes, the range of improvements we are seeking to make in services such as cancer and maternity across the system. It further details our planned work on prevention which is critical to support a healthy and productive population in the future. This work is already well underway.

3.3 ***Financial Summary***

We have conducted robust and in-depth analysis of our financial spending and how we compare to similar systems across the country. This suggests that we refer more people to hospital for elective care and have much higher fixed costs for our buildings and IT.

We have been working together to develop a financial model for the next five years, develop a set of shared assumptions and to play through the implications of continued historic trends in activity and cost. Our Deputy Finance Director network led this work, with support and direction from our Finance Directors. We have used national guidance where appropriate and locally aligned assumptions to prepare a robust baseline projection, on top of which we will be able to model the impact of system-led transformation initiatives.

1. We also, with the Regulator, appointed external support to validate the financial work we have done to date and to provide assurance. Their support ran alongside the LTP, and was in three parts:

    - Understanding the drivers of the system deficit, using targeted analysis to identify where the system is underperforming and to confirm what the efficient cost of care is for the Cambridgeshire and Peterborough population.
    - Alongside us, identifying major opportunities that could deliver a step-change in system performance, including looking at areas where leading health systems are transforming; and
    - Supporting us to identify the big issues that will need to be addressed to realise the opportunities, including the core enablers (such as data and governance), and understanding what investment will be needed to support transformation.

2. The output of this work formed a key part of our final LTP response, which included the delivery of stretching productivity, reducing the current rate of growth of non-elective admissions and making better use of our acute bed capacity in Cambridgeshire and Peterborough.

3.4 ***Engagement***

A wide-range of engagement has taken place to support the development of the LTP response, including with our local population, Local Authority Boards and clinical groups. A more in depth record of our communications and engagement activity is included at appendix one of the LTP draft.

3.5 ***Publication***

We expect to publish the final version of our LTP in April, following the publication of national implementation guidance. Until that point, the document remains in draft.

Preparing for implementation

3.6 ***Operational planning***

To ensure a robust approach, we plan to reflect the system transformation priorities in the organisational business plans of all system partners. This will ensure linkage between the high-level priorities and frontline delivery. In this way the implementation plan for the system should comprise the sum total of the operational plans of our system partners and Alliances as opposed to a ‘priority plan’ sitting separately.

Finance and planning teams are working together across the system to produce central guidance for system partners describing the savings required and the phasing, activity implications, how

these might be divided across partners, the proposed metrics for tracking delivery, further detail on relevant LTP commitments and underpinning analysis. This guidance will be used by organisations to inform the content of their own plans and by system partners to challenge each other.

3.7 ***Governance***

We are completing a review of our delivery infrastructure, so it supports the new phase of system work. This will include reviewing the governance of the STP so that it is increasingly delivery focused and ensuring that there is improved clinical engagement at all levels. We will ensure the system resource and enabling programmes are secure and able to support this work, as well as continuing to strengthen links to system partners outside the NHS.

3.8 ***System organisational development***

The Board previously discussed and agreed the need for a partner to support the next phase of our development as a system and as an STP Board. The specification for this work has now been developed and the procurement will be launched imminently, in order to have support in place from April 2020.

3.9 ***Financial plan***

Our draft financial plan aligns to our LTP narrative and represents a stretching but credible financial position over the period. We remain in discussion with the regional and national team about the support we need to underpin delivery of this plan, and the further actions we will need to take to build delivery confidence.

As our deliver plans continue to be developed, we will need to be clear about the financial targets we need to meet, the timescales for achieving this and the way they are allocated across the system.

4. APPENDICES

4.1 Appendix 1 – DRAFT Cambridgeshire and Peterborough NHS Long-term Plan

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Contents

Foreword

Welcome to our plan for health and care in Cambridgeshire and Peterborough for the next five years.

We live in a remarkable place. The fastest growing area in the UK brims with energy and innovation. Unique fen landscapes abut thriving new townships; medieval landmarks share the skyline with factories and industry; historic institutions are the genesis for world-leading research and development facilities.

The people of Cambridgeshire and Peterborough are remarkable too. Over 80 languages are spoken in Peterborough, and Cambridge is a truly cosmopolitan city. The high streets of our market towns bustle with locals and the more recently arrived. We have a significant older population – people who have lived locally all their lives, as well as people who have moved here to retire – and our younger population is boosted by those who have come here to work and live.

And it is for the people of Cambridgeshire and Peterborough that we, the NHS family and our councils, have developed this plan. A plan that puts people, wherever they live, at the heart of their own health and care; a plan that helps people, whatever their background, to protect their own health; a plan that makes sure people, whoever they are, have the right treatment and care when they need it.

We have some really difficult health and care challenges locally; however, we are also presented with tremendous opportunities to meet these challenges. Our job together – the NHS Family and our partners – is to nurture the collaboration, innovation, empowerment and processes that realise an NHS in Cambridgeshire and Peterborough of which we can rightly be proud.

Dr Mike More
STP Chair

Roland Sinker
STP Accountable Officer

Executive summary

1. In Cambridgeshire and Peterborough, we are working together to improve the health and wellbeing of local citizens. Our system partnership brings together those responsible for the NHS, general practice and local government around a common endeavour: how, working together, we can improve health outcomes for local people.

2. We have much in our favour. We understand our population having spent time speaking to our people in their communities about what matters to them. We have already integrated many of our services, created new partnerships and progressed plans for wider public service reform. We are home to dynamic institutions and industries of regional, national and global significance. And we are proud that in October 2019, one of our hospitals, Royal Papworth, became the first ever NHS hospital to be rated outstanding in all 5 of the Care Quality Commission (CQC) domains[1].

3. Yet we have not reached our full potential. Our conversations with local people tell us we could do more to support them to remain independent by providing high quality health and care services closer to home. In addition, some organisations within our partnership have had a difficult time in the recent past. Turning this around – which we have now done – has consumed time and effort and constrained our ability to fully realise our ambitions for local people. This has been exacerbated by our large financial deficit: the financial challenges within our system have lasted at least ten years and unless we are able to return to a position of financial sustainability, we will not be able to achieve our goals.

4. We know that there are significant economic, educational and health inequalities between the north and the south[2]. Citizens in areas of Peterborough, Fenland and North East Cambridge experience health deprivation much worse than the national average[3]. This is an issue we want to address, and **Chapter 1 sets out this context in detail.**

5. Our first Sustainability and Transformation Plan (STP) (2016) set out changes we wanted to make to health services in Cambridgeshire and Peterborough. It described our core clinical strategy: health and care services provided closer to people's homes and excellence in hospital and specialist services. The plan also set out how we would change the way we worked together as partner organisations across the system to implement this strategy.

6. We have made good progress and started to bring together health and care to meet the needs of our citizens closer to home. Our Public Service Board has begun to reform our public services, bringing together general practice, community, third sector and wider public services through a Think Communities approach which empowers local citizens to shape services. We have two Alliances in north and south Cambridgeshire and Peterborough that

[1] https://royalpapworth.nhs.uk/our-hospital/latest-news/royal-papworth-outstanding-care-quality-commission
[2] Joint Strategic Needs Assessment core dataset for Cambridgeshire and Peterborough: https://cambridgeshireinsight.org.uk/wp-content/uploads/2019/04/CP_JSNA_Dataset_Presentation_DRAFT_20190321-FINALv2.pptx
[3] https://cambridgeshireinsight.org.uk/health/healthcare/, North and South Alliance Data Packs, Cambridgeshire Insight (September 2019)

are developing models of place-based care and support in line with local community needs. They are supported by 21 Primary Care Networks (PCNs), which are, over time, bringing together primary, community and social care through Integrated Neighbourhoods.

7. We know that people sometimes find that our services are service-centred rather than patient-centred[4] and so we must go further in bringing together health care across our system, in our places and through our neighbourhoods as we develop to become an Integrated Care System (ICS) by April 2021. In doing so, we need to ensure that care is person-centred, and simpler and easier to navigate.

8. Our clinical and partnership strategy, which is in line with the approach articulated in the national NHS Long Term Plan (LTP), remains at the core of this new plan. We have updated the principles behind our approach, drawing on the lessons from the last three years. We have reconfirmed our headline clinical ambitions for the next five years, with targets for diabetes, cardiovascular and respiratory disease that will improve lives. And we have set out exciting developments in cancer, children's and mental health services. **More detail on this can be found in Chapter 2.**

Our approach

- Health and care services provided closer to people's homes with more support for people to stay healthy, to keep their independence and to make decisions about their own health and care;
- Accessible and responsive urgent and emergency care services;
- Access for everyone to the information, support and treatments they need, using leading edge digital and technology wherever appropriate;
- Using our world-famous research and global enterprise for the benefit of our local citizens.

9. We want to ensure that we use our assets, including our buildings, as effectively as we can. Our plans for Cambridge Children's Hospital (Cambridge Children's) will enable us to do more to improve mental and physical health care for children and young people across the East of England. The recent Government announcement that our system will receive a share of national seed funding of £100m means that we can draw up plans for a new hospital within a highly innovative system, and model entirely new approaches to healthcare as part of ongoing work to integrate services across Cambridgeshire and Peterborough.

10. Our vision for our system is to provide joined-up, proactive care in the most appropriate setting. Fully realising this ambition to transform health and care for local people is a huge programme of work. To be successful, we need both to focus on delivering high-quality care that meets the needs of our population, whilst also making the most of the excellence within our system, building on our strengths and addressing long-standing health inequalities. We are determined to learn the lessons from our previous work to transform our system: we will

[4] http://www.healthwatchcambridgeshire.co.uk/sites/default/files/what_would_you_do_full_report_final.pdf

focus on a small number of priorities and align our leadership and resource around delivery through existing and new cross-system transformational delivery programmes.

11. Delivering our priorities will not be easy but successful implementation will result in significant benefits for our population, the East of England region and the country as a whole. Our ambition is high: we want to transform, making very significant changes to how we use our resources and how we care for our population. In each of our priority areas, we are clear about what we have achieved to date and the initiatives we want to focus on next. **Chapter 3 sets out more detail on our chosen areas of priority transformation.**

12. The national LTP requires us to commit to make specific service improvements for local people and our staff over the next five years. The LTP also requires us to make the NHS a better place to work and to develop our digital infrastructure. We have prepared a series of annexes to our plan which set out our work in each area in more detail. **Chapter 4 describes key points from these detailed plans.**

Our 4+1 priorities

- Integrated out of hospital care
- Outpatient transformation
- Redesigning care pathways to improve efficiency and reduce unwarranted variation
- Making the most of our assets

  +
- Research and innovation

13. **Chapter 5 sets out the financial challenge we face as a system and our plans to address it.** We need to make better use of the money we have, for our local citizens. And we need to better utilise our hospital beds by managing demand, preventing delays and ensuring that only those patients who really need to come into hospital do so. This means that we must make some significant changes to enable many more people to be cared for in different and more appropriate ways closer to home.

14. We have gone further than the national requirement for productivity improvement. This is a stretching financial plan, aligned with and in support of ambitious service improvement and transformation. The robust analysis we have undertaken confirms that we still need national and regional support to deliver on this challenge.

15. **Chapter 6 sets out our arrangements for delivery.** We recognise the importance of developing a plan that strikes the right balance between being ambitious, realistic and deliverable. We know that focusing on priority areas and working across the system to co-produce and plan implementation will help us to ensure delivery. We also know that in the past we have sometimes spent too much time discussing changes and not enough time implementing them. So we also describe the lessons we have learned and how we will apply them to the delivery of our local LTP.

Our commitment to delivery

16. To develop this plan and to determine our areas of focus, we have brought together the views and experiences of our local citizens and patients, frontline staff, and clinical and executive leaders. The signatures below demonstrate the commitment of our organisations to working together to deliver the ambitions described in our local LTP.

NHS Cambridgeshire and Peterborough Clinical Commissioning Group	Jan Thomas, Accountable Officer	Dr Gary Howsam, Chair
NHS Cambridge University Hospitals NHS Foundation Trust	Roland Sinker, Chief Executive	Michael More, Chair
NHS Cambridgeshire and Peterborough NHS Foundation Trust	Tracy Dowling, Chief Officer	Julie Spence, Chair
NHS Cambridgeshire Community Services NHS Trust	Matthew Winn, Chief Executive	Nicola Scrivings, Chair
NHS Royal Papworth Hospital NHS Foundation Trust	Stephen Posey, Chief Executive	Prof. John Wallwork, Chair
NHS North West Anglia NHS Foundation Trust	Caroline Walker, Chief Executive	Rob Hughes, Chair

17. In addition, Cambridgeshire County Council and Peterborough City Council have participated in the development of the LTP with the intention to align their public health and social care services with NHS services in an integrated way for the benefit of local residents. The councils participate in the programme through their officer representatives, recognising that their policy and financial decisions are subject to the constitutional arrangements within their respective authorities. The councils also have a particular requirement to scrutinise proposals for NHS service changes, as elected representatives of their communities and must ensure the independence and integrity of those arrangements.

Cambridgeshire County Council

PETERBOROUGH CITY COUNCIL

NHS Cambridgeshire and Peterborough Long Term Plan

Introduction

18. The NHS LTP, published in January 2019, reminds us of the importance of health and care services in the lives of citizens across our country. It also set out the challenges these services face nationally: concern about funding, staffing, increasing inequalities, pressures from a growing and ageing population and growing public expectations. The national plan sets out the strategy for how, as health and care systems, we must respond to these pressures and accelerate the redesign of patient care to ensure health and care services can continue to support those who need them now and into the future.

19. In Cambridgeshire and Peterborough, we are well placed to respond. We have a track record of working together as one system and established governance arrangements that bring together individuals with their peers from across the system to develop strategies, share progress and learning and aim to ensure that services and processes are joined up.

20. We have already started to work together on how we understand and improve the health of our population, how we manage our finances, how people can move around the system and between organisations in a seamless way, and how we support our staff and develop their skills. Our plan describes how we will organise and manage health and care services in an integrated way in the future and how we will continue to work in partnership not only between our organisations, but also with our population, to better meet their needs.

21. Our local LTP also describes the priorities we have chosen to focus on and how we have responded as a system, in our places and through our neighbourhoods, to the requirements set out in the national LTP. It explains how our plan is supported by a robust understanding of our current financial position and by stretching programmes to make our health services more efficient, so that they are sustainable for the future, allied with clear plans for ensuring that what we have set out to do is delivered.

CHAPTER HEADING

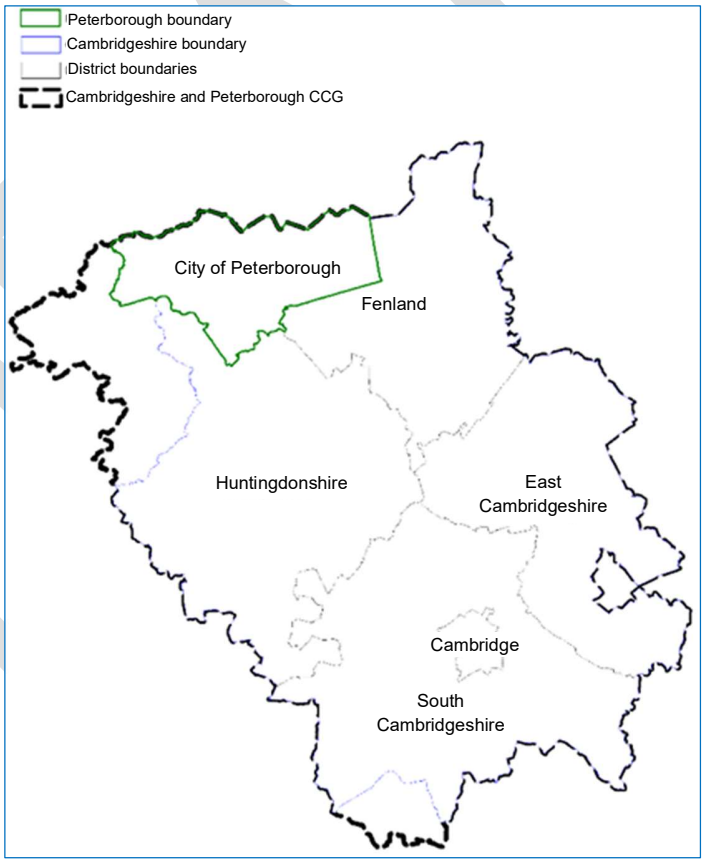
Chapter 1: Who we are

Our population

22. The Cambridgeshire and Peterborough system is large, diverse and predominantly rural with two large cities (Cambridge and Peterborough) to the south and north-west. We have one Clinical Commissioning Group (CCG), two upper tier local authorities (Cambridgeshire County Council, Peterborough City Council) and five District Councils. We have three hospital providers (Cambridge University Hospitals (CUH), North West Anglia (NWAngliaFT) and Royal Papworth (RPH)) and two community providers (Cambridgeshire and Peterborough Foundation Trust (CPFT) and Cambridgeshire Community Services (CCS)).

23. Our general hospital services are used by people from Cambridgeshire and Peterborough as well as parts of Lincolnshire, Leicestershire, Northamptonshire, Norfolk, Suffolk, Essex and Hertfordshire, while some of our population receive treatment at Queen Elizabeth Hospital in Kings Lynn, Norfolk. Our specialist hospital services cover a regional and, in some cases, national catchment area.

Figure 1: Map of the Cambridgeshire and Peterborough system

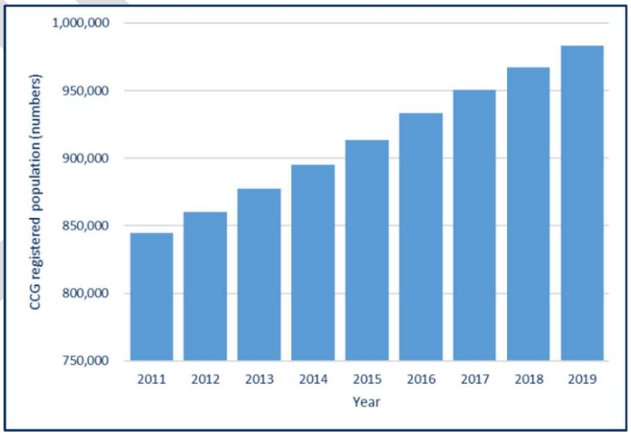


24. We have a population of over 980,000 patients[5]. Thriving industry means that this is increasing rapidly, putting pressure on housing availability, transport links and a range of public services. The rate of growth is highest for older people, placing particular pressure on health and care services. Our increasing population is one factor that has led to housing and homelessness issues in some areas, with a lower level of access to health services for vulnerable populations such as rough sleepers in Peterborough and Wisbech compared with Cambridge.

25. We expect population growth to continue, reflecting the ambition of the devolved Cambridgeshire and Peterborough Combined Authority to double the size of the economy over 25 years. We have the only non-urban Combined Authority in the country; the NHS, police and fire services sit together alongside local authority leaders to drive growth and opportunity and seek to address the deep inequalities within our area. It is recognised that economic growth must be matched by good quality public services and that without this there is a risk of losing the talent that we grow and attract to the area. A recently undertaken independent economic review found that Cambridgeshire and Peterborough are net contributors to the economy and recommended that action needs to be taken to ensure continued and sustainable growth[6].

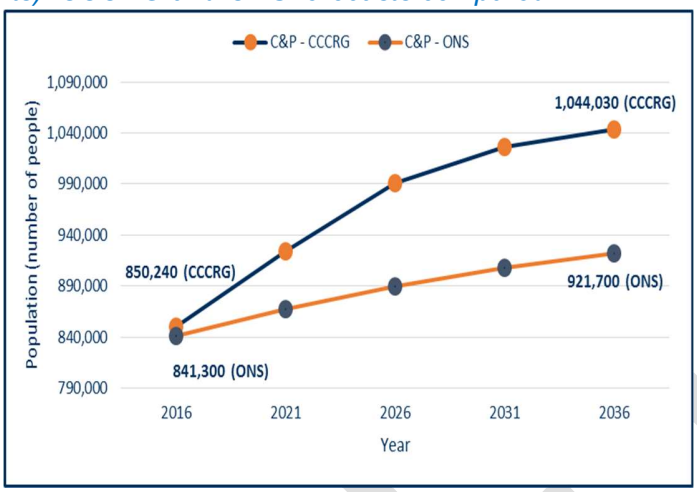
26. The local Cambridgeshire County Council Research Group (CCCRG), which forecasts population growth based on known housing developments, predicts that our population will be approximately 1,022,000 by 2021. This is 30,000 higher than the Office for National Statistics (ONS) prediction for the same time period. This significant difference leads to challenges when planning future services. However, both sets of population forecasts make it clear that the population is ageing – with the most rapid percentage increases seen in the over 65 age group.

Figure 2: Cambridgeshire and Peterborough CCG registered population 2011-2019 [7]



[5] Source: NHS Digital GP Registered Patient Population Data
[6] https://www.cpier.org.uk/final-report/
[7] Source: Serco and NHS Digital *Data from April each year JSNA

Figure 3: Cambridgeshire and Peterborough Local Authority residents (excluding patients in Herts and Northants): CCCRG and ONS forecasts compared [8]



27. Overall, approximately 39,000 (9.8%) of our population have two or more long term conditions, and 15.5% of the population have a long-term activity limiting illness. Our clinical staff tell us that this is not only our older population, but an increasing number of younger people. This figure is expected to rise overall as the population ages, resulting in increasing demands on the services we provide.

28. Peterborough, Cambridge and Fenland are the most ethnically diverse areas within our system, with transient populations including students and a higher than average number of migrant workers. Peterborough and Cambridge are both ethnically diverse, with longstanding residents from many different countries of origin including a significant Pakistani heritage community in Peterborough, and ongoing inward migration from overseas. In rural areas there are longstanding Gypsy and Traveller populations and there has been a significant influx of migrant workers from Eastern Europe, most marked in Wisbech and other areas of Fenland. Not all Cambridgeshire and Peterborough residents find it easy to speak and understand English; the 2018 annual schools census shows that over a third of children in Peterborough speak a language other than English at home.

29. We know from the Joint Strategic Needs Assessment core dataset for Cambridgeshire and Peterborough[9] that there are significant economic, educational and health inequalities between the north and the south. Areas in the south including Cambridge, South Cambridgeshire, and parts of Huntingdonshire and East Cambridgeshire are prosperous and attract many international businesses. Skills levels and wages are, in general, high, although it is important to note that there are pockets of high deprivation in Cambridge City and other parts of Cambridgeshire. Despite much industry and potential, deprivation levels in Peterborough are greater, and many residents feel untouched by the economic success of

[8] Source: ONS 2016-based Subnational population projections & CCCRG mid-2015 based population forecasts JSNA

[9] https://cambridgeshireinsight.org.uk/wp-content/uploads/2019/04/CP_JSNA_Dataset_Presentation_DRAFT_20190321-FINALv2.pptx

the Greater Cambridge area. This is also true in the agricultural areas and market towns that make up the third area, broadly defined as the fens.

30. The table below is based on the recently released national Index of Multiple Deprivation (IMD) (2019). It paints a picture of socio-economic deprivation significantly worse than the national average for most indicators in Peterborough and Fenland, compared with a better than average picture in the rest of the STP. The most striking difference is for 'education, training and skills deprivation' where Fenland is in the worst 1% of local authorities nationally and Peterborough in the worst 10%. This contrasts with South Cambridgeshire's position in the top 5%. These different levels of education and skills across the STP area need careful consideration when planning health campaigns, self-care interventions and digital innovation.

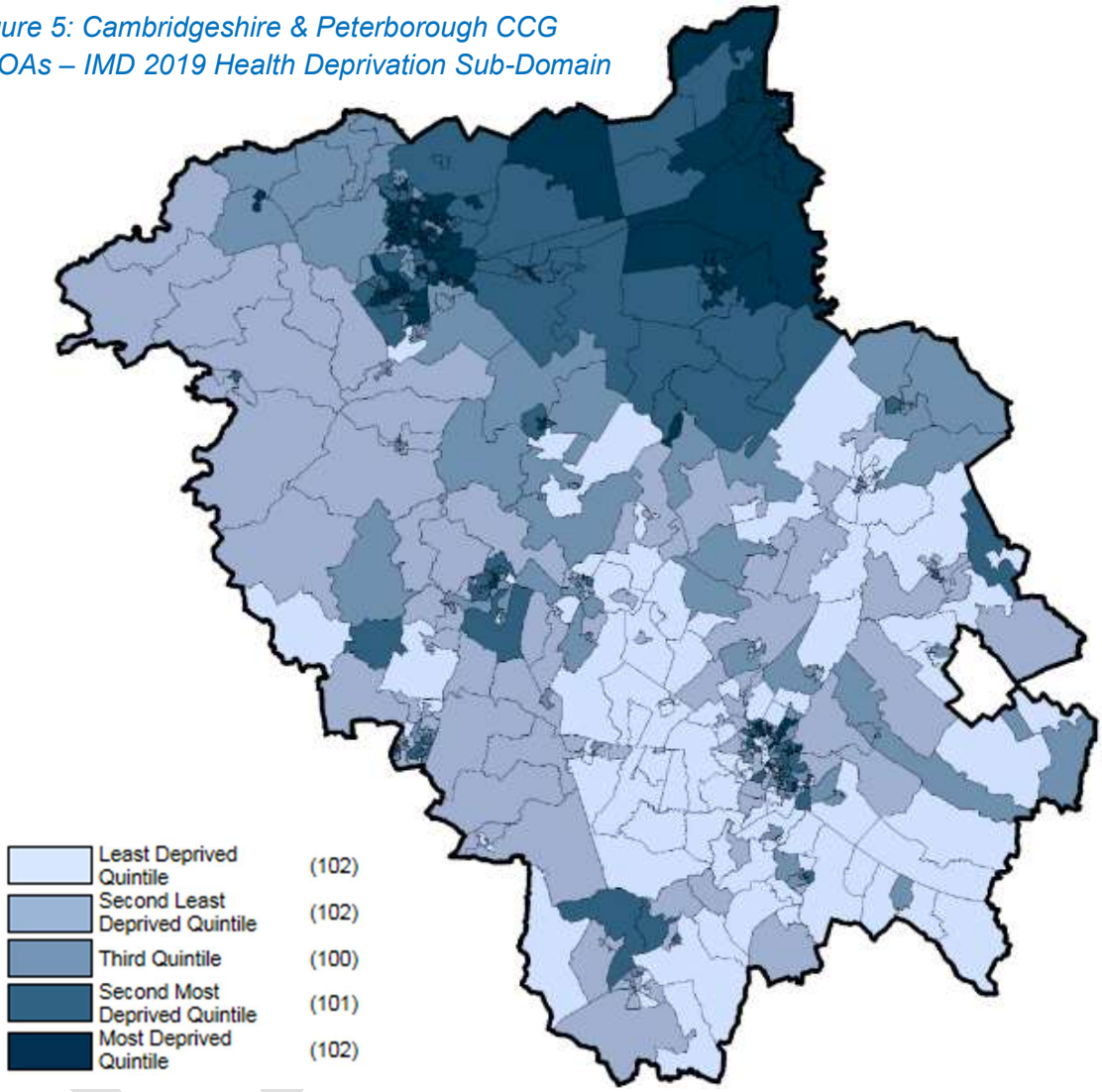
Indicator	Local Authority					
	Peterborough	Cambridge	East Cambridgeshire	Fenland	Huntingdonshire	South Cambridgeshire
Overall local authority rank	53	245	266	51	247	300
Income deprivation domain rank	59	245	259	56	250	302
Employment deprivation domain rank	73	270	274	54	245	304
Education, skills and training deprivation domain rank	31	284	195	3	175	307
Health and disability deprivation domain rank	65	202	288	55	242	304
Crime deprivation domain rank	32	95	286	136	222	248
Living environment deprivation domain rank	172	51	216	204	208	258
Barriers to housing and services deprivation domain rank	41	96	46	108	117	98
IDACI (income deprivation affecting children) rank	52	200	278	46	234	293
IDAOPI (income deprivation affecting older people) rank	78	172	211	81	268	301

Key	Least deprived quintile	Second least deprived quintile	Third least deprived quintile	Second most deprived quintile	Most deprived quintile

31. The IMD also includes a Health and Disability Deprivation index which combines data on premature death, disability rates, emergency hospital admissions and mental health. Fenland is in the worst 20% of all local authorities for health deprivation and Peterborough is in the worst 30%, indicating resident populations with a high need for health and care services. The other four district/city councils in Cambridgeshire all have better levels of health deprivation than the national average, with South Cambridgeshire in the top 10% of local authorities nationally. This IMD Health Deprivation index is also calculated for Lower Super Output Areas (LSOAs) - small areas with populations of about 1500 people – and the map below shows

how these small areas are distributed around the county. While the majority of small areas with the worst health deprivation are in Peterborough and Fenland, there are also some in Cambridge City and Huntingdon[10].

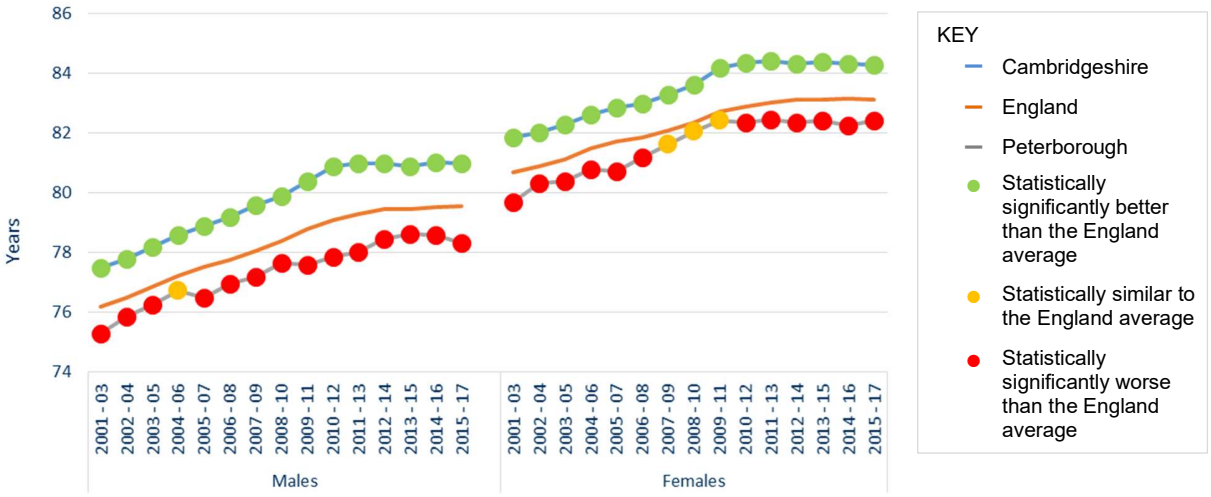
Figure 5: Cambridgeshire & Peterborough CCG LSOAs – IMD 2019 Health Deprivation Sub-Domain



32. Some of our care outcomes are excellent, but overall improvements in life expectancy across the area have stalled in recent years. Life expectancy in Cambridgeshire for both men and women remains well above the national average, but in Peterborough and Fenland, life expectancy is below national averages and, for men in both areas, has recently started to fall.

[10] Source: Indices of Deprivation 2019, Ministry of Housing, Communities & Local Government

Figure 6: Life expectancy at birth, 2001-03 to 2015-17[11]



33. When addressing inequalities in health outcomes it is essential to work across the NHS and local government to take a holistic approach which covers the wider social determinants of health and lifestyle behaviours including smoking, alcohol and unhealthy diet, good quality primary care, and access to wider NHS services which can adapt to meet the needs of disadvantaged groups. This year, for the first time, a joint Health and Wellbeing Strategy (2019-2024) is being developed across Cambridgeshire and Peterborough. This is taking a proactive approach, particularly focused on the wider determinants of health (such as housing and the economy) and ensuring children have the best start in life, as well as supporting healthy lifestyles and reducing unwarranted variation in health outcomes. We are working in partnership to ensure that our LTP and the joint Health and Wellbeing Strategy are complementary and aligned.

Our health and care system

34. The Cambridgeshire and Peterborough health and care system is busy and patients are accessing services in record numbers. Last year we had over 185,000 admissions to hospital, 300,000 attendances at Accident and Emergency (A&E) and walk-in centres, and over five million GP appointments. Emergency admission activity has grown on average at 4.2% a year for the past five years, not all of which can be explained by the increase in population or health need. Demand for adult social care correlates with the increase in emergency admissions and the people we support have more complex needs which leads to more costly placements.

35. Performance against national standards around referral to treatment times, cancer waits and A&E performance are consistently below target or decreasing in performance; last year only 86% of patients seen at A&E at our two main hospitals were treated within four hours. The number of serious incidents in hospital has reduced since last year, however Trusts have mixed performance against the NHS Improvement Safety Thermometer. We think that people

[11] Source: Public Health Outcomes Framework

are not always seen in the place that can best meet their needs and we have work to do to improve patient experiences of the health care they receive.

36. Overall, we have good quality general practice: 88% of patients report a good level of satisfaction with their GP surgery. However, we know that some of our practices are struggling with demand, staff numbers, estates and finances and this year, the number rated by the CQC as 'inadequate' or 'requires improvement', has risen to 15%, compared to 5% nationally. Many of these poorer ratings are for practices serving deprived areas in Peterborough. We are working with our Local Medical Committee, Healthwatch, the CQC and patient groups to identify and tackle issues. Our developing Primary Care Networks will improve the resilience of individual practices and our move towards wrapping community care around surgeries in Integrated Neighbourhoods will also help.

37. In spite of the challenges we face, we have much to be proud of. In October 2019, one of our hospitals, RPH, became the first ever NHS hospital to be rated outstanding in all 5 of the CQC domains; safe, effective, caring, responsive and well-led. And as a system, we have demonstrated the ability to make real and rapid progress together: delayed transfers of care (DTOCs) have been brought down from 10% to 4.5%; the system capital plan secured £140m in December 2018, the biggest allocation to any single STP; and we were able to sign up to a system control total for the first time, building on the work to establish Guaranteed Income Contracts. Our staff are working hard together and are committed to making changes that improve health and care for our population.

38. Our local citizens have told us where we are doing well and where they would like us to do better[12]. We have aimed to respond to this feedback in the development of our Long Term Plan.

What our population have told us they would like

- Faster, easier access to primary care services, particularly to GPs
- Support to access information (not only via the internet) and appropriate services
- Improved communication between services
- Improved listening, especially to people with long-term conditions who are often 'experts' in their condition and able to recognise when their health changes
- Person-centered services, particularly for autism and mental health
- Joined-up care, especially for people with long-term or multiple conditions.
- Recognition that transport difficulties can be a barrier to accessing health care

39. Many of the issues outlined in this plan also affect wider public sector partners, particularly Local Government. We are aware that the complex public sector system can, at times, hinder rather than help to tackle the underlying issues that individuals and communities face by focusing on delivering their own priorities, rather than working collaboratively to truly understand the holistic needs of the person and the place.

[12] http://www.healthwatchcambridgeshire.co.uk/sites/default/files/what_would_you_do_full_report_final.pdf

40. We have sought to tackle this with our Alliance approach. Both Alliances are developing placed based models of delivery that seek to better integrate services and provide a more effective person-centred approach. Within Local Government, the Think Communities approach has developed a similar set of principles which closely align with our Alliance model to ensure our citizens are at the heart of decision making. These principles include the following:

- Taking a shared approach to work in areas of high risk and vulnerability;
- Understanding and removing barriers for community led activity;
- Building capacity for communities to work together for the benefit of all our services;
- Introducing system change, taking a broader view to recognise the complexities and allow multi agency conversations with communities;
- Supporting communities to develop and deliver their own priorities which in turn will help to address the need for costly and complex public sector service engagement.

41. Supporting the system to work smarter together is at the heart of Think Communities. Through greater sharing of data and intelligence between organisations, coupled with understanding the needs of communities we can have a greater collective impact that will improve health outcomes for the individual and reduce the cost to the public sector.

42. Within District Council areas, new Placed Based boards will be established to drive the Think Communities approach. These boards will take a holistic and multi-agency approach to look at the underlying, entrenched and complex issues which are impacting on individuals, communities and public sector.

43. We have established system working and governance, and a new way of working through our places and neighbourhoods. We are working closely with our local authorities recognising that working collaboratively is the best way to address the issues our communities face. Yet we have much further to go to become an ICS, and to realise all the benefits of working in this way for our local citizens, ensuring that care is person-centred, simpler and easier to navigate.

Our challenges and opportunities

44. As well as our growing population, the significant variation in outcomes and health inequalities, and responding to growth in activity, we face other challenges as a system. Our financial system deficit is a long-standing challenge; Cambridgeshire and Peterborough have been struggling with finances for at least ten years and has only recently been able to begin to tackle this as a system. Previous attempts at ambitious system change have also gone wrong, for example, with the collapse of the Uniting Care Partnership in 2015. The Local Authorities face similar challenges.

45. We need to work within our means, both in terms of workforce that we can recruit and the finances available for our system. Our system currently employs over 25,000 staff in our

Trusts and over 2,000 staff in Primary Care. Trusts are currently running at high vacancy rates with 5% to 15% of registered nursing roles vacant and 2% to 18% of medical roles vacant. Our primary care workforce is ageing, with 23% of GPs aged over 55. We had a 10% nursing vacancy rate across our system in March 2019 and a collective system deficit of £192 million in 2018/19. It is imperative that we address these challenges - we know, for example, that to achieve on-time hospital discharge we need sufficiently resourced home care. Only by working in partnership will we be successful.

46. There are also opportunities available to us. We are exploring how to go further and faster in our collaborations with partners, local industry including the biomedical campus in Cambridge, large global businesses in Peterborough and the universities in Cambridge and developing university in Peterborough. We have exciting new developments planned, such as Cambridge Children's and the delivery of more hospital activity from our Hinchingbrooke hospital site; these are both important for local citizens and for young people and families. And we will be using our share of the national seed funding of £100 million recently announced by the Government to draw up plans for a new Addenbrooke's Hospital; the money will enable us to model entirely new approaches to healthcare as part of ongoing work to integrate services across Cambridgeshire and Peterborough. This will be of significant benefit to the development of our integrated health and system serving our whole population.

47. We are working within this context both to secure improvements to health and care services locally, and to realise a unique set of opportunities for research, innovation and collaboration with industry partners. We have made progress recently, but challenges remain, and this plan sets out how we intend to overcome them.

CHAPTER HEADING

Chapter 2: How we want services to change

48. Our first STP in 2016 set out the changes we wanted to make to health and care services within Cambridgeshire and Peterborough. Since then we have improved how health and care services work together, for example, by reducing the number of people delayed for too long in hospital, but we know that others across the country have gone further and faster. In this plan, we first need to reaffirm the changes we want to make to health, care and wider public services and then how we are going to organise ourselves to do this.

Changes to health, care and wider public services

49. In 2016, we said that we wanted to provide health and care services closer to people's homes and ensure that hospital and specialist services were excellent. This core approach is in line with the national NHS long-term plan and, as local partners, we continue to believe that it is right for our system and our citizens. However, we have updated and developed our vision to make sure it is right for this new plan.

Our approach

- Health and care services provided closer to people's homes with more support for people to stay healthy, to keep their independence and to make decisions about their own health and care;
- Accessible and responsive urgent and emergency care services;
- Access for everyone to the information, support and treatments they need, using leading edge digital and technology wherever appropriate;
- Using our world-famous research and global enterprise for the benefit of our local citizens.

50. Primary care is the foundation of our local health service. Every day, GP practices support thousands of people to manage their health and act as a gateway to hospital and specialist services. Primary care is best placed to care for our frail older people and those with chronic conditions, and it can have a major impact on health inequalities. We know that integrated working at a very local level works and reduces the need for patients to access more specialist services. We need core primary care across the system to become stable and high-performing.

51. We want to see more care moved out of hospital and provided closer to home because evidence tells us that this is better for patients. We know that we will need to shift resources into primary and community settings to enable this to happen. We want to build on the understanding that primary care services already have of their local populations, using real-time data flows and digital tools to identify those with chronic conditions at risk of an admission to hospital, and to use a multi-disciplinary team to support these people proactively, keeping them well and independent.

52. Our Think Communities approach supports this multi-disciplinary team model, also focusing on non-health issues (for example housing, crime and community safety) that can contribute towards poor life outcomes and negatively impact on physical and mental health. Part of the approach is to change the conversation between communities and public sector organisations, building upon the assets and strengths within each place, and harnessing them to start to meet both local and organisational priorities. The voluntary sector has a key role to play and is highly effective at developing innovative solutions to complex challenges.

Think Communities approach

- Taking a shared approach to work in areas of high risk and vulnerability
- Understanding and removing barriers for community led activity
- Building capacity for communities to work together for the benefit of all our services
- Introducing system change, taking a broader view to recognise the complexities and allow multi agency conversations with communities
- Supporting communities to develop and deliver their own priorities which in turn will help to address the need for costly and complex public sector service engagement.

53. As well as trying to avoid the need for some emergency hospital care, we think more planned care can take place out of hospital. Specialist advice and support need to be available much more readily within local communities so that outpatient appointments are not always required. Making this change will require a shift in resources over time out of hospital and into the community. We also know that some primary care networks will need more support than others to make these changes and we will work closely with them to develop this capability. We will actively address health inequalities by concentrating our resources and initiatives in those areas that have the poorest outcomes.

54. Preventing disease is more powerful than managing it better. We want to focus on prevention at every opportunity: working with children, families and communities and supporting healthy lifestyles; working with local government on improving housing, employment opportunities and other determinants of health; and working with staff to understand how every contact can be used to promote good health and wellbeing.

Case study: a new approach to leg ulcer care

Granta Integrated Neighbourhood in South Cambridgeshire is implementing a new approach to leg ulcer care. This includes a cutting-edge surgical intervention endorsed by the Department of Health and Social Care, to prevent the future incidence of ulcers, ongoing management through an app and support from group clinics led by tissue viability nurses in Granta's flagship surgery.

55. When people do need to access hospital services, we want them to receive consistently outstanding clinical care. The hospital merger that created NWAngliaFT has enabled the new Trust to focus on ensuring consistency, with patients able to be seen in different locations knowing there will be continuity of care from one site to another. RPH's move on to the

Cambridge Biomedical Campus has also unlocked new opportunities for joined-up clinical care and better use of resources.

56. Across all our hospitals, we want to make continuous quality improvements, such as in day surgery and ambulatory care, ensuring we achieve quality standards and accreditations and providing sustainable out of hours cover for emergency care. These will be underpinned by data and analytics, including patient feedback. However, our hospitals need to make significant changes to how they work so that they no longer consume an ever greater proportion of health resource.

Case study: support, advice and interventions to people with no fixed abode
The Access Surgery in Cambridge provides proactive healthcare support, advice and interventions to local people with no fixed abode. A health needs assessment for rough sleepers and formation of a wider NHS Inequalities Strategy is ongoing. Learning from this model will inform the development of Health Check facilities across PCNs in Cambridgeshire and Peterborough, proactively reaching out to groups who find it more difficult to access current services and access full health checks in Primary Care

57. As well as delivering hospital services to our local population, very specialist services for people across the East of England are provided within Cambridgeshire and Peterborough. We have ambitious plans spanning the East of England on mental health, children's services, neurosciences and cancer. We think we can, over time, provide more specialised services locally, reducing the need for people to travel to London or further afield.

Case study: a common clinical approach for stroke patients
Having a common clinical approach for stroke patients means that when they transfer from their hyper-acute care at Peterborough or Cambridge to a specialist rehabilitation centre at Hinchingbrooke, they will be on a joined up pathway with a single team who work together to similar aims.

58. We can also do more locally to connect our clinical services to the centres of excellence we host and to use their expertise to improve treatment for patients across Cambridgeshire and Peterborough. The research we do is of global significance, including for mental health. Cambridge Children's will be unique in the integration of child physical and mental health and world-leading research including genomics.

Case study: Joined up local and specialist cancer care
NWAngliaFT received over 23,000 suspected cancer referrals in the last 12 months and diagnosed over 3,300 new cancers. Most were seen and treated in their local hospital; only patients requiring specialist treatments need to be referred to services at RPH and CUH. NWAngliaFT plans to continue providing hospital care close to home with oncology and specialist nurse support provided at Peterborough and Hinchingbrooke and more outreach clinics at Doddington, Ely and Spalding to reduce travel time for patients who require many visits to complete a course of treatment. This will provide opportunities for more joint working with primary care, community and third sector colleagues and opportunities for greater integration of routine cancer care.

59. We are evolving our position in neuroscience to develop a networked service across Cambridgeshire and Peterborough and beyond, with close links to mental health services to support all aspects of brain disorders. We expect the Institute of Metabolic Science and the new Cardiothoracic Institute to help us improve the treatment of diabetes and cardiovascular disease for patients in Wisbech; that Cancer Research UK can help cancer patients in Peterborough to access innovative new therapies earlier; and that the East of England NIHR Applied Research Collaboration can help people in Huntingdon with mental health conditions. We are collaborating with medtech companies in other countries including Sweden and Switzerland. We have the support of the University of Cambridge, Cambridge University Health Partners, the Eastern Academic Health Science Network and the Cambridge Biomedical Campus in taking these partnerships forward.

How we will work together differently

60. Our 2016 plan set out how we would change the way we worked together as partner organisations. As a result, we have established three levels of partnership working, supported by a Joint Clinical Group which brings together clinical leaders from across the system.

- Our 21 PCNs bring together GP practices into larger groupings each covering 30-85,000 people. Eight of these have already become Integrated Neighbourhoods, bringing together community, social care, mental health, the voluntary sector and wider public services. We recognise that as this approach develops, we will need to focus more locally, to innovate and to develop a place based approach at sub-PCN level.
- Our Alliances organise care around two ‘places’ within our system. They cover around 415,000 people in the south (East Cambridgeshire, South Cambridgeshire, Cambridge City) and 575,000 people in the north (Peterborough City, Huntingdonshire, Fenland). They bring together system partners to support the development of PCNs and Integrated Neighbourhoods and coordinate services more effectively.
- Finally, we have one system, covering around 1 million people, that brings leaders together to set priorities informed by population health needs, to manage system finances and resources, to deliver strategic work programmes and to coordinate service change.

61. We need to go further to become an ICS by April 2021. This means taking the next steps to join-up and coordinate out of hospital services effectively, to make it easier for staff to work together across organisations supported by digital tools and to embed world-class research, innovation and teaching alongside delivering care. We have many strengths to build on including strong relationships and a positive culture, with a stable leadership cadre working effectively to implement change. We have a coherent system architecture, a single CCG overseeing commissioning, and places and neighbourhoods established that form the building blocks for managing population health.

62. In other areas, we have more to do. We need to test and refine our vision with citizens and staff, building on our extensive public engagement to date, to ensure it fully resonates. We need to make better use of data to redesign care and implement integrated care. We know we also need to improve our financial position, overcoming years of struggle to get back on to a sustainable financial footing. We need clear strategic commissioning and workforce plans to ensure that resources are targeted to need, service quality is consistent across the whole STP area, and inequalities in health outcomes are appropriately addressed.

63. Our understanding of how care is best delivered in places and neighbourhoods has developed since 2016. Our Alliances are starting to take on greater accountability for the design and delivery of services, including urgent and emergency care. Neighbourhoods are working collaboratively to deliver new pathways, such as new ways to access mental health support for students in Cambridge City. We will accelerate this work, developing these strong foundations into delivery vehicles capable of implementing the changes described. Our focus will particularly be on supporting PCNs to develop high levels of maturity and for PCN clinical directors to increasingly shape system strategy. We will also be working with PCNs and other partners to implement our Integrated Neighbourhoods Framework by April 2022. Alliances will focus on redesigning urgent and emergency care in 2020/21 and planned care in 2021/22.

64. We will continue to work across all system partners to set priorities, allocate resources and enhance clinical leadership, improvement and organisational development. We also need, in due course, to explore changes to organisational form on both the commissioner and provider side.

How we will work together

- As system leaders, we will work together for the benefit of the system, even where this is challenging for our organisations;
- We will prioritise our focus and resource, as well as funding, so that we back our priority projects and set them up for success; and
- We will be clear about what we are trying to deliver, how and when we are going to deliver it, and will hold each other to account.

CHAPTER HEADING

Chapter 3: An ambitious programme of transformational change

65. So far in this plan, we have described our population, the pressure our health and care services are under and how we want to change to improve the care we provide. This is set against the backdrop of very significant financial pressure which means we cannot continue as we are.

66. We think that, as system partners, we need to embark on a programme of transformational change to deliver sustainable improvements in the quality of the care we deliver. We do not make this commitment lightly because we know that no other health system has successfully achieved the totality of what we are proposing. We know it will be extremely difficult; nonetheless, we think we have a huge opportunity to transform services, to improve patient care and to deliver better value for money for the taxpayer.

Choosing where to focus

67. We have looked at a wide range of data, alongside the Health and Wellbeing strategy, to help us decide which areas we need to focus on. On the whole, our population health outcomes are good, but we know we have large health inequalities associated with areas of deprivation; we need to tailor services to local populations and target resources to where they are most needed. Our health system is busy and not consistently meeting quality and performance standards, and as a result some people have a poor experience; we need to look carefully at avoiding unnecessary trips to hospital and keeping people well at home. We also have high vacancy rates for doctors and nurses; we won't be able to significantly expand our workforce so we need to make best use of the people and clinical time we have.

68. These challenges are not unusual for systems across the country and are reflected to some extent in the national LTP. This plan sets out some clear requirements on developing out of hospital care and reducing outpatient appointments which have been factored into our decision making. In addition, we have considered where we have opportunities locally to go further and faster, for example through realising a unique set of collaborations between research, industry and digital partners.

69. Furthermore, we have conducted robust and in-depth analysis of our financial spending and how we compare to similar systems across the country. This suggests that we refer more people to hospital for outpatient appointments and operations and that we have much higher fixed costs for our buildings and IT.

70. Finally, we have built on a prioritisation process undertaken by our clinicians in February 2019 to determine the specific clinical areas on which our system should focus to improve population health outcomes. The process considered national priorities reflected in the LTP, potential impact on health inequalities, and fit with the Integrated Neighbourhoods model.

System priorities

71. Considering all this evidence, we have chosen a set of 4+1 transformational priorities. Our ambition is high: we want to transform, making very significant changes to how we use our resources and how we care for our population. We have deliberately picked a small number of areas to focus on, around which we will align our resources. These priorities are described in detail below. We will deliver them through 9 major work programmes, some of which are established (e.g. Urgent and Emergency Care) and some of which are new.

4+1 transformational priorities

- **Integrated out of hospital care**
  Focusing on population needs, we will join up out-of-hospital services more effectively, building on the foundations of strong primary care and providing additional support where necessary.
- **Outpatient transformation**
  We will change the way we deliver our outpatient services to ensure that our patients are seen by the right professionals in the right places.
- **Redesigning care pathways to improve efficiency and reduce unwarranted variation**
  We will improve the quality of the care we provide by reducing variations in the way services are delivered, adopting best practice.
- **Making the most of our assets**
  We will identify opportunities to make the best use of our high fixed cost assets, including estates and digital infrastructure.
  +
- **Research and innovation**
  We will ensure that our system derives maximum benefits from links with research to deliver improvements for our population and for our staff.

Integrated out of hospital care

72. We want to join up services out of hospital much more effectively. We will build on the foundations of strong primary care, providing additional support where necessary and bringing together staff from across social care, community, acute and voluntary sectors, to address urgent care needs, access specialist advice and support, and combine primary and community services. Primary care networks will understand the health needs of their population using a population health management approach and tools such as ECLIPSE and PHE Analytical Skills Mapping. This will help identify people who would benefit from more joined-up working to prevent the exacerbation of chronic conditions and to allow people to leave hospital more quickly. Working in this way should reduce the number of beds needed in our hospitals for emergency patients and the number of outpatient appointments. Organising these services around primary care networks, addressing the current fragmentation, should allow us to make some economies of scale and improve coordination and productivity.

73. This will be very challenging to achieve in practice. While some of our primary care networks are mature and ready to take on responsibility for these new services, others will require significantly more support.

74. We will start this programme of work immediately. In 2020/21, we will focus on developing capability within PCNs and start work to devolve accountability for community services to them, with the services recommissioned for them to provide. We will also focus on out-of-hours urgent care services, bringing together extended GP access, 111 and rapid response community services, and trialling a new way of working which will make GP appointments more accessible.

75. Over time, we expect that the success of PCNs will have a significant impact on the hospitals. We expect that older people will have shorter stays in hospital when they are admitted in an emergency, and that accessing specialist input in the community will reduce the amount of planned care that takes place in a hospital setting. At their most ambitious, our plans therefore mean that the hospitals do not spend more in five years' time than they do now, even though our population will have increased.

76. This links to how we use our buildings to provide integrated care services, planning for the changing needs of our population as well as changes to services. This process – for developing plans for out of hospital estate - has already started. We will also look to PCNs to implement our identified clinical priorities. Our first step will be to determine which local areas to target first, looking particularly at health outcomes and inequalities.

Diabetes	*An ambition for remission*	• More than half of type 2 diabetics meeting treatment targets • Reduction in adverse events (CV and amputations)
Cardiovascular disease (CVD) and stroke	*100 hearts - avoiding 100 heart attacks*	• Upper quartile for CVD outcomes • Thrombectomy available 24/7
Respiratory disease	*Take a big breath*	• 25% reduction in smoking rates • Reduction in days spent in hospital for people with chronic obstructive pulmonary disease • Improving outcomes for children with asthma

77. We know we need to develop more detailed plans over the coming months. We need to set out more clearly how this model will work in practice, including thinking about setting priorities, managing performance and administration costs, and flow of resources. We also need to think through the implications for our existing organisations and understand if any changes need to be made over time.

Outpatient transformation

78. Too often, when, where and how care is being delivered is a source of frustration, waste and missed opportunity for patients and the teams looking after them. We want to address this and we believe there is significant potential to radically change the way we deliver our outpatient services to ensure that our patients are seen by the right professionals in the right places.

79. We want to modernise the patient pathway from end to end, from pre-referral to diagnostic testing to supporting self-management. This programme of work will include ensuring that our primary care clinicians are fully equipped to refer the right people onto acute care with specialist training and advice. We will support our acute care clinicians by implementing the technology to facilitate video and email-led conversations with patients; we will use trained nurses and health care assistants to support both patients and clinicians. We will also do more to help patients to remember appointments, reducing the number of 'do not attends'.

80. We believe that the traditional face to face model of outpatient care is outdated and often means that neither clinicians' nor patients' time is best used. Transitioning face-to-face outpatients to digital channels should bring care closer to home, improve staff satisfaction and productivity, offer more flexible working patterns, reduce physical space required for clinic and waiting rooms, reduce the need for support staff, reduce congestion on busy hospital sites and reduce carbon emissions. As a system, we are working on ensuring all Trusts have digital communication with patients around booking, correspondence and patient information provision/ self-assessment, as well as end-to-end outpatient pathways.

81. We will begin this programme of work in 2020/21, introducing a systematic approach to ensure referrals are appropriate and directed to the right place. In particular, we will start by looking at ophthalmology and musculoskeletal services, as these have high levels of outpatient appointments.

82. We will develop detailed plans over the coming months. We need to work with our clinicians across all specialities to consider which improvements each want to take on and then define a best practice care pathway for each area. We need to decide how best to pay for outpatient appointments in the future, and how we will incentivise and track performance.

83. The consequences of success for acute hospitals are profound. We expect the number of outpatient appointments to drop by around one third over four years, with knock-on implications for the number of staff and amount of building space needed. We will, however, need to invest in the necessary digital tools, for example to optimise administrative processes across the hospital.

Redesigning care pathways to improve efficiency and reduce unwarranted variation

84. The 'Getting in Right First Time' (GIRFT) programme has made a wide range of recommendations for how hospitals can improve the quality of the care they provide by reducing variations in the way services are delivered. GIRFT identifies changes that both improve patient care and outcomes, and save money, for example by reducing the number of unnecessary procedures. [13]

85. Our analysis suggests that we could spend approximately £70m less by 2023/24 if we adopt this best practice across every speciality within Cambridgeshire and Peterborough. We need to undertake further work to identify which areas to prioritise, but our initial analysis suggests we should look at ophthalmology, and trauma and orthopaedics as these are high volume and high cost pathways.

86. These changes will provide better and more efficient care, but they do involve making lots of changes to the way our hospitals and staff currently work. For example, adopting these recommendations in trauma and orthopaedics would mean moving to a consultant-delivered service, making better use of operating theatres and patients spending less time in hospital after procedures. In addition, we will develop new workforce planning and rostering tools that make the most of the flexibility digital platforms offer to staff working patterns, staffing new models of integrated neighbourhood based care and matching staffing to expected patient demand. We will ensure that staff are able to read and write into an interoperable digital health and care record.

87. We will also continue with our existing work to introduce plans, after appropriate consultations, to develop a centralised stroke and neuro-rehabilitation service for the whole system, and to concentrate trauma and orthogeriatrics on two acute sites in order to optimise patient outcomes.

88. In 2020/21, we will look to integrate service provision to drive efficiency over sites and deliver single agreed care protocols across the system to reduce variation.

89. By working in partnership across Cambridgeshire and Peterborough we have already made substantial reductions to DTOCs from, at any one time, over 200 people being delayed in hospital, to the current position of approximately 75. This work will continue. (Annex 2 provides further information).

Making the most of our assets

90. We know as a system we have high costs around digital infrastructure and estates. We are looking into opportunities to better use these assets or reduce their overall cost. We have begun this work at NWAngliaFT, with the aim to make full use of facilities on their five-site estate at Peterborough, Stamford, Hinchingbrooke, Doddington and Ely. We will expand the

[13] https://gettingitrightfirsttime.co.uk/

urgent care facilities at Hinchingbrooke Hospital with increased ambulatory care to reduce pressure on A&E and inpatient wards. We will also increase bed numbers on the Hinchingbrooke site to cope with the predicted demand due to demographic growth and support our two larger acute hospitals in Cambridge and Peterborough and we will invest in theatres to expand planned surgical and rehabilitation capacity. Finally, working in partnership with RPH we will enable better diagnostic imaging capacity for cardiology patients. We also have significant digital assets which we are not yet fully exploiting and aim to foster person-centred health and wellbeing by accelerating the adoption of digital health.

Research and innovation

91. Our Trusts contribute to the largest centre of medical research and health science in Europe, with two Global Digital Exemplars, eight Medical Research Council Units, the largest NIHR Biomedical Research Centre, industry partnerships with major international players (AstraZeneca, GSK, Microsoft, Philips and Abcam) and 450 life sciences companies. NWAngliaFT is consistently rated as one of the top contributors for entering patients into clinical trials in the region; CPFT is the third most research active mental health Trust in the country; Cambridge Children's will extend this to integrate child physical health, mental health and world leading research including genomics; and the new Addenbrooke's will extend this across the full range of services provided at CUH. We will ensure that our system, our population and our staff derive maximum benefits from these links with research.

Mobilising for delivery

92. Taken together, our 4+1 priorities describe an exciting and transformational programme of work which will impact on every part of the health and care system in Cambridgeshire and Peterborough, improving care both in and out of hospital and using resources much more efficiently. The priorities have been agreed by each partner in the system and in-year operating plans for each organisation will align to these five areas.

93. To deliver these priorities we will build on existing system-wide work programmes, such as our UEC collaborative, and establish new programmes and projects where required. We will ensure that clear objectives are developed, appropriate leadership and resource is identified and delivery is undertaken according to a shared methodology. We will work with our staff to co-create improved system working. For more detail on our delivery architecture, see Chapter 6.

CHAPTER HEADING

Chapter 4: Delivering the must-dos

94. The national LTP, published in January 2019, set out a desire to keep all that is good about the NHS, tackle head-on the pressures faced by staff and redesign patient care to future-proof the NHS for the decade ahead. We have taken this national plan and made our own decisions locally about where to prioritise over the next five years in response to these challenges.

95. The national plan also set out some very specific changes to particular services. We have chosen to prepare 20 annexes to our local LTP which respond in detail to the national requirements and set out how different services will improve. This chapter summarises our proposals, highlighting the key points from each annex.

Delivering a model for the 21st century		2019/20	2023/24
	Transformed 'out-of-hospital care' and fully integrated community-based care	Partial Compliance	Full Compliance
	Reducing pressure on emergency hospital services	Partial Compliance	Full Compliance
	Giving people more control over their own health and more personalised care	Partial Compliance	Full Compliance
	Digitally-enabling primary care and outpatient care	Partial Compliance	Full Compliance
	Better care for major health conditions: improving cancer outcomes	Partial Compliance	Full Compliance
	Better care for major health conditions: improving mental health services	Partial Compliance	Full Compliance
	Better care for major health conditions: shorter waits for planned care	Partial Compliance	Full Compliance

Achieving performance standards

96. The NHS performance standards, particularly for A&E, cancer and waiting times will remain priorities. We are committed to achieving the national standards within Cambridgeshire and Peterborough.

97. We have a plan in place to deliver all eight cancer waiting time standards. Our priority pathways are lung, prostate, colorectal and breast cancer. We also aim to improve time to diagnosis focusing initially on lung, prostate and colorectal pathways.

98. We know we need to continue to work together to improve our emergency care services. We will do this through better organising services around primary care networks, breaking down traditional barriers between organisations and being more proactive to prevent unnecessary admissions to hospital. Implementation of the Same Day Emergency Care and Acute Frailty services models are already well underway and will be fully embedded by April 2020. We are also developing local services for high intensity users, initially focusing on patients who attend A&E inappropriately multiple times each month.

99. We have a plan to ensure our planned care services have sufficient capacity and capability. As well as redesigning outpatients, including through using digital channels, we will leverage data, research and innovation, offer patients a choice of service provider and simplify care pathways.

Transforming out of hospital care

100. As described in Chapter 2, we have already created 21 PCNs and we will continue to support their development. Each one has a Clinical Director, and in September 2019 we launched a new year-long Primary Care Innovation Academy through the Judge Business School to give PCN Clinical Directors access to world class leadership development and ensure they are equipped to lead and innovate, working collaboratively with partners. We are proud to have established this programme and look forward to the significant benefits it will bring to our whole system. Where PCNs face the greatest challenges, for example those with high levels of deprivation and health needs, or where there are quality issues for member practices, our system will provide appropriate additional support.

101. We have also described in Chapter 3, and in more detail in Annex 1, how developing fully integrated out of hospital care is a top priority. Over the next five years, the per head spend on and in primary care will increase as additional money and resources stop flowing into the acute sector. All additional transformation monies given to primary care will be spent in primary care. Out of hospital workforce growth commitments will be met and training hubs and support structures will be created. Each of the four strategic priorities for community health will be met. Our next steps are to devolve urgent care community services by April 2021, including proactive care, care homes support and high-risk patient medication review.

Urgent and emergency care

102. Urgent and emergency care is a main concern for the system and a key enabler to the successful delivery of our 4+1 priorities. We already have in place a cross-organisational programme of work to improve our performance. We want to achieve upper quartile activity rates in acute services with upper quartile performance. Alongside the implementation of Same Day Emergency Care and Acute Frailty Services by April 2020, we will have implemented Urgent Treatment Centres by Autumn 2020. Underpinning these new models will be compliance with the Emergency Care Dataset by March 2020.

103. Following the horizontal integration of acute services at Hinchingbrooke and Peterborough City Hospital, NWAngliaFT has strengthened emergency care with emergency and major surgery on one site with a single ‘on call’ for surgical specialties. Discussions around the movement of inpatient trauma are ongoing. The co-location of RPH and CUH provides further opportunities for improved use of clinical services.

104. Our out of hospital Urgent Care Collaborative brings together 12 organisations and is working across boundaries to redesign our urgent care pathways and make it simpler for patients to

know where to go. In 2020 it will be possible to book urgent appointments, via 111, into primary care, GP out of hours and Minor Injury and Urgent Care Centres. We are also piloting innovative emergency department front door triage models.

Comprehensive model for personalised care

105. We have begun moving towards the delivery of a comprehensive model for personalised care and aspire to make available to every patient support for self-management and decision making regarding their own health. We have a number of excellent examples where this is already underway, including by our local authorities who have driven this agenda locally.

Case studies: social prescribing and community based support:

- We made arrangements for a community member whose first language was not English to access a community social group attended by speakers of the same first language. This reduced the social isolation she had been experiencing and significantly decreased her hospital attendances.
- We installed a medication dispenser in an individual's home. He had disliked carers visiting him to supervise him taking his medication and much preferred the new arrangements which he felt gave him greater control and independence and improved his self-esteem, self-worth and confidence.
- An individual supported by the reablement team wanted help to improve his mobility and independence. An occupational therapist and reablement physiotherapist supported him. Adaptations were made in his home and assistive technology was added. This improved his quality of life and independence.
- One of our GPs reviewed a patient who had attempted suicide, was out of work and suffered with depression and anxiety. She was referred to attend some IT and counselling skills courses. She is now working part time using the skills she has learnt and is engaging with an art project on a weekly basis.

Case study: personalised care and support planning

- Nuffield Road Medical Centre has implemented care and support planning for people living with cardiovascular disease. Patients have an initial appointment with a healthcare assistant where they have blood tests, physical checks and are asked about their wellbeing and activation. Results are reviewed by a GP and shared with them. Depending on the results they are then invited to attend an appointment with a GP, pharmacist or social prescribing link worker.

Case study: supported self-management

- Granta Medical Practices have recently introduced group consultations for pre-diabetics. The key benefits of this approach are that consultations are delivered in a familiar environment by a person who is known to the participants. Participants meet in small groups, discuss what matters to them and, where appropriate, can involve family members or carers. The group provides peer support opportunities.

106. Full implementation of the prescribed national model is challenging within our constrained resources, but we believe that the move to more self-management, greater ownership and better use of local assets is core to the future of health and care provision and we intend to make further progress on this agenda in the coming years. (See Annex 3 for further information).

Cancer

107. As a system, our cancer performance has been considered outstanding for the last two years and we have built strong relationships with the cancer alliance. However, we recognise that our performance falls short of the ambitious national long-term plan requirements for 70% five-year survival and 75% of patients diagnosed at an early stage. Key to making progress in these areas is to improve GP referral practices and to implement faster diagnosis pathways. In addition we will continue to work in partnership to improve our care pathways and to adopt new innovations and techniques. We also want to increase the uptake of screening for bowel, cervical and breast cancer by developing new ways of inviting people for screening; we will be particularly mindful of the health inequalities across our system in this work.

108. Our planned Cambridge Cancer hospital is uniquely poised to radically transform patient care, delivering hope and better health outcomes for millions of people around the world. We will bring together clinical expertise at CUH with world-class scientists from Cancer Research UK Cambridge and the University of Cambridge and locate them in the heart of our clinic and hospital spaces – bringing the bench to the bedside. This will dramatically transform our ability to beat cancer, saving millions of pounds of public money in the process. By uniting experts in biological and physical sciences with cutting-edge mathematical and computational ability we create a critical mass of cancer expertise and deliver real benefits straight to patients at our one-of-a-kind cancer research hospital.

109. We will take all actions necessary and practicable to ensure that we continue our strong waiting time performance for cancer and to maintain our performance on faster diagnosis. Locally, we would like to progress the Rapid Diagnostic Centres and await more information on the funding. (See Annex 4 for more detail about our plans).

Diabetes and cardiovascular disease

110. Care for diabetes has not been good enough within our system in the recent past. Although we have a low prevalence of diabetes compared to the national average within the system as a whole, we have some PCNs with higher rates of obesity than the national average: Fenland (16.9%), Wisbech (11.8%), Huntingdon Central (11.5%) and Peterborough City (10.3%). In addition, there are poor diabetes outcomes for type 2 diabetes, with only 35% of patients achieving all three National Diabetes Audit treatment targets.

111. To address this, we have developed a new Diabetes and Obesity strategy. This has several components, including addressing prevalence and rising risk and investing in prevention strategies. We have accepted a system-wide challenge to aspire to an "ambition for remission" for all newly diagnosed Type 2 diabetes patients. All prevention and weight management strategies for diabetes will be aligned within a wider obesity strategy from pre-school children through to adulthood. The strategy specifically addresses health inequalities by starting our interventions in those areas with the worst outcomes and greatest deprivation. It will link seamlessly with our local authority Healthy Weight strategies, which address the wider determinants of health.

112. We have also identified cardiovascular disease as a clinical priority for our system. Hypertension is the leading risk factor for deaths in Cambridgeshire, and second, to smoking, in Peterborough. Treatment outcomes are below the national average for hypertension, management of atrial fibrillation and heart failure. We have developed a number of initiatives to address this including system-wide referral guidelines, standardised clinical pathways and new heart failure nurses in the community.

113. We will review every aspect of the pathway from prevention to hyper-specialist treatment, delivering as much care close to home as possible. Now that RPH has moved on to the Cambridge Biomedical Campus, the two trusts will transfer and streamline some services. NWAngliaFT and RPH will also work together to make joint consultant cardiologist appointments to develop system-wide collaboration and to allow the implementation of a seven-day service at Hinchingbrooke and in Peterborough. (See Annexes 12 and 14).

Learning disabilities and autism

114. We have a clear local vision in our learning disabilities and autism services and are building on foundations of integrated provision and commissioning in this area. The Learning Disabilities Partnership hosts commissioning and delivery of integrated health and social care provision for people with learning disabilities and autism. This arrangement stands out because of the full integration of health into a single team, managed by social care colleagues. We will build on this to put in place one health and social care integrated model across Cambridgeshire and Peterborough to ensure that there is one integrated pathway and care planning process which has successfully maintained support in the community even in crisis situations. We will also improve data collection and analysis so we can make smarter

decisions and embed a Quality Framework by 2023/24 which supports the delivery of learning disability services. (See Annex 11).

Mental health

115. Our system has a long track record of partnership working in mental health with health and care providers and commissioners working collaboratively. Over the last four years, we have worked with system partners to co-produce an integrated primary care based health and social care service (PRISM) for adults of working age who are experiencing mental health challenges. The focus of this service is on early intervention and a seamless patient journey through the mental health system, including post-discharge support. We will now go further, and our plan is for mental health services to become more embedded in primary care networks, developing and delivering services that reflect the particular health, wellbeing and environmental needs of each neighbourhood. Our services will be safe, responsive, flexible, inclusive and able to meet demand.

116. We will further integrate services by developing a model of trusted assessments to reduce duplication and create a more efficient system, with better experiences for patients and their families. We will also continue to innovate, being leaders in our field and building on our strong research-based approach. We intend to mature our digital offer, not only in the diagnosis and treatment of mental illness but also in terms of operational processes. This includes the use of data and artificial intelligence to better predict rising risk and agitation, promote independence, improve outcomes and safety and to reduce adverse outcomes such as suicide and self-harm. We also expect utilisation of digital to increase productivity and the experience of service users, carers and staff.

117. We also intend to further integrate primary care based mental health, including pharmacy, coaching and peer support, and will improve the services we deliver to children and young people, and to adults with personality and eating disorders. As a system, we will be moving traditionally secondary care-based services into primary care, focusing secondary care staff on more specialist interventions. We have secured national early implementer transformational funding to help us achieve these aims, and this work will be externally evaluated and used to inform national policy. We will also focus further on prevention and gain new intelligence from our research into the causes and prevention of mental illness, as well as developing processes for early intervention and securing greater recovery rates. (See Annex 5).

Children and young people

118. We have developed a five year ‘Best Start in Life’ strategy which will improve the life chances of children in Cambridgeshire and Peterborough by addressing inequalities, narrowing the gap in attainment and improving outcomes for all children including disadvantaged children and families. Evidence is clear that the early years are a crucial period and that the experiences that parents, babies and children have during this time lay the foundations for their future. We will work across organisational boundaries, with place-based teams

combining midwifery, children and family centres and early years, using data and systems to spot signals to intervene early and focus resource where it is needed. Using a mix of universal and targeted approaches, we will work with families to build self-efficacy and increase peer and community-based support, using evidence-based messages and digital tools to enable families to access quality advice and support.

119. There will be a further roll out of NWAngliaFTs 'ready steady go' which builds confidence and the understanding of children, younger people and their families when transitioning into adult services. The approach has already reduced emergency admissions for young adults with epilepsy, diabetes and asthma and will be extended to more long-term conditions. (See Annex 9).

Maternity and neonatal

120. For maternity services, we are ensuring that babies born within our area have the best possible start in life, consistent with the long-term plan commitments and the conclusions of the Better Births report. We are working towards a target of more than 51% of women receiving 'continuity of carer' by 2021. We are particularly focusing on continuity of carer in our most deprived areas and are piloting a whole area approach to improving quality and safety in March, Cambridgeshire, in support of the national ambition. As part of our Local Maternity Services Safer Care workstream we are monitoring and are on trajectory for a 50% reduction in stillbirth, neonatal and maternal deaths and brain injury by 2025. We are also developing our neonatal critical services, support for perinatal mental health, and our postnatal physiotherapy and multidisciplinary pelvic health services. Over time our services will work increasingly closely with health visitors and child and family centres through our local 'Best Start in Life' strategy from pre-birth to age five – delivering place based teams around the child, linked with wider community assets.

121. We will continue to work closely with the three prisons in Cambridgeshire and Peterborough to provide specialist physical and mental health support. NWAngliaFT provides consultant-led prison outreach outpatient consultations across a range of specialties and a specialist midwife outreach service with the women's prison unit at Peterborough. Existing services will be made more accessible and less disruptive for prisons and prisoners through provision of Skype hospital consultations. (See Annex 10).

Medicines optimisation

122. The Cambridgeshire and Peterborough Medicines Optimisation Team, in collaboration with the pharmacy teams from our main provider trusts, PCNs and other key stakeholders, will continue to develop and deliver a whole system medicines strategy and associated workstreams, in line with the STP and CCG priorities and as agreed by the Cambridgeshire and Peterborough Joint Prescribing Group to deliver safe and affordable prescribing. The work will continue to build on key successes in 2019/20 around the development of a joint system formulary and improvements in the quality of antimicrobial prescribing as well as self-care priorities.

123. Our work in 20/21 will aim to improve the quality and safety of prescribing by strengthening the use of innovative IT solutions alongside pathway and formulary choice development in priority key therapeutic areas, with a strong focus on partnership working to reduce or stop medications that may no longer be of benefit, reducing medication burden or harm while improving quality of life for patients across the STP.

Research and life sciences innovation, including genomics

124. Research is a unique asset within our system. The system, benefited by the Genomic Laboratory Hub and Cambridge Biomedical Campus, proximity to technology and science parks, and close links with universities, has a long history of generating game-changing ideas for advancing medicine, with companies continuing to choose locations in Cambridge rather than abroad – benefiting UK PLC – with pharma, biotech and medtech companies, and Wellcome Sanger Institute all nearby.

125. We maintain a thriving environment for biomedical research at CUH, respiratory and cardiac at RPH, and mental health research throughout Cambridge University and CPFT, with high patient participation rates widely recognised. Our future research ambitions encompass population health management, contributing to global health through accelerating the translation of life sciences research.

126. CUH is a nationally and internationally recognised centre of excellence for genomics, with a strong commitment and history of validating and translating research results into an actionable clinical service. A leader in the implementation of cutting-edge science, CUH is also the first accredited NHS laboratory to provide a Next Generation Sequencing (NGS) exome diagnostic service to a clinical standard, transforming the diagnosis of patients with rare conditions.

127. With the potential offered by genomics increasingly intertwined with our research, development and campus redesign, our world class assets will enable disease prevention, early detection and precision intervention. We will make an environment for leading edge “science into health”, creating a discovery-to-market lead time of five years for new drugs, and an in situ development model for new medical devices and digital tools, based on a revolutionary strategic partnership model which deploys data to compress trial phases. Whole genome sequencing and other advanced technologies will be a routine part of patient care and support the development of clinical research, academia and industry across our system.

128. Over the next five years the campus will be home to shared spaces that bring together research and frontline services. With building starting in 2020, the first is the Cambridge Heart and Lung Research Institute, which will be situated next to RPH. Next, we will build a new specialist integrated physical and mental health children’s hospital, with CUH and CPFT clinicians and clinical academics working alongside each other to offer holistic care for children and young people.

129. Outside of the city of Cambridge the prevalence of cancer is significantly higher than across England; to help address this, at Cambridge Cancer our vision is to change the way we find and treat cancer. We also intend to establish a virtual centre of excellence for population health management by 2022, to draw together applied research and operational improvement, contributing to global health by accelerating the translation of life sciences research. (See Annex 16).

Digital and innovation

130. Our digital and innovation programme has the aspiration to foster person-centred health and wellbeing by accelerating the adoption of digital health. We have made a number of digital commitments, although these remain subject to securing the necessary funding.

131. For the future, we have prioritised the development of an interoperable digital health and care record that staff can both read and write into, and we want this to be adopted across all our NHS partner organisations. We also want at least 90% of patients to be able to access their full personal health and care record, with at least 70% of the population (not including primary school age children) registered to use the NHS app by March 2024. In developing the integrated care record, it is essential that citizens and patients trust us to keep their data secure and share their records only with their permission. While developing this capability we will be sensitive to the needs of residents with different levels of education and skills, and those who do not have English as a first language.

132. We think digital has an important role to play in supporting efficiency and ensuring that staff spend more time caring for patients. We intend to automate non-clinical support processes, freeing up that time for our clinical staff to care for patients instead. This builds on work already undertaken by CUH and RPH as part of their digital exemplar programmes.

133. We will continue to work closely with the three prisons in Cambridgeshire and Peterborough to provide specialist physical and mental health support. NWAngliaFT provides consultant-led prison outreach outpatient consultations across a range of specialties and a specialist midwife outreach service with the women's prison unit at Peterborough. Existing services will be made more accessible and less disruptive for prisons and prisoners through provision of Skype hospital consultations. (See Annex 10).

134. While our system is on course to meet the national requirements for digital primary care, the focus of our effort and attention will be on supporting practices, primary care networks and patients to exploit the new digital capabilities, particularly as these will help manage operational pressures in practices. By April 2020, local patients will be able to access their GP record via the NHS App, book appointments online, order repeat prescriptions and use a symptom-checker that is supported by machine learning.

135. Digital tools can also support people to access healthcare when they need it and to manage their conditions. We aim to have at least half of patients with long-term health conditions, mental health or care needs to have digital tools in their homes or their hands by 2024,

although we recognise that this approach will not be right for everyone. Starting with diabetes and cardiovascular disease, we will work with primary care networks with poor health outcomes to automate care protocols, support patients with digital self-help tools and digital information prescriptions and implement remote or point of care diagnostics to minimise travel time. Respiratory and mental health pathways will follow.

136. As an innovation exemplar, we want to make Cambridgeshire and Peterborough system an eco-system of entrepreneurs who promote the sustainable adoption and spread of a world-leading catalogue of digitally enabled innovation for the benefit of local people. We will do this by both supporting a local, grass-roots movement of innovators, through the systematic identification of opportunity, selection of partner (be they an entrepreneur, small-to-medium enterprise or global), evaluation and proactive spread of innovation, and by creating new types of mutually beneficial frameworks (e.g. for finance, regulatory, legal, information governance). We are incomparably placed to be an innovation exemplar.

137. Digital capability building extends far beyond our Boards. We need to support our digital leaders and wider staff and citizens, all the time promoting an inclusive approach to technology. So, to support all the other commitments we have made, the STP Board, NHS partner boards and our Health and Wellbeing Boards will undertake bespoke development to become digitally capable leaders, creating a culture of innovation and continuous learning. (See Annex 18).

Workforce

138. We are committed to establishing a skilled, motivated and healthy workforce, proud to work in our system. We believe that our workforce is an enabler and key to ensuring our systems' future success. We have a mature system-wide collaborative workforce delivery plan, tailored to the workforce challenges specific to our local area. We are working collectively to understand the changing workforce requirements of our system and to ensure that our workforce plans reflect local health inequalities and are responsive to health needs. For example, we are working with our Primary Care Networks and local Training Hub to ensure that our workforce plan supports and enables the transformation of clinical and non-clinical services and that we help shape, support and create the strong infrastructure in general practice - now and in the future.

139. We are working to maximise the apprenticeship levy, working across the system and region whilst also widening access for all through ensuring clarity around career pathways and routes into careers in health and social care. For example, we are establishing an Apprenticeship Collaborative as a new 'centre of excellence', which will be able to identify areas where apprenticeships could benefit the system, such as developing new entry-level posts, implementing a career advice service and preparing for the system-wide implementation of T-levels widening participation for school leavers.

140. We are also focused on the systems culture, leadership and engagement at all levels. Building on the system success in establishing a locally delivered Mary Seacole programme

for 275 first-line system leaders across 16 cohorts, we are now establishing a local 'Stepping Up' programme for black, Asian and Minority Ethnic staff, whilst also supporting clinicians and those shaping and leading services.

141. We also want to enable our workforce to work flexibly, efficiently and effectively, including working collaboratively on temporary staffing to reduce our premium pay bill, whilst maintaining efficiency and making it easier for staff to move between organisations locally. We have in place a process to agree how staff can work flexibly between NHS organisations, for example by accepting pre-employment checks and mandatory training across organisations and will now work to include non-NHS partners (this includes primary, social care, 3rd and independent sectors). We also want our staff to have opportunities to develop their skills and use state of the art equipment; through establishing a plan to improve the digital skills of the workforce during 2019/20, including our Boards becoming digitally capable leaders. In addition, we will develop and deliver the New to Practice programme using national funding to support working in general practice as being a first destination career option

142. We want to support our staff to be healthy themselves. This includes bringing together a system-wide community of health and wellbeing professionals and related specialisms to build a shared approach to learning and delivery of healthy work and healthy communities, building a bank of workforce and public health data to inform health needs assessments, plans and measure interventions better and ensuring sustainable, safe and effective modern occupational health and wellbeing provision across our system, sharing or commissioning resource or interventions for across the system, such as for doctors' mental health support. (See Annex 20).

Estates

143. In order to make best use of our resources, we also need to make good use of our estate and buildings. As well as ensuring our estate is safe for patients by addressing growing backlog maintenance, we also need to review our combined estates overheads and identify joint actions to increase utilisation, reduce costs and share space where possible.

144. We have been successful in securing funding for three capital projects over the next five years: a children's hospital, redevelopment of Hinchingbrooke Hospital and a capacity solution on the Addenbrooke's site. We are focussed on delivering these projects for the system.

145. However, as our system is working towards delivering more out of hospital care we need to have appropriate estate to deliver services closer to patients. This means working with our Integrated Neighbourhoods to identify what they need to provide services differently. In some areas this will require new hubs that allow the co-location of services, whereas in others this will be how they use their existing estate more collaboratively. In other areas, including primary care, we will need to ensure that the facilities we have are sufficiently modern to support our plans.

146. Over the next year, each Integrated Neighbourhood will be developing plans on how to use the combined estate to provide services for the increasing population. Initially those where there are large housing developments planned will be prioritised to help plan for the rapidly increasing populations. We recognise that the phasing of the implementation is crucial and the development of capacity and capability outside hospital is essential prior to the shift of activity out into the community.

147. We need to match capacity and demand more effectively, including by redeveloping Hinchingbrooke hospital. We plan to improve the A&E unit and put in place an expanded ambulatory care facility to better manage emergency demand. And we will upgrade the operating theatres and add additional ward capacity, so that more planned care can take place on the Hinchingbrooke site.

148. A key priority is developing and improving our out of hospital estate. The rebuilding of Addenbrooke's Hospital as part of the new healthcare infrastructure plan, at the heart of a highly innovative system and underpinned by the world-leading research of Cambridge, includes developing estate to support the new integrated out of hospital care described in this plan. We are therefore developing local estates strategies to support primary care networks in planning for future estates' needs, working through the Think Communities approach to best utilise public assets across the NHS, local government and voluntary sector. We also want to make the most of the opportunity to co-locate services to provide integrated care, including developing the Princess of Wales and North Cambridgeshire hospitals.

149. Finally, we intend to build additional world class services within Cambridgeshire and Peterborough. We are developing a children's hospital that integrates physical and mental health services, and plan to develop a cancer research hospital and a regional thrombectomy service. (See Annex 19).

CHAPTER HEADING

Chapter 5: Addressing our financial challenge

In development.

CHAPTER HEADING

Chapter 6: Governance

150. So far, we have described our plans for the next five years. In this chapter we set out how we intend to undertake and oversee the implementation of these plans. A table summarising our critical milestones is set out below.

System programmes

151. We will deliver the priorities set out in Chapter 3, and the changes described in Chapter 4 and in our annexes, through a set of transformation programmes. These will focus on our 4+1 transformation priorities, Urgent and Emergency Care through our existing collaborative work programme, and three enabling programmes: digital; workforce; and system development. In total, this means we have nine major cross system programmes of work.

Delivery infrastructure

152. Since the development of our first system plan in 2016, we have put in place a governance structure to lead and oversee our work. We know that we can achieve much more by continuing to work together across the system rather than as individual organisations, and so all partners are involved. Our current governance includes:

- The STP Board, made up of Chief Executives, Chairs and local Councillors and clinicians, which has a leadership and oversight role, setting direction for the system, resolving strategic challenges and acting as the most senior decision-making body;

- System Leaders, made up of Chief Executives and others playing a key leadership role in the system, which provides leadership, problem-solving and decision-making capability;
- The Public Service and Health and Wellbeing Boards, which provide the wider public service and governance framework, and lead on work to tackle the wider determinants of health;
- A Joint Clinical Group which provides strategic clinical leadership and oversees a range of clinical committees. These groups ensure our clinicians and engaged, involved and can work collaboratively with colleagues from across the system.
- The Financial Performance and Planning Group, which brings together the Directors of Finance to provide financial leadership, support cross-system working and to drive financial delivery; and
- At a place-based level, North and South Alliances, co-chaired by clinicians who also sit on the Health and Care Executive, which oversee and drive delivery in partnership with leaders from our 21 primary care networks.

153. We have a small cross-system team in place overseen by a Programme Director who is a member of the STP Board, Health and Care Executive and the Joint Clinical Group. The team provides leadership, facilitation and coordination of our system working. It will continue to lead on system strategy and planning, governance and decision-making, and system development as well as delivery and transformation and engagement with stakeholders.

154. It is important that we make decisions at the right level, balancing distributed with centralised leadership, with delegated responsibility for agreed milestones. With this in mind, we intend to review our structures as we focus on the implementation of this plan to ensure they continue to work well. We need to assure ourselves that we have the right representation from all partners, including primary care, at all levels. We also need to ensure that our structure enables scrutiny and challenge of our implementation plan.

Implementation and accountability

155. We know we need clear delivery plans to ensure that the changes we have described happen in practice. We have already shown that clear leadership focus and aligning our resources to priorities delivers results, such as bringing DTOCs down sustainably across the system.

156. We are committed to working as a system and to doing things once to avoid duplication. We will continue to base our actions and decisions on shared analysis of problems and a system-wide understanding of the options and implications.

157. The clinical strategy articulated in Chapter 2 is common to systems across England. However, the priority areas set out in chapter three add up to a very significant, transformational programme of work which will have a huge impact on our clinical services both in and outside of hospital. We do not underestimate the challenge of implementing these work programmes because they require fundamental changes to how our services are organised and how our staff work.

158. As we move into implementing our plans we will:

- confirm the leadership and resources required to deliver our programme of work, including shifting resources from organisational initiatives to system-wide transformation;
- agree a system-wide way of working and consistent methodology to monitor progress;
- ensure we have a robust process to resolve the critical decisions we will need to make as we proceed;
- ensure that our governance continues to function appropriately to support our work programme;
- invest in cross-cutting enablers such as programme management; data, digital and analytics; and governance, accountability and financial incentives;
- undertake system development to ensure that those involved are equipped to deliver their part of the changes.

159. We know in the past we have sometimes spent too much time discussing changes and not enough time implementing them. So, we have articulated key milestones, as follows, for each of our system transformation priorities in chapter 3, by which we will drive and measure our success. Our approach will be underpinned by continuous improvement methodology and co-produced by all partners in our system.

Finance	
Agree the 20/21 and 23/24 finance plans with NHSE/I regionally and nationally	December 2019
Budget for primary care agreed with Primary Care leaders for 20/21	February 2020
Plans accepted by Boards and contracts signed with NHS providers with challenging activity and workforce numbers aligned to the LTP	March 2020
Governance	
New governance implemented, with extended system leadership and new delivery committee	January 2020
Appoint system support director jointly with NHSE/I regional team	December 2019
Decision over appointing Independent Chair jointly with NHSE/I regionally	June 2020
Implement OD programme for system, programme and clinical leaders, including CEs	Commence January 2020

Priority programmes	
Implementation of 4+1 transformation programmes, identifying leadership and resources and allocating savings targets.	December 2019 for initiation phase. Programme plans in place by February 2020
Integrated out of hospital	
Agree accountability, responsibility and resource associated with 'place', and place this on firmer footing as Integrated Care Partnerships	February 2020
Agree accountability (outcomes, metrics), transfer of resources to PCNs and commence transition to integrated out of hospital contract, including process, governance and future of community services.	April 2020
Agree the phased transfer of service accountability to PCNs	August 2020
Go live with new out of hospital urgent care model – integrated contract	October 2020

160. We have more to do over the coming weeks to develop our implementation plans. We already have some established work programmes in place which will contribute to the delivery of our 4+1 priorities. One of these is our UEC programme. We intend to set up new programmes as required to take forward the priority areas not covered by what is already in place. Each will be led by a dedicated Senior Responsible Officer from within our system partners and using a consistent programme initiation methodology.

161. The programmes will be resourced by the most appropriate staff from across the system, including those who currently work within the care models we are changing and who have the direct ability to effect the necessary changes. Clinicians will be a critical part of the programme teams from the outset. We will ensure that the programmes of work described in Chapter 4 and in more detail in the annexes continue to be led and resourced effectively, and that they report into an overarching system architecture so that our system leaders maintain oversight of each key area of work.

162. We will agree a set of high-level metrics to enable us to monitor the delivery of the changes we are going to implement. We will also ask each work programme to develop their own metrics through which delivery can be tracked and reported.

163. We know that there will be difficult decisions to take as we start to articulate our plans. We want to move as quickly as we can and will be pragmatic about finding ways through barriers to progress, such that we are not delayed unnecessarily by questions of organisational form. Equally we know that in due course we are likely to have to make some structural changes to organisational responsibilities, and we will confront these in an open, timely and collaborative manner.

System development

164. We know we need to continue to focus on system leadership and relationships. We will be implementing organisational development plans that help build trust and connection between our leaders and help the groups in our structure to work together more effectively. We will be appointing an expert partner to support us in this work.

165. Cambridgeshire and Peterborough are on a significant journey in moving from an STP to an ICS by 2021. To enable this, we will ensure that our leadership and organisational development performance capability meets our systems aspirations. Our focus will be on building trust, confidence and embedding our system vision across all partners. We will consider the value we bring to our patients, our management systems (structures, decision making, knowledge management) and our behaviours (how we act, cultural norms, skills, knowledge, behaviours) as these all impact on our performance.

166. Our programme will identify and engage leaders from across the system to enable them to work across organisational boundaries to deliver successful and sustainable integrated care. We know that each of our partner organisations, including primary care, are at different stages, with differing needs and we will target our support with this in mind.

167. We expect to focus on:

- Chief Executive and Chairs: we are strengthening the joint decision-making role of the STP Board by building relationships between Board members and exploring the roles of individuals as system leaders;
- Clinical leaders: we are strengthening the clinical voice and the input of primary care by working to develop our Clinical Leaders and PCN directors through bespoke development programmes. This includes a programme developed with the Judge Business School to give the PCN Directors access to world class leadership development. We are also seeking to strength the cross-organisation working between our clinicians where this is not already in place.
- Directors: we are working with our Medical Directors and Directors of Nursing to become one single clinical voice for the system
- Alliances: we are developing a bespoke leadership programme building on the success of a similar models elsewhere;
- Project groups: we are supporting our project groups to become the system leaders in their areas and ensure successful delivery of their plans;
- Front line staff: we are delivering a range of targeted leadership and development programmes including *Mary Seacole* (attended to date by around 300 people from health and care organisations in our system), *Stepping Up* (for staff from BAME backgrounds) and *Stepping in My Shoes* (enabling people from different disciplines to learn from each other and broaden their understanding of other roles).

Mitigating risk

168. Since the development of the 2016 STP plan, we have learnt many lessons that we will apply to the delivery of our local LTP to ensure successful implementation. We have in place a robust structure for financial monitoring, reporting and oversight. We understand the steps that we need to undertake to manage the risks we have identified and we encourage the national bodies to support us to deliver the plans that we have set out.

169. To ensure we are able to translate our words into delivery we will continue to utilise our existing governance structures with the ability to escalate any unresolved issues to our Chief Executive and Chairs at STP Board level if necessary.

170. To be successful in the delivery of our plan we will require the support of senior political stakeholders, time to address our problems sustainably, capital investment and support as we develop our leadership and operating model to transition to an ICS.

APPENDICES HEADING

Appendix 1: Communications and engagement

171. We have a good track record of engaging with our communities and we recognise the benefits of this approach. Our local people interact with health and care services in different ways at different times - as patients receiving care, as the family members or carers of loved-one and at other times as a citizen and taxpayers. We have considered the different perspectives this may bring.

172. Our approach has been to engage as widely as possible at place, neighbourhood and system level. We have undertaken a bespoke programme of engagement, between March and November 2019, to inform our LTP. This included using the Healthwatch compiled report 'What would you do?' to inform specific aspects of our LTP, as well as bespoke engagement with key audiences, as part of our Communications and Engagement Plan developed with the input of all system partner communication leads.

> **Case study 1: What would you do?**
> Healthwatch Cambridgeshire and Peterborough were recently commissioned to find out what local people felt about their health services and what they would like to see for future service development and investment. 757 people completed surveys. 43 people attended focus groups and 1,100 pieces of feedback were received over a year period. The research sought to gather a narrative of people's experiences and their ideas about what the future of health and care services should look like. The findings of this work have been incorporated into the development of our plan.

173. One example of this approach is our work to develop a system-wide diabetes strategy; this has had ongoing involvement from local diabetics, carers, clinicians and Diabetes UK. Another example is our programme of work to develop Integrated Neighbourhoods, such as in Wisbech where GP practice staff, the Wisbech PCN, council colleagues and the voluntary sector have been holding events to understand local population needs and develop local priorities. A third example is joint engagement undertaken by the CCG and Local Authority around the Health and Wellbeing Strategy and local priorities.

174. Our approach has also incorporated and built on the outputs of the ongoing dialogue we have had since 2016 with key stakeholders, staff and local people, in the various strands of the LTP response.

175. On an ongoing basis we work with our population in a range of different ways:

- Our STP Board meets in public giving members of our population the opportunity to ask questions and listen to the conversations of our system leaders. The locations of our meetings vary across Cambridgeshire and Peterborough and meetings are generally well attended.

- We also work through our own groups, through patient forums and through Healthwatch. The Local Authorities have a number of Partnership Boards organised by Healthwatch and linked into patient participation groups.
- We engage with community groups, local citizen and voluntary sector services. An example of where this has worked well is in the development of our Integrated Neighbourhoods model, which aims to build on the strengths of individuals and local communities. Local events were held with groups to co-design our local, leading Integrated Neighbourhoods (in Granta in the South and Wisbech in the North).
- Our Think Communities approach and our organisations involves engaging the public in a wider conversation about public services and the use of public service funding.
- Where appropriate we take a targeted approach. For example, we have targeted communities which have been historically underserved to understand how we can enable local people to make the best of their assets. We heard from 1,000 local citizens as part of our 'I Love Wisbech' campaign over the course of the summer.
- We have also worked with our front line staff. Our clinical leaders recently ran a programme of clinical engagement to hear directly from frontline practitioners about areas that they believe can be transformed to improve outcomes for patients and improve service efficiency.

Case study 2: Maternity Voices Partnerships (MVPs)
There are a number of patient forums across our system. An example of this is two MVPs within Cambridgeshire and Peterborough STP, one supporting The Rosie at CUH and the other supporting NWAngliaFT in Peterborough City Hospital and Hinchingbrooke Hospital. The Local Maternity System has a regular report from each of the MVPs who are actively engaging with local women to understand their views and working with the Heads of Midwifery to ensure co-production as we implement the Better Births initiatives.

176. The table below sets out examples of the key meetings and groups we have engaged with since the publication of the national Long Term Plan in January 2019:

Who we've engaged with	Purpose	Approach
Local residents, patients, local population	*'BIG conversation'* with local residents focussing on finding out people's views on local NHS priorities, the services our local population value most and to listen to ideas about how to change the way people access and use healthcare services.	This 12-week engagement conversation included 10 public meetings with a format of a presentation followed by questions and comments from the public.

Who we've engaged with	Purpose	Approach
Seldom heard individuals and communities - Northstowe healthy new town	Engaging seldom heard individuals and communities to gain insights to feed directly into service design in the new township.	Participatory appraisal approach to engagement whereby individuals from different backgrounds are recruited and trained to lead focus groups drawn from their own diverse networks. Feedback fed into LTP integrated neighbourhood vision for integrated out-of-hospital care.
People with type 1 & 2 diabetes; carers of people with diabetes	Engage people in the development of system-wide Diabetes & Obesity Strategy and input to LTP.	Four Diabetes UK hosted events between June and November 2019.
Partner Board lay members; Foundation Trust Governors; NHS CEOs; CCG members; Healthwatch; OSC members; HWB members; Clinical leads; patient groups;	Opportunity for system partners to influence, both the emerging overall LTP, as well as specific areas.	Stakeholder event held with discussion and feedback relating to specific aspects of the LTP: workforce; finances; diabetes & obesity; research & innovation; cardiovascular; mental health; Integrated Neighbourhoods; and digital.
STP Board [NHS Chairs/CEOs; CCC/PCC Elected councillors; CCC/PCC Directors of ASC/PH; GP leaders]	Member discussion on LTP process, timelines, priorities, proposals and finances; sign-off of LTP under delegated arrangements from partner organisations.	Papers submitted to scheduled meetings.
STP Board Chairs	Chairs discussion at key stages of LTP development.	Informal briefings and discussion.
Joint Council of Governors: [Partner NHS Foundation Trust Governors]	Discussion about becoming LTP elements including our journey to becoming an Integrated Care System, system finances and fairer funding for Cambridgeshire and Peterborough, and what this means for Trusts and Council of Governors.	Workshop session.

Who we've engaged with	Purpose	Approach
Health & Care Executive (HCE) [Partner CEOs; Cambridgeshire County Council/ Peterborough City Council Directors; GP Federation leaders; Clinical leaders]	Determine what more needs to be done to secure a credible, deliverable LTP.	Briefing paper containing specific questions, followed by discussion.
Leadership and Organisational Development Subgroup [NHS and Local Authority partner Directors of Workforce/Organisational Development; Transformation/ OD/ Leadership Leads/ HEE.	Member discussion on LTP priorities, proposals and finances, as well as specific discussion on the workforce aspects of the LTP.	On-going development of LTP workforce plans; Short briefing tabled regarding overall LTP with members to reflect and feedback following meeting.
Estates Group [NHS Estates Leads; Planning Leads; Finance]	Member discussion on LTP priorities, proposals and finances	Presentation of a short briefing to prompt discussion.
Local Workforce Advisory Board [Directors of HR; Professional Leads; GP Rep; Combined Authority]	Member discussion on LTP priorities, proposals and finances as well as specific discussion on the workforce aspects of the LTP.	On-going development of LTP workforce plans; Presentation of a short briefing to prompt discussion.
Cambridge University Hospitals NHS Foundation Trust Management Executive Team	Engagement in thinking and developing the local LTP response.	Attended scheduled meeting.
Joint Clinical Group [Partner Medical Directors and Nurse Directors; DPH; Clinical Co-Chair of North/South Alliances]	Member discussion on emerging LTP priorities, proposals and finances; In depth member discussion on detailed LTP priorities and finances	Presentation of a short briefing to prompt discussion; followed by in-depth workshop.
Clinical Communities Forum (CCF) [NHS Trust Medical and Nursing Directors; Public Health; Condition clinical leaders]	Raise awareness and agree CCF role in LTP process; Member discussion on LTP priorities, proposals and finances; In depth discussion on detailed LTP clinical and other priorities including finances.	Attendance at scheduled meetings; Short briefing paper followed by discussion.

Who we've engaged with	Purpose	Approach
South Alliance [NHS CEOs and officers; GP Federations; county and district council officers; Primary Care; Healthwatch; Voluntary sector rep]	Discuss and inform the LTP across key elements relating to the South Alliance including improving outcomes for local citizens, place based model, PCN development and IN implementation	Workshops and discussion to inform LTP priorities, must-do's and integrated out-of-hospital care aspects of LTP.
North alliance [NHS CEOs and officers; GP Federations; Council officers; Primary Care; Healthwatch; Voluntary sector rep]	Member discussion on emerging LTP priorities, review, comments and approval of Alliance chapter of LTP response	Formal briefing, facilitated discussion and agreed outcomes.
Primary Care Network Clinical Directors	Discussion on emerging LTP priorities, proposals and finances; In depth discussion on detailed LTP clinical and other priorities including finances	Workshop event and discussion to inform LTP priorities, must-do's and integrated out-of-hospital care aspects of LTP.
Local Medical Committee (LMC)	Discussion on early LTP priorities, proposals and finances; How GP engagement can be optimised in the LTP process.	Meeting with LMC Chief executive Officer
Diabetes Clinicians [Diabetes clinicians, GPs, Nurses, Dieticians, Podiatry, community pharmacy, clinical leads]	Engage clinicians in the development of the Diabetes & Obesity Strategy and input to LTP	Diabetes clinical workshop in March 2019, and establishment of a Diabetes & Obesity Clinical Community for on-going clinical engagement.
Clinically led Digital Design Workshop for clinicians, operations teams and managers	Develop specification and requirements needed. It will enable us to; (1) develop use cases; and (2) explore tactical priorities for digital and innovation beyond the care record, including how best to address the culture, skills and digital inclusion barriers to adoption.	Workshop.
Local MPs	Brief regarding system priorities, issues and financial pressures.	On-going schedule of Individual meetings

Who we've engaged with	Purpose	Approach
Health Scrutiny Committee - Cambridgeshire County Council	Brief Committee on the background, purpose, approach and timelines to developing our LTP; Clarify the Committee's engagement requirements in the LTP; In-depth member discussion on detailed LTP priorities and finances.	Presentation of a briefing paper followed by discussion; informal workshops held for both Health Scrutiny Committees
Health Scrutiny Committee – Peterborough City Council	In depth member discussion on detailed LTP priorities and finances	Workshops held for the Health and Wellbeing Board joint sub-committee
Cambridgeshire and Peterborough Joint Health & Wellbeing Board Core Joint Sub-Committee.	In depth discussion on detailed LTP clinical and other priorities including finances	Development session.
NHS England/NHS Improvement	Ensure system LTP meets regulator requirements.	Series of formal, review and informal meetings.
Wisbech area: GP Practices; community staff; social care staff; Wisbech Primary Care Network; Cambridgeshire County Council, Voluntary and Community organisations; Healthwatch; neighbourhood groups	Events used to explain the vision for Integrated Neighbourhoods, provide time for people to meet one another and learn about their roles and for a joint understanding of population needs and local priorities to be developed.	Two events, each with over 50 people attending, to inform the integrated neighbourhood vision for integrated out-of-hospital care

Appendix 2: List of annexes

The following annexes are attached in a separate document.

- Annex 1: New model of integrated community and primary care
- Annex 2: Urgent and emergency care
- Annex 3: Control and personalisation
- Annex 4: Improving cancer outcomes
- Annex 5: Improving mental health services
- Annex 6: Shorter waits for planned care
- Annex 7: Becoming an integrated care system
- Annex 8a: A proactive approach to prevention and reducing health inequalities
- Annex 8b: A proactive approach to prevention and reducing health inequalities: reducing health inequalities
- Annex 8c: A proactive approach to prevention and reducing health inequalities: antimicrobial resistance
- Annex 9: Children and young people
- Annex 10: Maternity
- Annex 11: Learning disabilities and autism
- Annex 12: Cardiovascular disease
- Annex 13: Stroke
- Annex 14: Diabetes
- Annex 15: Respiratory
- Annex 16: Research and life sciences innovation, including genomics
- Annex 17: Volunteering and wider social impact
- Annex 18: Digital and innovation
- Annex 19: Estates
- Annex 20: Workforce

HEALTH SCRUTINY COMMITTEE	AGENDA ITEM No. 7
9 MARCH 2020	PUBLIC REPORT

Report of:	Cllr Wayne Fitzgerald	
Cabinet Member(s) responsible:	Cllr Wayne Fitzgerald, Deputy Leader and Cabinet Member for Adult Social Care, Health and Public Health	
Contact Officer(s):	Dr Liz Robin, Director Public Health	Tel. 01733 207175

CABINET PORTFOLIO HOLDER FOR PUBLIC HEALTH PERFORMANCE REPORT

RECOMMENDATIONS	
FROM: Cllr Wayne Fitzgerald	
It is recommended that the Health Scrutiny Committee note and comment on the Portfolio Holder's Performance Report.	

1. ORIGIN OF REPORT

1.1 This report was requested by the Health Scrutiny Committee during planning of the Committee's annual work programme for 2019/20.

2. PURPOSE AND REASON FOR REPORT

2.1 This report provides an overview of the performance of the public health functions of the Council over the past year.

2.2 This report is for the Health Scrutiny Committee to consider under its Terms of Reference Part 3, Section 4 - Overview and Scrutiny Functions, paragraph No. 2.1 Functions determined by Council - Public Health.

2.3 This report focuses on the Strategic Priority: **'**Achieve the best health and wellbeing for the City'

2.4 This report supports the Children in Care Pledge 'Help encourage you to be healthy'

3. TIMESCALES

Is this a Major Policy Item/Statutory Plan?	**NO**	If yes, date for Cabinet meeting	N/A

4. BACKGROUND AND KEY ISSUES

4.1 In 2013 under the Health and Social Care Act (2012), upper tier local authorities were given a statutory duty to improve the health of their local population. The Councils' public health function supports this duty by:

- Providing public health system leadership, specialist advice and analysis, and practical support to the City Council and partner organisations, in order to improve the health and wellbeing of local communities.

- Commissioning and contract managing a range of public health programmes.

To maximise value for money and make best use of specialist staff, these functions are delivered by a joint public health directorate across Peterborough City Council and Cambridgeshire County Council.

4.2 **Public Health Funding**

The majority of funding for the Council's public health functions comes from the national ring-fenced public health grant. The grant allocation to Peterborough City Council in 2019/20 is approximately £10.6M. The national public health grant allocation to local authorities has been reducing year on year, with a Health Foundation analysis finding a real terms reduction of 25% between 2015/16 and 2020/21.

Peterborough's ring-fenced public health grant allocation (originally based on historic funding transferred from Peterborough Primary Care Trust) is particularly low in relation to local levels of need. In 2014/15, Peterborough' general public health grant funding was 20% below its 'target' fair funding allocation, based on a formula developed by the Department of Health Advisory Committee on Resource Allocation. When children's public health grant funding was transferred to the Council in 2015, it was 16% below national average funding per 0-4 year old and 29% below the funding per 0-4 year old, in local authorities with similar levels of deprivation (Index of Multiple Deprivation 2015 score).

4.3 In 2019/20, Peterborough City Council planned to spend the ring-fenced public health grant on services as outlined in the table overleaf.

Key points are:

- The majority of spend (over 80%) is on external contracts for public health programmes as listed in the national public health grant commissioning categories. Another 10% is spent on external contracts for wider preventive services which benefit health and wellbeing – Children's Centres and young people's counselling.

- A third (34%) of total public health spend is on children's public health services (health visiting, school nursing, breastfeeding support, healthy schools). If spend on Children's Centres and the CHUMs counselling service for children and young people is added, this rises to over two fifths of total spend (44%).

- 5% of the total grant is spent on in-house public health staff, who deliver mandated specialist advice and analysis services, public health commissioning, partnership work and campaigns.

CATEGORY	**PLANNED PUBLIC HEALTH GRANT SPEND 2019/20 £k**	**PERCENTAGE OF TOTAL PH BUDGET**
External public health contracts		
Children's public health (health visiting/school nursing)	3,597	34%
Drug and alcohol treatment	2,269	21%
Sexual health and contraception	1,937	18%
Preventing long term conditions (smoking/weight management/ health checks/mental health)	958	9%
Sub-Total	**8761**	**82%**

PCC – Children's Services Portfolio and Communities Portfolio/ Pooled budgets		
Children's Centres, and CHUMs young people's counselling	1040	10%
Community safety	277	3%
Corporate overheads and communications	108	1%
Sub-Total	**1425**	**14%**
Public health staffing		
Public health staffing (joint team)	**497**	**5%**
TOTAL	**10,683**	**100%**

4.4 Early in 2019/20 it became clear that there was a gap between the funding transferred to Peterborough City Council to fund our health visiting and school nursing contract, and the cost of the service. After savings from service transformation and a joint Section 75 with Cambridgeshire County Council had been taken into account, this still left a funding gap or pressure of £870,000.

In order to address this, public health grant reserves totalling £355,383 were used to subsidise the contract, the National Childhood Measurement Programme was transferred to another provider, therefore reducing costs, and measures to recurrently address a further £541,000 of annual costs were agreed. A new section 75 was signed in October 2019 which took these changes in to account, and will continue to provide some additional Peterborough City Council public health funding into the contract above the level in previous years..

To balance the additional funding for health visiting and school nursing, some reductions in funding for other services have been planned for 2020/21 as outlined in the Tranche 1 Medium Term Financial Strategy. These include savings through joint reprocurement of contracts with Cambridgeshire County Council.

The current Budgetary Control Reports for 2019/20 indicate that the public health budget does not show any significant variances and is likely to end the year on or close to its target.

4.5 **Performance of commissioned public health services**

- Performance of Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) on delivering mandated health visitor checks for new babies and young children has been generally good over the past year with the majority of targets achieved. Nationally benchmarked data indicates that breastfeeding rates when the baby is aged 6-8 weeks are better than average in Peterborough, but child dental health and 'school readiness' – the proportion of children achieving a good level of development by the end of reception year - are worse than average.
- Performance of CGL (Aspire) drug and alcohol treatment services is good - generally above benchmark for numbers of clients completing treatment, and in some cases top quartile. The most recent figures on drug related deaths and on alcohol related admissions to hospital in Peterborough are similar to the national average. Financial pressures on services are being closely monitored.
- Performance of Cambridgeshire Community Services NHS Trust (CCS) delivering integrated sexual health and contraception services is generally good. Demand for the service continues to be high with challenges meeting this and a number of measures are in place. The rate of diagnoses of Chlamydia infections among 15-24 year olds in Peterborough is better (higher) than the national average, and the teenage pregnancy rate and the proportion of cases of HIV diagnosed late have both improved and reached a similar level to the national benchmark, when previously they were significantly worse than benchmark.

- Integrated Lifestyle Services delivered by Solutions4Health are on track to deliver against the majority of their contract key performance indicators (KPIs) weight management, physical activity and falls prevention, although smoking cessation KPIs for Q2 were not achieved. The latest figures indicate that smoking and obesity rates are both higher than the national average in Peterborough. The service is succeeding in reaching more vulnerable communities, delivering sessions in community venues as well as GP surgeries, and with staff who speak a number of languages.
- NHS Health checks delivery by GP practices is currently below target but this may be related to late return of data from some practices. The total proportion of eligible residents who have received health checks in the past five years is well above the national average.
- Sixteen pharmacies in Peterborough are now providing free Emergency Hormonal Contraception, for which public health contracts were introduced in 2017/18. There is a gradual increase in uptake of the service.

4.6 **Local authority public health dashboard**

Public Health England produce a Local Authority public health dashboard. This recognises that public health outcomes are closely related to deprivation and therefore the performance of local authorities should (a) be compared with local authorities with similar deprivation levels and (b) reflect some 'process measures' such as waiting times for services and delivery of mandated checks, as well as outcome measures. On the domains for the Local Authority public health dashboard, Peterborough City Council scores as follows:

Domain	Quartile compared with local authorities with similar deprivation	Quartile compared with England
Childhood obesity	Quartile 2 (better than average)	Quartile 3 (worse than average)
NHS health check	Quartile 2 (better than average)	Quartile 1 (best quartile)
Tobacco control	Quartile 4 (worst quartile)	Quartile 4 (worst quartile)
Alcohol treatment	Quartile 1 (best quartile)	Quartile 1 (best quartile)
Drug treatment	Quartile 1 (best quartile)	Quartile 1 (best quartile)
Sexual health	Quartile 1 (best quartile)	Quartile 1 (best quartile)

https://fingertips.phe.org.uk/topic/public-health-dashboard

This **dashboard** which focusses on public health service performance, provides a different picture from Peterborough's local authority public health **profile** (4.11 and Annex A) which focusses on population level health outcomes compared with the national average.

4.7 **Recommissioning and Transformation of Commissioned Public Health Services**

2019/20 has seen significant development work on recommissioning of public health services. The approach has generally been to recommission joint contracts with Cambridgeshire County Council. This helps to maintain front line services despite a difficult funding position, through reducing management costs and creating economies of scale. It also makes joint commissioning of services with the NHS more feasible, as the Clinical Commissioning Group covers both Cambridgeshire and Peterborough. In all re-commissioning exercises, needs assessments have identified the local community issues and diversity in Peterborough, and specified a requirement to address them in the services to be provided.

The re-commissioning and transformation outlined above has covered

- Health visiting and school nursing services – a new Section 75 joint with Cambridgeshire County Council implemented on 1st October 2019.
- Integrated Lifestyles Services – currently out to procurement for a joint Peterborough and Cambridgeshire service including joint commissioning with the CCG, for implementation in June 2020.
- Sexual health and reproductive services – currently out to procurement for a joint Peterborough and Cambridgeshire service, including joint commissioning with NHS England and the CCG, for implementation in October 2020.
- Sexual ill health prevention services – procurement exercise across Peterborough and Cambridgeshire completed, and new service due to commence in April 2020.

4.8 **Public Health Specialist Advice to NHS Commissioners**

Provision of public health specialist advice to Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) is a statutory duty for the local authority public health team. This service is provided jointly by Peterborough City Council and Cambridgeshire County Council. The services delivered included:

- Public health advice on NHS clinical policies and thresholds.
- Public health advice on the Sustainability and Transformation Partnership Plans (STP).
- Public health advice covering the 'health' response to housing growth and associated NHS priorities and planning.
- Partnership work covering preventive and healthcare services for children and young people.
- Partnership work covering preventive and healthcare services for older people.
- Partnership work for mental ill health prevention and mental health services.
- Partnership work providing advice on prevention of diabetes and cardiovascular disease
- Public health attendance at CCG and STP meetings,
- General partnership area-based needs assessments and local health and wellbeing strategy monitoring - in partnership with local Health and Wellbeing Boards.
- Production of health profiles for STP Alliances and Primary Care Networks
- Further public health intelligence based analytical support.

4.9 **Health Protection and Emergency Planning**

Provision of specialist health protection advice is a statutory duty of local authority public health teams. The Director of Public Health and a local NHS England Director co-Chair the Local Health Resilience Partnership, which oversees health emergency planning in Cambridgeshire and Peterborough.

The Annual Health Protection Report for Cambridgeshire and Peterborough (2019/20) is available on weblink
HWB Board Whole System Sub-Committee March 2020
Key points from the 2019/20 Annual Health Protection Report included:

- Some childhood vaccinations are lower than the recommended 95% target. Flu vaccination uptake overall are slightly lower than last year, for those under 65 years and at risk, those over 65 years and pregnant women.
- Screening, in which cervical screening continues to have lower than ‘acceptable’ uptake, corresponding with the national pattern.
- Healthcare associated infections, the reduction in cases of MRSA, the observed increase in E. coli bacteraemia, and the successful work to reduce anti-microbial resistance.
- The Environmental Health role of city and district councils in protecting health including pollution control and air quality monitoring and advice.
- The higher rate of TB cases diagnosed in Peterborough, compared with national rates and the local work to assess the need and appropriate service response across Cambridgeshire and Peterborough.
- Sexual health including the increasing level of sexually transmitted infection diagnoses, and an improvement in the rates of late HIV diagnosis. The teenage pregnancy rates in Cambridgeshire and Peterborough have declined, and the latest Peterborough rates are statistically similar to the national average.

Work on public health emergency planning delivered through the public health directorate over the past year includes:

- Ongoing Delivery of a local action plan following a national audit of arrangements for Health Protection Incidents.
- Finalising the Cambridgeshire and Peterborough Local Resilience Forum Vulnerable People Protocol
- Participation in system-wide emergency planning training and exercises
- Work with communications team to deliver health messages to the public during episodes of very hot weather

4.10 **Health in All Policies**

The following work has been carried out by public health staff working with other Council directorates, to support a Health in All Policies approach:

- Work with Children's Services and Early Years Education Services on the 'Best Start in Life' Strategy and Service Model
- Work with Children's Services on a needs assessment for vulnerable adolescents and a needs assessment for children and young people's mental health
- Work with Children's Services on the action plan for the Peterborough SEND statement of action including providing a responsible officer for workstream 4- Getting support early.
- Work with the officer group supporting the development of the Think Communities approach and service model
- Working with the Communities and Safety Rough Sleepers outreach team to introduce a part time drug and alcohol worker
- Public health input to the Adult Social Care Service management team and work with Adult Social Care and Communications colleagues on the 'Stay Well in Winter' campaign.
- Work with Environmental Health to support the launch of their Peterborough 'Healthier Options scheme for food outlets.
- Public health input to the Member working group on air quality
- Chairing 'Discarded needles' task force, working closely with Community and Safety directorate
- A presentation to managers across the Council on how their work helps to improve the health of residents.
- Work with the communications team to promote public health messages through the Council's social media channels.

4.11 **Partnership working**

Public Health staff work with many multi-agency partnerships, providing public health input, evidence and analysis in order to maximise impact on health and wellbeing. In some cases public health staff chair and co-ordinate the work of the partnership. Relevant partnerships include:

- Peterborough Health and Wellbeing Board
- Safer Peterborough Partnership
- Cambridgeshire & Peterborough (C&P) Safeguarding Boards
- C&P MASH Governance Board
- C&P Child Death Overview Panel
- C&P Child Health and Wellbeing Executive Board
- C&P Children's' Emotional Health and Wellbeing Board
- C&P County-wide Community Safety Strategic Board
- C&P Drug and Alcohol Misuse Delivery Board (Co-Chair)
- C&P Sexual health delivery board (Chair)
- C&P Mental health Partnership board
- C&P Suicide Prevention Steering Group (Chair)
- C&P Integrated Commissioning Board
- C&P Child health and wellbeing joint commissoning board
- C&P Ageing Well Board (Chair)
- C&P Local Nature Partnership

- C&P Road Safety Partnership
- C&P Health Protection Steering Group (Chair)
- C&P Health and Care Executive
- C&P Sustainable Transformation Partnership (STP) Board

Some examples of partnership work delivered this year include:

- Ongoing implementation of a successful bid to Sport England, across Cambridgeshire and Peterborough, to support participation in physical activity for disadvantaged families, working closely with Vivacity.
- Input to the Combined Authority's Local Transport Plan Steering Group to ensure that appropriate advice was provided on health and wellbeing policies within the plan
- Work with the Sustainable Transformation Partnership on Suicide Prevention, including a successful bid for national NHS funds.
- Work with Cambridgeshire County Council, Cambridgeshire and Peterborough CCG and NHS England to develop a joint commissioning model for sexual and reproductive health services (currently out to tender).
- Work with Cambridgeshire County Council and Cambridgeshire & Peterborough CCG to develop joint commissioning of Integrated Lifestyle Services (currently out to tender)
- Preventive work with the Safer Peterborough partnership on key priorities in relation to drugs and alcohol, and other relevant issues.
- Ongoing joint work on the Best Start in Life Strategy across PCC, CCC, the local NHS and voluntary sector.
- Work to implement a health and wellbeing action plan from the Diverse Ethnic Communities: South Asian Joint Strategic Needs Assessment (JSNA)

4.12 **Health and Wellbeing Board**

Peterborough Health and Wellbeing Board have a statutory duty to deliver a Joint Strategic Needs Assessment (JSNA) and a Pharmaceutical Needs Assessment (PNA) for the area. During the past year, public health staff have led production of the

- Cambridgeshire and Peterborough JSNA Core Dataset 2019
- Peterborough JSNA Core Dataset 2019
- Diverse Ethnic Communities: South Asian Joint Strategic Needs Assessment 2019

These are available on
https://www.peterborough.gov.uk/healthcare/public-health/JSNA/

The Peterborough Joint Health and Wellbeing Strategy (JHWS) 2016-19 has now completed its third year and has been extended while a draft joint Cambridgeshire and Peterborough Health and Wellbeing Strategy is consulted on. The consultation materials are available on
https://www.peterborough.gov.uk/council/consultations/joint-health-and-wellbeing-strategy-for-cambridgeshire-and-peterborough

4.13 **Public Health Outcomes**

The Public Health England Health Profile for Peterborough (2018) is attached as Annex A. This compares a range of health outcomes in Peterborough with the England average. Life expectancy in Peterborough remains below the England average, and health outcomes are generally either similar to or worse than national averages.

As stated earlier in section 4.2, public health need and outcomes are closely linked with socio-economic deprivation. Because Peterborough has a higher level of socio-economic deprivation than the national average (Index of Deprivation 2019), the most realistic comparison is with health outcomes in other local authorities with similar levels of deprivation (Peterborough's deprivation decile). It is possible to make these comparisons using the national Public Health Outcomes Framework (PHOF) website www.phoutcomes.info/

Public health outcomes which may be particularly worthy of further attention, which the 'PHOF indicates are worse than Peterborough's deprivation decile average as well as the England average include:

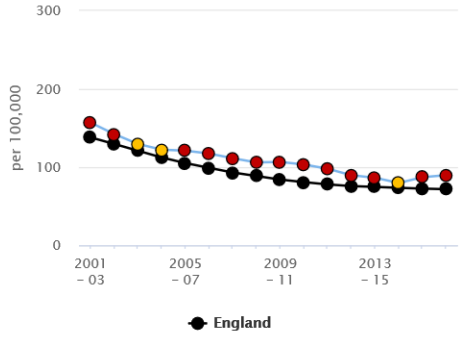
- Infant mortality rate
- School readiness (children achieving a good level of development at the end of reception)
- Percentage of five year olds with dental decay
- Hospital admissions for unintentional and deliberate injuries, young people aged 0-14
- Hospital admissions for self-harm
- Uptake of bowel cancer screening
- Uptake of some childhood vaccinations including MMR, and adult flu vaccination
- Incidence of TB
- Mortality from specified infectious diseases (including influenza)
- Hip fractures in people aged 85+

4.14 **Cardiovascular disease in Peterborough**

There was a specific request from the Health Scrutiny Committee to include information on cardiovascular outcomes in Peterborough in the Cabinet Portfolio Holder's report. The national public health outcomes framework includes benchmarking of mortality from cardiovascular disease under the age of 75. In Peterborough the death rate under age 75 from cardiovascular disease has historically been significantly above the national average (coloured red on the graph below). In 2013 the Clinical Commissioning Group made reducing inequalities in heart disease across Cambridgeshire and Peterborough one of its three main priorities. A programme of close joint work between GP practices and City Council public health was developed, including a focus on health checks, smoking cessation, and provision of preventive advice and best medication by GP practices. The graph below indicates that this may have had some effect as for one 'point' covering 2014-16, rates of premature death from cardiovascular disease fell to similar to national average. However since then, they have returned back to levels significantly above average, although still lower than historical rates before 2010.

E04a - Under 75 mortality rate from all cardiovascular diseases Peterborough — Directly standardised rate - per 100,000

Export chart as image | Show confidence intervals | Export table as CSV file



Recent trend: –

Period		Peterborough Count	Value	Lower CI	Upper CI	Third more deprived decile (IMD2019)	England
2001 - 03	●	519	156.9	143.6	171.0	-	138.0
2002 - 04	●	475	142.2	129.6	155.7	-	129.5
2003 - 05	●	439	129.5	117.6	142.3	-	120.9
2004 - 06	●	420	122.3	110.8	134.7	-	112.3
2005 - 07	●	421	121.0	109.6	133.3	-	105.1
2006 - 08	●	411	117.3	106.2	129.4	-	99.0
2007 - 09	●	397	111.3	100.5	122.9	-	93.1
2008 - 10	●	386	106.0	95.5	117.2	-	88.6
2009 - 11	●	397	106.6	96.2	117.8	-	84.0
2010 - 12	●	389	103.3	93.2	114.3	-	80.8
2011 - 13	●	375	97.9	88.1	108.5	-	77.8
2012 - 14	●	352	89.6	80.3	99.6	-	75.7
2013 - 15	●	349	86.3	77.4	96.0	-	74.6
2014 - 16	●	331	79.7	71.3	88.9	-	73.5
2015 - 17	●	373	87.0	78.3	96.4	-	72.5
2016 - 18	●	396	89.7	81.0	99.0	83.9	71.7

Source: Public Health England (based on ONS source data)

When compared with other local authorities with similar levels of deprivation, rather than the national average, premature deaths from cardiovascular disease in Peterborough are higher than average, but this is not statistically significant difference.

There are significant differences between the most and least deprived areas of Peterborough in rates of early deaths from heart disease, particularly for men. The chart below shows that cardiovascular disease accounts for almost three year of the difference in life expectancy between men in the most and least deprived quintiles (20%) of small areas in Peterborough. Nationally and locally, heart disease is linked with social and economic deprivation and with ethnicity – there are higher rates in both South Asian and some Eastern European communities.

Bar chart showing the breakdown of the life expectancy gap between the most deprived quintile and least deprived quintile of Peterborough, by broad cause of death, 2015-17

Source: Public Health England based on ONS death registration data and mid year population estimates, and Ministry of Housing, Communities and Local Government Index of Multiple Deprivation, 2015

Public Health England. Segment Tool https://analytics.phe.gov.uk/apps/segment-tool/ Downloaded 14/01/2020

The ongoing inequalities in cardiovascular disease in both Peterborough and Wisbech are recognised across the health and care system and have been included as a priority in the draft Cambridgeshire and Peterborough Health and Wellbeing Strategy. The proposed actions for Health and Wellbeing Board member organisations to address this inequality are:

- Adopt and implement the Cambridgeshire and Peterborough Smoking and Tobacco Strategy, led by the Smoke Free Alliances.
- Adopt and implement the CCG prevention strategy, which has a strong focus on improved management of high blood pressure by GP practices.
- Adopt the STP Clinical Strategy for cardiovascular disease, to ensure that best treatment is available across the system
- Focus resources on working together with primary care networks in the most deprived areas of Peterborough and Wisbech to prevent and effectively treat cardiovascular disease.

Locally, work has started on co-producing a Health and Wellbeing action plan for South Asian communities, addressing the findings of a joint strategic needs assessment. One of the three priorities for this Health and Wellbeing Action plan is preventing diabetes and heart disease.

The specification for the reprocurement of the Integrated Lifestyle Service includes preventive services which will address cardiovascular disease risk – including smoking cessation, out-reach health checks, weight management and physical activity promotion services, and there will be a focus on communities at higher risk of heart disease.

5. CONSULTATION

5.1 Consultation has been carried out on public health savings as part of the wider Tranche 1 MTFS budget consultation.

There has been consultation with service users on changes to the CPFT health visiting service young parents' pathway; and on changes to the child health promotion clinic offer, which will be aligned with increased use of digital communication.

Consultation with stakeholders has been carried out as part of the process for re- procuring Integrated Lifestyle Services, Sexual and Reproductive Health Services, and Prevention of Sexual Ill Health Services.

6. ANTICIPATED OUTCOMES OR IMPACT

6.1 The overall impact of Peterborough City Council's public health functions should be to improve the health of local residents and reduce health inequalities.

7. REASON FOR THE RECOMMENDATION

7.1 This paper enables the Health Scrutiny Committee to consider and comment on the delivery of the public health functions of Peterborough City Council and make appropriate recommendations.

8. ALTERNATIVE OPTIONS CONSIDERED

8.1 The Committee may have chosen to focus on one topic, rather than a more comprehensive Cabinet Portfolio Holder's update report. However, the wider work of the Council's public health functions would not then have been submitted to the same level of democratic scrutiny in public.

9. IMPLICATIONS

Financial Implications

9.1 These are outlined in paragraphs 4.2 and 4.3

Legal Implications

9.2 Under the Health and Social Care Act (2012) the Council has a statutory duty to take such steps as it considers appropriate to improve the health of local residents. The public health grant is currently ring-fenced for use on services meeting the grant's terms and conditions.

Equalities Implications

9.3 There is a wider focus within public health services on reducing health inequalities, which in turn should impact positively on a number of equalities groups.

Rural Implications

9.4 The public health functions outlined should, where feasible, be delivered in both urban and rural areas of Peterborough. It is important to ensure that where services are based centrally within the City there is appropriate outreach into rural areas, based on need.

Carbon Impact Assessment

9.5 This is a general report on activity in the previous year not a new project and therefore does not have specific carbon impact implications. Some public health recommendations made to promote health and wellbeing – such as increased active travel (walking/cycling/use of public transport) and increased consumption of fruit and vegetables rather than meat, also result in improved carbon footprint.

10. BACKGROUND DOCUMENTS

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

10.1 Public health directorate budget spreadsheets
Public health joint commissioning unit performance reports
Annual health protection report (2019)
These documents are held by the public health directorate on electonic systems, based at Sandmartin House, Bittern Way, Fletton Quays, Peterborough, PE2 8TY

11. APPENDICES

11.1 Annex A: Health Profile for Peterborough 2019

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Public Health England

Peterborough

Published on 04/02/2020

Area type: Unitary authority
Region: East of England

Local Authority Health Profile 2019

This profile gives a picture of people's health in Peterborough. It is designed to act as a 'conversation starter', to help local government and health services understand their community's needs, so that they can work together to improve people's health and reduce health inequalities.

Visit https://fingertips.phe.org.uk/profile/health-profiles for more area profiles, more information and interactive maps and tools.

Health in summary

The health of people in Peterborough is generally worse than the England average. Peterborough is one of the 20% most deprived districts/unitary authorities in England and 18.8% (8,735) of children live in low income families. Life expectancy for both men and women is lower than the England average.

Health inequalities

Life expectancy is 9.7 years lower for men and 5.8 years lower for women in the most deprived areas of Peterborough than in the least deprived areas.

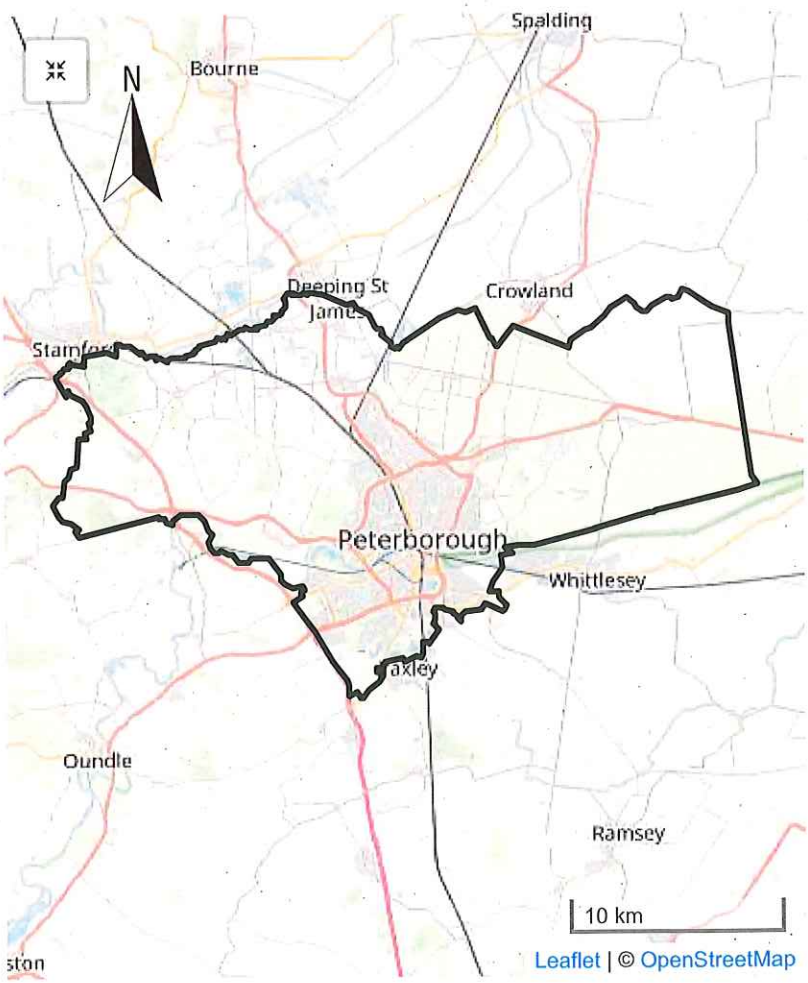
Child health

In Year 6, 22.7% (629) of children are classified as obese, worse than the average for England. Levels of GCSE attainment (average attainment 8 score) and breastfeeding are worse than the England average.

Adult health

The rate for alcohol-related harm hospital admissions is 591*, better than the average for England. This represents 1,059 admissions per year. The rate for self-harm hospital admissions is 228*, worse than the average for England. This represents 455 admissions per year. Estimated levels of excess weight in adults (aged 18+), smoking prevalence in adults (aged 18+) and physically active adults (aged 19+) are worse than the England average. The rates of hip fractures in older people (aged 65+), new sexually transmitted infections and new cases of tuberculosis are worse than the England average. The rates of statutory homelessness, violent crime (hospital admissions for violence), under 75 mortality rate from cardiovascular diseases and under 75 mortality rate from cancer are worse than the England average.

* rate per 100,000 population



Health summary for Peterborough

Key

Significance compared to goal / England average:

Significantly worse	Significantly lower	↑ Increasing / Getting worse	↑ Increasing / Getting better
Not significantly different	Significantly higher	↓ Decreasing / Getting worse	↓ Decreasing / Getting better
Significantly better	Significance not tested	↑ Increasing	↓ Decreasing
		↑ Increasing (not significant)	↓ Decreasing (not significant)
		– Could not be calculated	→ No significant change

Life expectancy and causes of death

Indicator	Age	Period	Count	Value (Local)	Value (Region)	Value (England)	Change from previous
1 Life expectancy at birth (male)	All ages	2016 - 18	n/a	78.2	80.3	79.6	↓
2 Life expectancy at birth (female)	All ages	2016 - 18	n/a	82.3	83.7	83.2	↓
3 Under 75 mortality rate from all causes	<75 yrs	2016 - 18	1,726	383.2	302.1	330.5	↑
4 Mortality rate from all cardiovascular diseases	<75 yrs	2016 - 18	396	89.7	63.4	71.7	↑
5 Mortality rate from cancer	<75 yrs	2016 - 18	630	145.0	126.0	132.3	↓
6 Suicide rate	10+ yrs	2016 - 18	61	12.2	10.0	9.6	↑

Injuries and ill health

Indicator	Age	Period	Count	Value (Local)	Value (Region)	Value (England)	Change from previous
7 Killed and seriously injured (KSI) rate on England's roads	All ages	2016 - 18	285	47.8	46.7	42.6 $	–
8 Emergency hospital admission rate for intentional self-harm	All ages	2018/19	455	228.5	173.1	193.4	↓
9 Emergency hospital admission rate for hip fractures	65+ yrs	2018/19	195	656.4	563.5	558.4	↑
10 Percentage of cancer diagnosed at early stage	All ages	2017	361	54.6	54.7	52.2	↑
11 Estimated diabetes diagnosis rate	17+ yrs	2018	n/a	82.7	76.7	78.0	↑
12 Estimated dementia diagnosis rate	65+ yrs	2019	1,510	80.6 *	65.7 *	68.7 *	↑

Behavioural risk factors

Indicator	Age	Period	Count	Value (Local)	Value (Region)	Value (England)	Change from previous
13 Hospital admission rate for alcohol-specific conditions	<18 yrs	2016/17 - 18/19	25	16.7	23.4	31.6	↓
14 Hospital admission rate for alcohol-related conditions	All ages	2018/19	1,059	590.6	633.6	663.7	↓
15 Smoking prevalence in adults	18+ yrs	2018	29,207	19.5	14.0	14.4	↑
16 Percentage of physically active adults	19+ yrs	2017/18	n/a	61.7	65.4	66.3	↑
17 Percentage of adults classified as overweight or obese	18+ yrs	2017/18	n/a	68.3	62.1	62.0	↑

Child health

Indicator	Age	Period	Count	Value (Local)	Value (Region)	Value (England)	Change from previous
18 Teenage conception rate	<18 yrs	2017	74	22.4	16.0	17.8	↓
19 Percentage of smoking during pregnancy	All ages	2018/19	276	10.9 ~	9.7 $	10.6	↓
20 Percentage of breastfeeding initiation	All ages	2016/17	1,927	68.8	76.1	74.5	↑
21 Infant mortality rate	<1 yr	2016 - 18	48	5.3	3.4	3.9	↑
22 Year 6: Prevalence of obesity (including severe obesity)	10-11 yrs	2018/19	629	22.7	18.0	20.2	↑

Inequalities

Indicator	Age	Period	Count	Value (Local)	Value (Region)	Value (England)	Change from previous
23 Deprivation score (IMD 2015)	All ages	2015	n/a	27.7	- $	21.8	–
24 Smoking prevalence in adults in routine and manual occupations	18-64 yrs	2018	n/a	30.6	25.7	25.4	↑
25 Inequality in life expectancy at birth (male)	All ages	2016 - 18	n/a	9.7	8.2	9.5	↑

Indicator	Age	Period	Count	Value (Local)	Value (Region)	Value (England)	Change from previous
26 Inequality in life expectancy at birth (female)	All ages	2016 - 18	n/a	5.8	6.1	7.5	→

Wider determinants of health

Indicator	Age	Period	Count	Value (Local)	Value (Region)	Value (England)	Change from previous
27 Percentage of children in low income families	<16 yrs	2016	8,735	18.8	14.1	17.0	↑
28 GCSE attainment (average attainment 8 score)	15-16 yrs	2017/18	n/a	42.3	46.9	46.7	↑
29 Percentage of people in employment	16-64 yrs	2018/19	93,100	75.3	78.4	75.6	↑
30 Statutory homelessness rate - eligible homeless people not in priority need	Not applicable	2017/18	128	1.6	0.6	0.8	↓
31 Violent crime - hospital admission rate for violence (including sexual violence)	All ages	2016/17 - 18/19	345	56.0	33.6	44.9	↓

Health protection

Indicator	Age	Period	Count	Value (Local)	Value (Region)	Value (England)	Change from previous
32 Excess winter deaths index	All ages	Aug 2017 - Jul 2018	127	25.8	30.9	30.1	↑
33 New STI diagnoses rate (exc chlamydia aged <25)	15-64 yrs	2018	1,171	923.9	614.9	850.6	↑
34 TB incidence rate	All ages	2016 - 18	119	19.9	5.6	9.2	↑

For full details on each indicator, see the definitions tab of the Local Authority Health Profiles online tool.
For a full list of profiles produced by Public Health England, see the fingertips website: https://fingertips.phe.org.uk/

Indicator value types

1,2 Life expectancy - years 3,4,5 Directly age-standardised rate per 100,000 population aged under 75 6 Directly age-standardised rate per 100,000 population aged 10 and over 7 Crude rate per 100,000 population 8 Directly age-standardised rate per 100,000 population 9 Directly age-standardised rate per 100,000 population aged 65 and over 10 Proportion - % of cancers diagnosed at stage 1 or 2 11 Proportion - % recorded diagnosis of diabetes as a proportion of the estimated number with diabetes 12 Proportion - % recorded diagnosis of dementia as a proportion of the estimated number with dementia 13 Crude rate per 100,000 population aged under 18 14 Directly age-standardised rate per 100,000 population 15,16,17 Proportion 18 Crude rate per 1,000 females aged 15 to 17 19,20 Proportion 21 Crude rate per 1,000 live births 22 Proportion 23 Index of Multiple Deprivation (IMD) 2015 score 24 Proportion 25,26 Slope index of inequality 27 Proportion 28 Mean average across 8 qualifications 29 Proportion 30 Crude rate per 1,000 households 31 Directly age-standardised rate per 100,000 population 32 Ratio of excess winter deaths to average of non-winter deaths 33 Crude rate per 100,000 population aged 15 to 64 (excluding Chlamydia) 34 Crude rate per 100,000 population

*	Value compared to a goal (see below)
~	There is a data quality issue with this value
$	Aggregated from all known lower geography values

Thresholds for indicators that are compared against a goal

Indicator Name	Green	Amber	Red
12 Estimated dementia diagnosis rate (aged 65 and over)	>= 66.7% (significantly)	similar to 66.7%	< 66.7% (significantly)

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HEALTH SCRUTINY COMMITTEE	AGENDA ITEM No. 8
9 MARCH 2020	PUBLIC REPORT

Report of:	Director of Public Health, Service Director Communities and Safety	
Cabinet Member(s) responsible:	Cllr Wayne Fitzgerald, Deputy Leader and Cabinet Member for Adult Social Care, Health and Public Health	
Contact Officer(s):	Dr Liz Robin, Director of Public Health Adrian Chapman, Service Director Communities and Safety	Tel. (01733) 207176

CONSULTATION ON THE CAMBRIDGESHIRE AND PETERBOROUGH DRAFT JOINT HEALTH AND WELLBEING STRATEGY 2020-24

R E C O M M E N D A T I O N S	
FROM: Director of Public Health	**Deadline date: The consultation on the draft Joint Health and Wellbeing Strategy closes on 30th April 2020**

It is recommended that the Health Scrutiny Committee:

1. Discuss and comment on the draft Joint Health and Wellbeing Strategy 2020-24.and the consultation process for the draft Strategy
2. Discuss and comment on the Think Communities Health Deal Agreement
3. That the minutes of the Health Scrutiny Committee are fed into the consultation responses to the draft Joint Health and Wellbeing Strategy (2020-24)

1. ORIGIN OF REPORT

1.1 This report is submitted to Health Scrutiny Committee following its inclusion in the 2019/20 Health Scrutiny Work Programme as discussed by Committee members.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to present the draft Joint Health and Wellbeing Strategy 2020-24 and associated consultation documents to the Health Scrutiny Committee, to obtain the views of the Committee on the priorities, focus areas and proposed actions in the draft Strategy, and the overall consultation process.

2.2 This report is for the Health Scrutiny Committee to consider under its Terms of Reference Part 3, Section 4 - Overview Scrutiny Functions, paragraph No. 2.1 Functions determined by Council:

1.Public Health

2.4 The draft Joint Health and Wellbeing Strategy links to Corporate Priority

- Achieve the best health and wellbeing for the city

3. TIMESCALES

Is this a Major Policy Item/Statutory Plan?	**YES/NO**	If yes, date for Cabinet meeting	N/A

4. BACKGROUND AND KEY ISSUES

4.1 Health and wellbeing boards were established under the Health and Social Care Act 2012 to act as a forum in which key leaders from the local health and care system could work together to improve the health and wellbeing of their local population. They became fully operational on 1 April 2013 in all 152 local authorities with adult social care and public heath responsibilities.

The Peterborough Health and Wellbeing Board is chaired by the Council Leader Cllr John Holdich, and the Vice-Chair is the Clinical Chair of the Cambridgeshire & Peterborough Clinical Commissioning Group (CCG), Dr Gary Howsam, who is also a local GP.

Developing a Joint Health and Wellbeing Strategy (JHWS) to meet the needs identified in their Joint Strategic Needs Assessment (JSNA) is a statutory requirement of all Health and Wellbeing Boards.

4.2 Peterborough and Cambridgeshire Health and Wellbeing Boards have chosen to work together through a 'Whole System' Joint Sub-Committee, which includes the full membership of both Boards, to develop one Joint Health and Wellbeing Strategy across Peterborough and Cambridgeshire. This will increase the strategic impact of the JHWS on the wider health system. Cllr Holdich currently chairs this 'Whole System Joint Sub-Committee', and in the longer term the Chair will alternate between Peterborough and Cambridgeshire.

4.3 The approach to developing the new Joint Health and Wellbeing Strategy (JHWS) was to discuss the key findings of the Cambridgeshire and Peterborough Joint Strategic Needs Assessment (JSNA) with a wide range of local stakeholders. These discussions focussed on health and wellbeing outcomes where we face challenges as a system - for example the impact of population growth on infrastructure and demand for services; significant inequalities between communities; or outcomes where the system as a whole does worse than average. These discussions helped to develop the key priorities and areas of focus for the JHWS.

4.4 The four priorities identified for the JHWS are:

Priority 1: Places that support health and wellbeing
Priority 2: Helping children achieve the best start in life
Priority 3: Staying healthy throughout life
Priority 4: Quality health and social care

Further detail of the background to these priorities, the areas of focus within them, and the proposed actions for the Health and Wellbeing Board and partner agencies are described within the Strategy consultation documents attached as Annexes A,B, C and D.

4.5 Communities we live in are fundamental to our health, and we are taking a 'Think Communities' approach to the Joint Health and Wellbeing Strategy.

Our Think Communities System Ambition is to develop a public sector workforce that listens, engages with and aligns to communities and each other, through mobilisation of citizens and communities into positive action and commits to delivering services in ways that support communities to drive lasting change.

The Think Communities Health Deal Agreement (Annex E) identifies how the System partners will commit to working collaboratively with the focus on place /local communities whilst aiming to empower people to take responsibility to improve their health outcomes.

Supporting the health and well-being of our communities is fundamental to Local Government, and the NHS, therefore we recognise that many of the most important factors which affect our residents' health are social, economic and environmental.

The Think Communities approach is based on place and partners supporting Communities /individuals to be enabled to take back responsibility, rather than organisations working in silos .The action needed to address the Wider Determinants of Health can be challenging therefore we need to adopt a much more holistic approach to delivering solutions with Communities which contribute to the delivery of some of the Health and Well-being priorities.

5. CONSULTATION

5.1 The HealthWatch 'What would you do?' Consultation Report on the NHS Long Term Plan was used in preparation of the draft JHWS and is quoted within it.

5.2 The consultation on the draft JHWS was launched on February 7th 2020 and will close on 30th April. The consultation documents and questionnaire are available on weblink https://www.peterborough.gov.uk/council/consultations/joint-health-and-wellbeing-strategy-for-cambridgeshire-and-peterborough

The consultation documents include the full draft Joint Health and Wellbeing Strategy, an Executive Summary, and an Easy Read version which has been tested with HealthWatch Access Champions.

Hard copies of the consultation documents will be made available in libraries, or by request from the Public Health administrative team.

Hard copies of the Easy Read version are being sent to organisations working with people with learning disabilities.

5.3 Presentations and/or workshops on the Joint Health and Wellbeing Strategy consultation are in process of being planned for the following Committees and Boards, although at the time of writing some are still to be confirmed:

- Peterborough City Council Health Scrutiny Committee
- Cambridgeshire County Council Health Committee, and any other Committees as appropriate
- A relevant Committee, Panel or Workshop in all District and City Councils
- A relevant forum at the Cambridgeshire and Peterborough Combined Authority (TBC)
- Cambridgeshire Public Service Board
- The Sustainable Transformation Partnership (STP) Board and relevant Alliances and Clinical Sub-Groups.
- The CCG Governing Body
- Cambridgeshire and Peterborough HealthWatch Board
- Patient Participation Groups and Forums
- Partnership Boards (for Older People, Mental Health, People with Disabilities)
- Voluntary Sector Chief Executives Group
- Cambridgeshire Countywide Community Safety Board (TBC)
- Safer Peterborough Partnership (TBC)
- Cambridgeshire & Peterborough Executive Safeguarding Board
- Think Communities Senior Officer Board
- Children's Health and Wellbeing Executive Board
- Cambridgeshire Sub-Regional Housing Board
- Planning Policy Officers Group
- Public Health Reference Group
- Cambridgeshire and Peterborough Smoke Free Alliance

5.4 A progress report on the consultation will be taken to the Cambridgeshire and Peterborough Health and Wellbeing Boards Joint Whole- System Sub-Committee meeting on March 5th 2020.

The consultation feedback report together, with the final draft of the JHWS as modified in response to the consultation, will be taken to the Joint Whole System Sub-Committee for approval on June 4th 2020.

6. ANTICIPATED OUTCOMES OR IMPACT

6.1 The Health and Wellbeing Board doesn't hold its own budget, but works as forum to bring local organisations and leaders together, to develop a joint approach to health and wellbeing.

One outcome of the pre-consultation discussions with stakeholders, was that for most of the key issues in the JHWS we were able to identify a multi-agency board or group which was already addressing the strategic priority or focus area of concern. In some cases this group had agreed a multi-agency plan across Cambridgeshire and Peterborough to achieve this. Sometimes, other key stakeholders were not aware of this work – leading to a risk of duplication and fragmented working across the wider system.

A key proposed outcome from the JHWS is therefore to keep it simple – working with a 'Think Communities' approach and highlighting, endorsing and signposting to those existing multi-agency Boards and groups, which are addressing key health and wellbeing priorities. The role of the Health and Wellbeing Boards then becomes to support these groups and their work with communities, prevent unnecessary duplication, regularly monitor their progress against JHWS priorities and the outcomes achieved for residents, and provide strategic challenge, support and 'unblocking' where necessary.

7. REASON FOR THE RECOMMENDATION

7.1 The Peterborough City Council Health Scrutiny Committee has the remit to scrutinise the work of the Health and Wellbeing Board. The Joint Health and Wellbeing Strategy is a key statutory function of the Health and Wellbeing Board, and therefore it is important for the Scrutiny Committee to consider this work and make clear their views and recommendations.

8. ALTERNATIVE OPTIONS CONSIDERED

8.1 The Health Scrutiny Committee could have decided not to consider the draft Joint Health and Wellbeing Strategy 2020-24, and the associated consultation process. However, this would mean that an important statutory Strategy was not subjected to democratic scrutiny in Peterborough.

9. IMPLICATIONS

Financial Implications

9.1 The draft Joint Health and Wellbeing Strategy does not have direct financial implications, as the Health and Wellbeing Board does not hold a budget. However it may influence how Council budgets are spent, particularly where this is done in partnership with NHS organisations.

There are implications for officer time in drafting and consulting on the Joint Health and Wellbeing Strategy. Because this is a statutory duty, it is included within core business and staff costs.

There are some limited costs for design and printing (delivered in-house through Peterborough City Council design and print service) and social media. These are shared between Cambridgeshire County Council and Peterborough City Council.

Legal Implications

9.2 Producing a Joint Health and Wellbeing Strategy is a statutory duty of the Peterborough Health and Wellbeing Board.

The appropriate delegations have been agreed by full Council, for the Cambridgeshire and Peterborough Joint Health and Wellbeing Strategy, to be approved by the Cambridgeshire and Peterborough Health and Wellbeing Boards Joint Whole System Sub-Committee.

Equalities Implications

9.3 The JHWS includes a focus on addressing inequalities in health and its determinants. The consultation questionnaire includes questions on age, gender, ethnicity, long term condition or dsability, and sexual orientation - which will enable consultation responses to be analysed in relation to equalities characteristics.

Rural Implications

9.4 The JHWS is relevant to both rural and urban areas of Peterborough.

Carbon Impact Assessment

9.5 The JHWS proposes that the Health and Wellbeing Boards can endorse and support member organisations' Climate Change Strategies and Action Plans as these develop. There is a clear statement in the Foreword to the strategy that many of the behaviours that reduce carbon impact – such as active travel rather than car use; reducing meat consumption and increased consumption of fruit and vegetables – are also beneficial to health and wellbeing. Because the Strategy is at high level it does not have specific quantifiable impacts on Peterborough City Council's carbon emissions.

Children in Care Pledge

9.6 The draft JHWS includes a section on Priority 2 'Helping Children achieve the Best Start in Life'. Focus area 2.2 'Developing an integrated approach for older children and adolescents' includes the proposed outcomes for residents of: 'Vulnerable young people are included in local communities and get help and support when they need it' and 'Fewer young people are taken into care'

10. BACKGROUND DOCUMENTS

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

10.1 None

11. APPENDICES

11.1 Annex A: Cambridgeshire and Peterborough draft Joint Health and Wellbeing Strategy (2020-24) for Consultation
Annex B: Joint Health and Wellbeing Strategy Executive Summary
Annex C: Consultation questions
Annex D: Easy Read Health and Wellbeing Strategy and Questionnaire
Annex E: Think Communities Health Deal Agreement

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Cambridgeshire County Council

NHS Cambridgeshire and Peterborough Clinical Commissioning Group

PETERBOROUGH CITY COUNCIL

Consultation Draft

CAMBRIDGESHIRE and PETERBOROUGH

Joint Health and Wellbeing Strategy **2020-24**

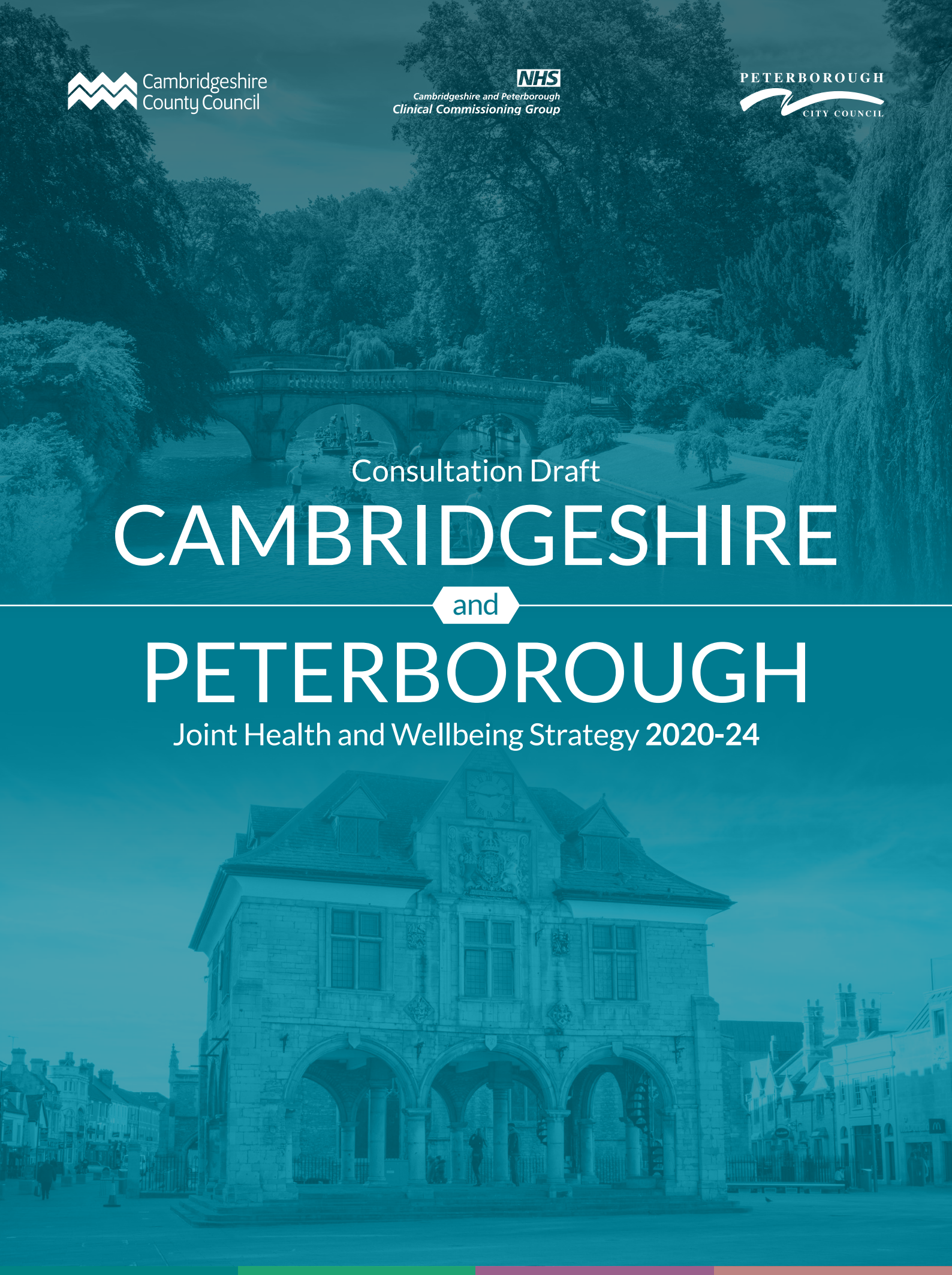


TABLE OF CONTENTS

FOREWORD

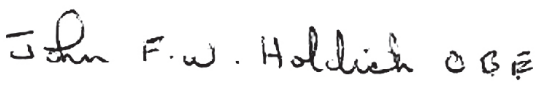
Supporting the health and wellbeing of our communities is fundamental to Local Government, as well as to the NHS. As a Health and Wellbeing Board, we recognise that many of the most important factors which affect our residents' health are social, economic and environmental.

At the time of writing our Councils have declared a Climate Change Emergency, and are working on the actions that we will be taking to address this over the coming years. Many of the actions that individuals and organisations can take to benefit the climate will also be good for our own health – walking or cycling rather than using the car; increasing the use of electric vehicles; eating more local vegetables and less meat; and making sure our houses are well insulated.

The Health and Wellbeing Board is the place where politicians, health and social care professionals and other leaders across the system work together to solve problems and lead change to benefit our residents. This year for the first time we have agreed to work together to create a joint Health and Wellbeing Strategy (2020-2024) across Cambridgeshire and Peterborough. We are also working closely with the authors of the local NHS five year plan (2019-24), so that both plans make sense together.

The communities we live in are fundamental to our health, and taking a 'Think Communities' approach based on place, rather than a silo approach based on organisations is at the core of this draft Strategy. One of the many benefits of this approach is that it helps tackle loneliness and isolation, which can be so damaging to health and wellbeing.

The local health issues are often clear, while the actions we can take locally to address them can be more challenging to agree. This draft Health and Wellbeing Strategy will now go through an extended further process of consultation with stakeholders and the public, to ensure that the actions we endorse and lead as a Health and Wellbeing Board are the right ones for our communities.

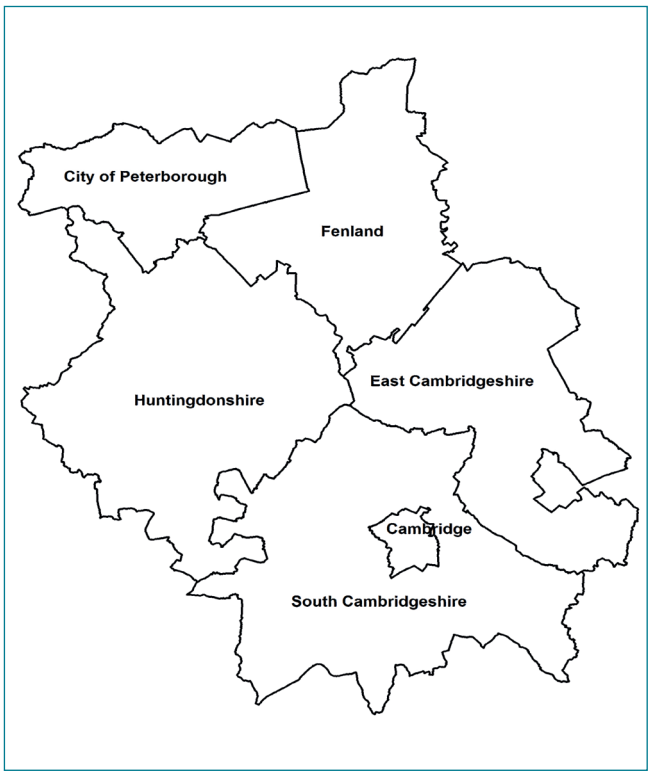


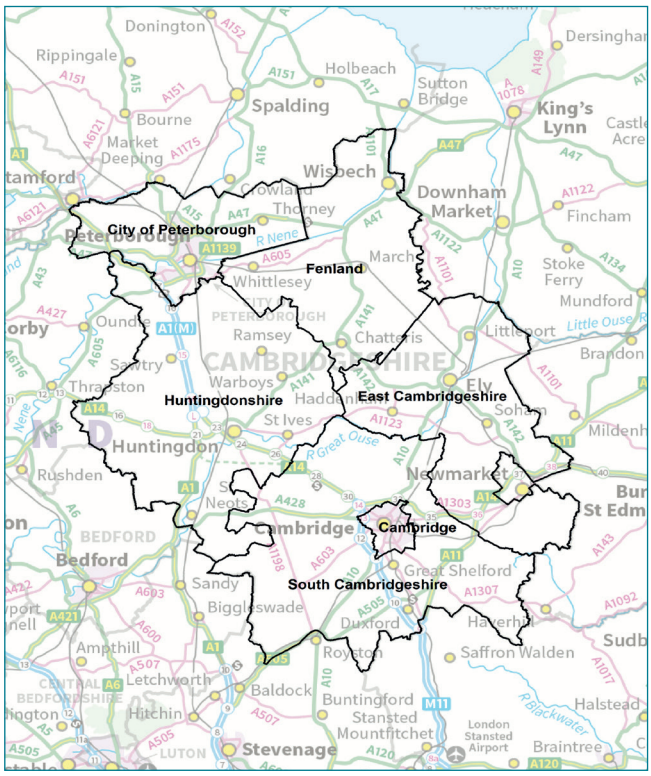
Cllr John Holdich OBE
Leader Peterborough City Council and Chair,
Peterborough Health and Wellbeing Board

Cllr Roger Hickford
Deputy Leader Cambridgeshire County Council and Chair,
Cambridgeshire Health and Wellbeing Board

INTRODUCTION
DEVELOPING THE JOINT HEALTH AND WELLBEING STRATEGY

This Joint Health and Wellbeing Strategy for Cambridgeshire and Peterborough covers the local authority areas shown on the maps below.





These maps show Peterborough City Council and the five City and District Councils in Cambridgeshire – Cambridge City, East Cambridgeshire, Fenland, Huntingdonshire and South Cambridgeshire. The City and District Councils provide many services which are key to health and wellbeing, so their engagement in this strategy is essential, together with NHS organisations, the community and voluntary sector and other stakeholders.

The first stage in developing the Joint Health and Wellbeing Strategy was to identify four key priorities across the organisations which make up the Health and Wellbeing Boards:

Priority 1: Places that support health and wellbeing

Priority 2: Helping children achieve the best start in life

Priority 3: Staying healthy throughout life

Priority 4: Quality health and social care

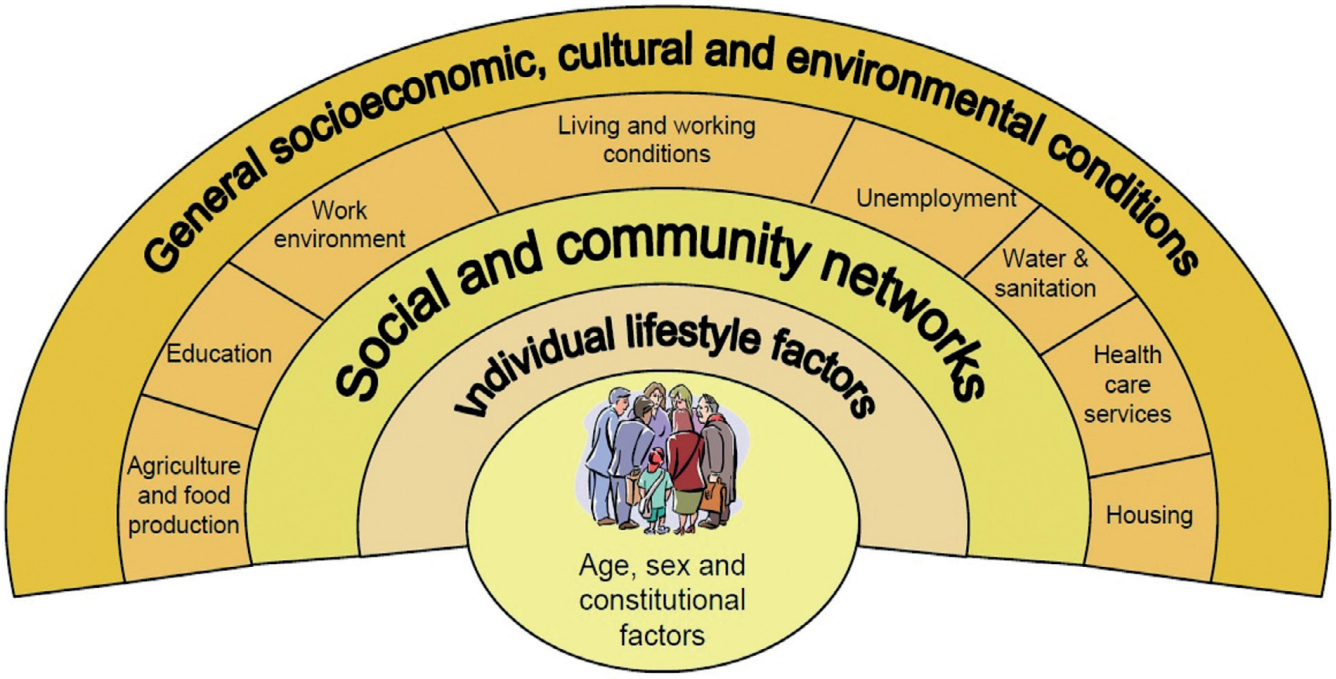
We then looked at health statistics in our Joint Strategic Needs Assessment (JSNA) Core Dataset, and identified health outcomes or inequalities across Cambridgeshire and Peterborough, which could be improved.

We presented this information from the JSNA core dataset to key staff in a range of local organisations and Boards, and asked them whether they already had strategies and plans in place to improve some of the health outcomes and inequalities. We also asked whether there were actions they would like the Health and Wellbeing Board to take and include in the Joint Health and Wellbeing Strategy.

We are now bringing this draft Joint Health and Wellbeing Strategy to the next stage of engagement and consultation, with a wider range of stakeholders and with the public.

PRIORITY 1
PLACES THAT SUPPORT HEALTH AND WELLBEING

The places where we live, work, learn and socialise have a big impact on our health..



Source: Dahlgren & Whitehead 1991

Information from the Joint Strategic Needs Assessment and discussions with a range of local stakeholders about 'Places that support our health and wellbeing' have identified three areas of focus:

1.1 Housing developments and transport which support residents' health and address climate change.

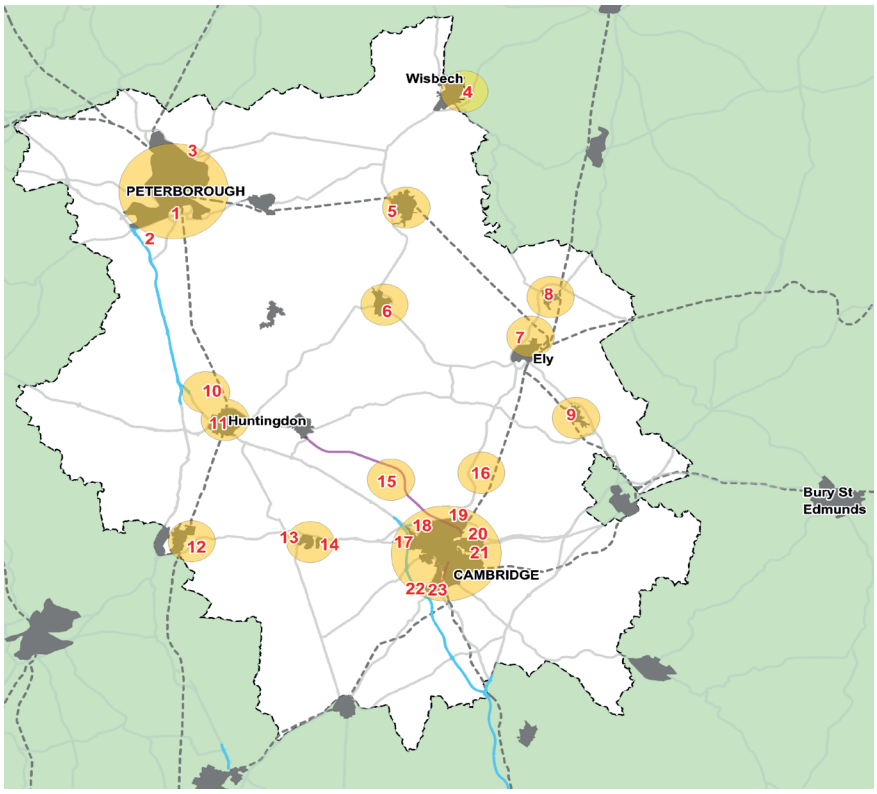
1.2 Preventing homelessness and improving pathways into housing for vulnerable people.

1.3 Reducing inequalities in skills and economic outcomes across our area.

HOUSING DEVELOPMENTS AND TRANSPORT WHICH SUPPORT RESIDENTS' HEALTH AND ADDRESS CLIMATE CHANGE

What does the JSNA tell us?

We have several new housing development sites in Cambridgeshire and Peterborough, and are developing new transport infrastructure and access to public transport services for both existing and new communities. If plans reflect what is known about the effects of housing, green space, walking and cycling, and good community networks on health - residents will have the best chance to be healthy. We also need to plan health and care services for the larger new housing developments.



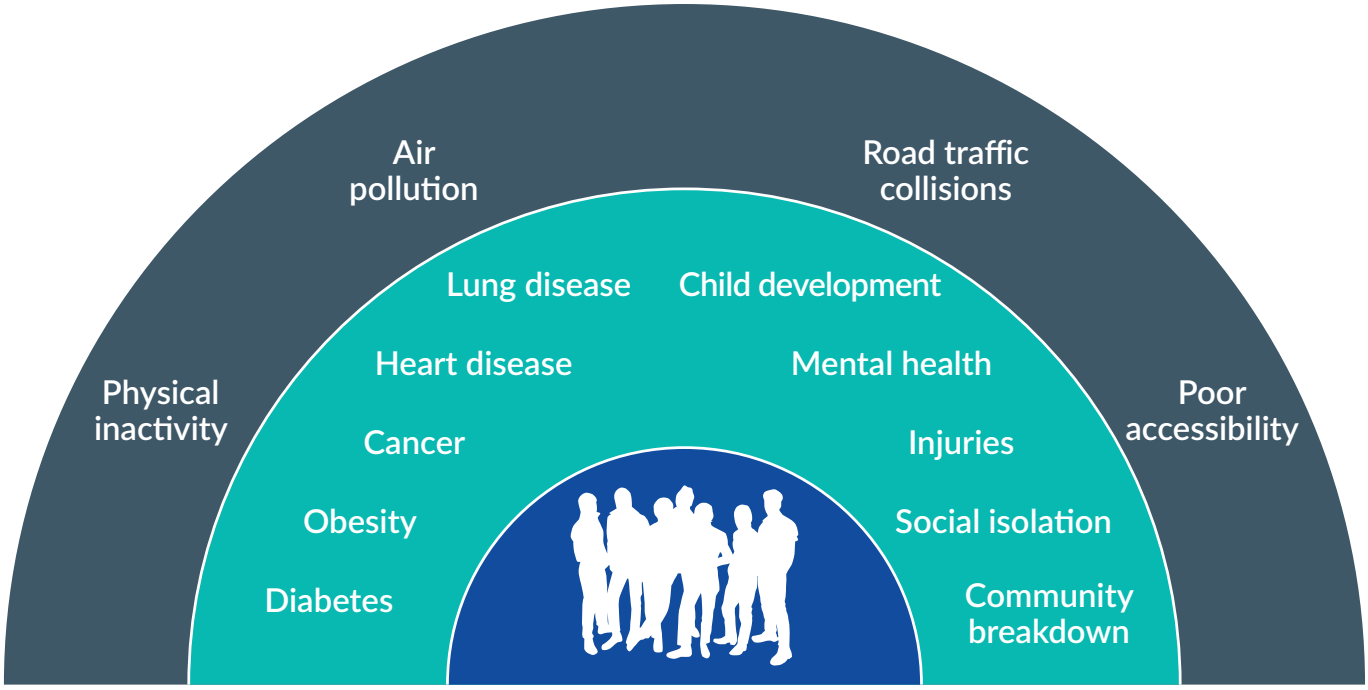
Source: Business Information Team, Cambridgeshire County Council

	Site	Indicative Number of Homes	Timescale
1	Hampton urban extension	3,632	By 2036
2	Great Haddon urban extension	5,300	By 2036
3	Norwood	2,300	By 2036
4	East Wisbech	1,450 (550 in Kings Lynn & West Norfolk)	By 2031
5	West March	2,000	By 2031
6	South Chatteris	1,000	By 2031
7	Ely (north)	3,000	By 2031
8	Littleport	1,850	By 2036
9	Soham	2,100	By 2036
10	Alconbury Weald	5,000	By 2036
11	Ermine Street (south), Huntingdon	1,050	By 2036
12	St Neots East (Wintringham Park and Loves Farm 2)	WP: 2,800 LF2: 1,020	By 2036
13	Cambourne West	1,655 935	By 2031 Post 2031
14	Bourne Airfield New Village	1,360 2,140	By 2031 Post 2031
15	Northstowe	3,203 6,784	By 2031 Post 2031
16	Waterbeach New Town	2,300 6,700	By 2031 Post 2031
17	Cambridge North-West (University site)	2,927	By 2031
18	NIAB (Darwin Green)	2,377 250	By 2031 Post 2031
19	Cambridge Northern Fringe East (AAP)	Potential for 7,600	Unknown
20	Cambridge East (north of Newmarket Road)	1,300	By 2031
21	Cambridge East (north of Cherry Hinton)	1,257	By 2031
22	Trumpington Meadows	637	By 2031
23	Glebe Farm, Clay Farm and Bell School	996	By 2031

How are we working together already?

- Northstowe new town in South Cambridgeshire is one of a small number of 'Healthy New Towns' in England, which received funding to create a healthy environment. Learning from these towns has led to agreement of ten national 'Healthy New Town' planning principles ("Putting Health into Place"), which have been adopted by several large housing developers. Locally we're developing a toolkit to implement the 'Healthy New Town' principles.
- District Council planning officers from Cambridgeshire and Peterborough have met with representatives of the local NHS 'Estates' group, to work out how to plan better together for health and care services in new housing developments.
- The Combined Authority Local Transport Plan has included health and wellbeing for both existing and new residents as a key policy element. The diagram opposite summarises the potential impacts of transport on health outcomes and demonstrates the issues which need to be tackled.

HOUSING DEVELOPMENTS AND TRANSPORT WHICH SUPPORT RESIDENTS' HEALTH AND ADDRESS CLIMATE CHANGE



Source: Business Information Team, Cambridgeshire County Council

What can the Health and Wellbeing Board do?

- Member organisations of the Health and Wellbeing Board can adopt the ten 'Healthy New Town' principles for local housing developments, and support the development and adoption of a local planning 'toolkit' to implement them.
- Member organisations of the Health and Wellbeing Board can commit to involvement in joint work across Planning Authorities and the NHS (STP) Estates Group, to plan health and care infrastructure.
- The Health and Wellbeing Board can endorse the Combined Authority's Local Transport Plan policies for 'Creating Healthy Thriving Communities' and monitor their implementation.
- The Health and Wellbeing Board can endorse and support member organisations' Climate Change Strategies and Action Plans as these develop.

Outcomes for residents

- The design of new housing developments prioritises the health and wellbeing of residents.
- Local transport infrastructure and access to public transport services helps all residents stay healthy and active.
- Housing and transport infrastructure is designed to help tackle climate change.

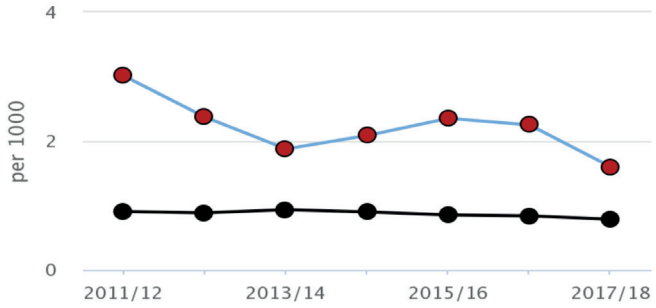
1.2 PREVENTING HOMELESSNESS AND IMPROVING PATHWAYS INTO HOUSING FOR VULNERABLE PEOPLE

What does the JSNA tell us?

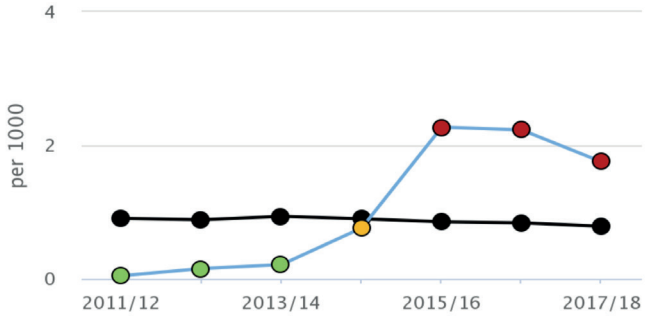
There are higher than average numbers of statutorily homeless people in both Peterborough and Cambridge. Councils are required to provide temporary accommodation for homeless families but not for single people who are not classed as in priority need. Homeless rough sleepers often have poor mental health, drug and alcohol problems and are at risk of early death. Mental health, drug and alcohol, and criminal justice service providers say that lack of housing and homelessness may cause people to relapse into illness, addiction or criminal behaviour, when this could have been prevented. This leads to more demand on services.

People living with disabilities or coming out of hospital may need adaptions to their houses, so they can stay in their own home, or in some cases a new home tailored to their needs.

Peterborough: people who are statutorily homeless but not in priority need



Cambridge: people who are statutorily homeless but not in priority need



Source: Public Health England. Fingertips https://fingertips.phe.org.uk/ Downloaded 14/01/2020

How are we working together already?

Local City and District Councils are working to prevent homelessness, to provide housing and services to vulnerable people, and to make sure people with disabilities and long term conditions have access to the right adaptions for their houses. Partnership work across Cambridgeshire and Peterborough is led by the 'Sub-Regional Housing Board', which has overseen a successful homelessness prevention 'Trailblazer' pilot.

The Access Centre GP Surgery in Cambridge provides health services to rough sleepers and very vulnerable adults, but similar services are not funded in Peterborough or Wisbech, where there are also several rough sleepers. The local Clinical Commissioning Group (CCG) are assessing the health needs and current provision for rough sleepers across the area.

What can the Health and Wellbeing Board do?

- Health and care providers on the Health and Wellbeing Board can commit to working with sub-regional Housing Board members, to prevent homelessness and develop joint pathways into housing for vulnerable people. This includes organisations working together at local level to solve problems, and strategically at Sustainable Transformation Partnership (STP) Alliance and STP Board level.
- Health and Wellbeing Board member organisations can work with the CCG to address the recommendations of the rough sleeper health needs assessment.

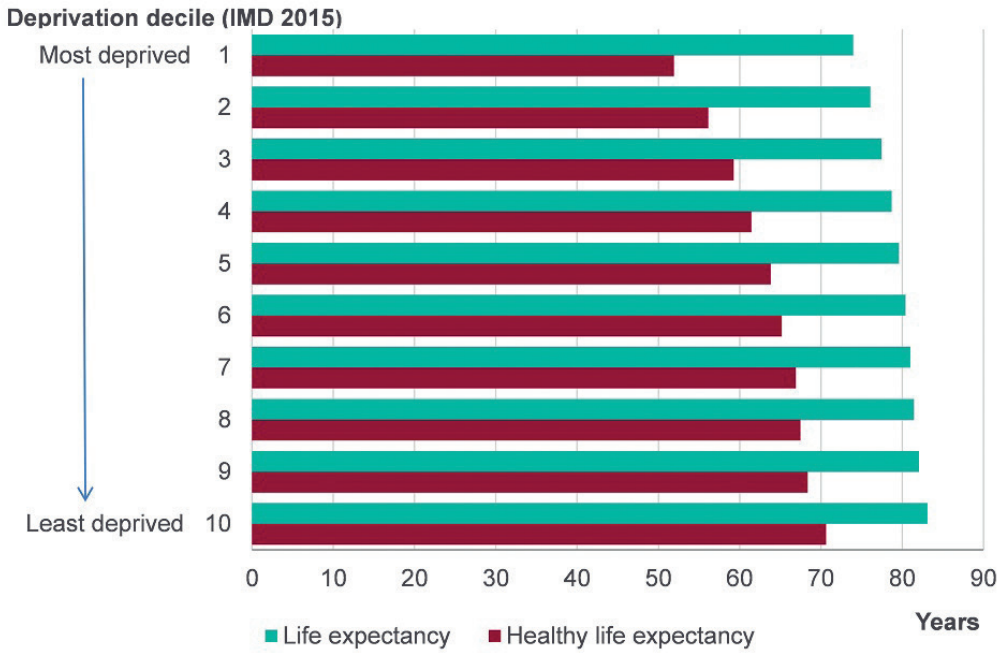
Outcomes for residents:

- Fewer people with health problems and other vulnerabilities are homeless or in unsuitable housing.
- Rough sleepers are helped to improve their physical and mental health.

1.3 REDUCING INEQUALITIES IN SKILLS AND ECONOMIC OUTCOMES ACROSS OUR AREA

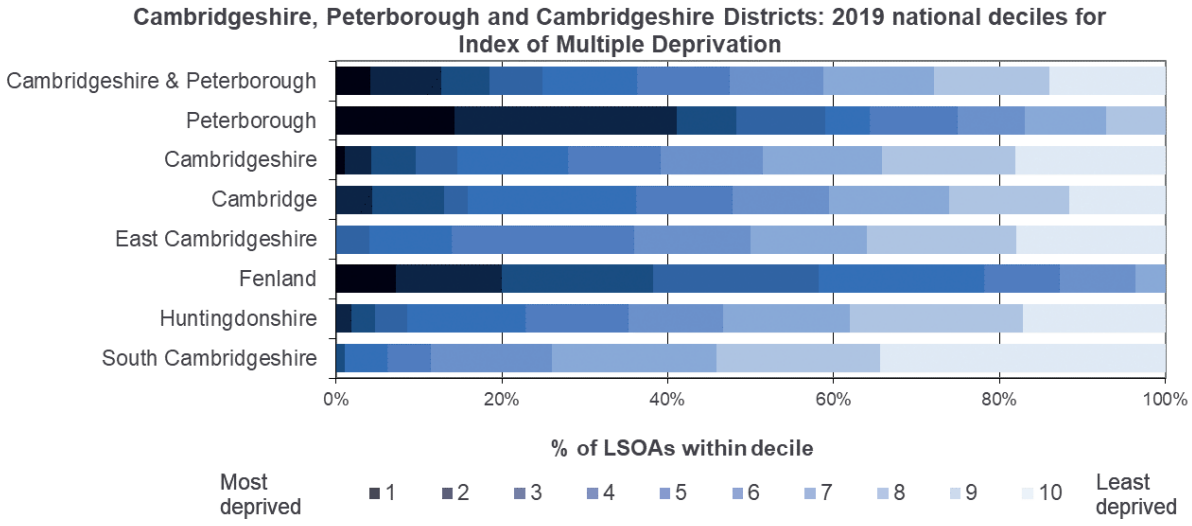
What does the JSNA tell us?

Nationally, there is a strong relationship between people's social and economic circumstances and their health. On average, men who live in areas with the worst social and economic deprivation have significant health problems by their early fifties – while in the least deprived areas they stay healthy until over age seventy. The picture is similar for women.



Source: Health Profile for England 2017

In Cambridgeshire and Peterborough we see these inequalities. Many communities are prosperous and healthy with good outcomes compared to the national picture. But some communities experience poverty, low education and skills, and poor health outcomes. There are more communities with these issues (shown as blue-black on the chart below) in Peterborough and Fenland, and a smaller number in Cambridge and Huntingdon.



Source: MHCLG https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019 Downloaded 14/01/2020

1.3 REDUCING INEQUALITIES IN SKILLS AND ECONOMIC OUTCOMES ACROSS OUR AREA

Some local people are not working because they have long term health problems - and this number is greater than people who are out of work and looking for a job.

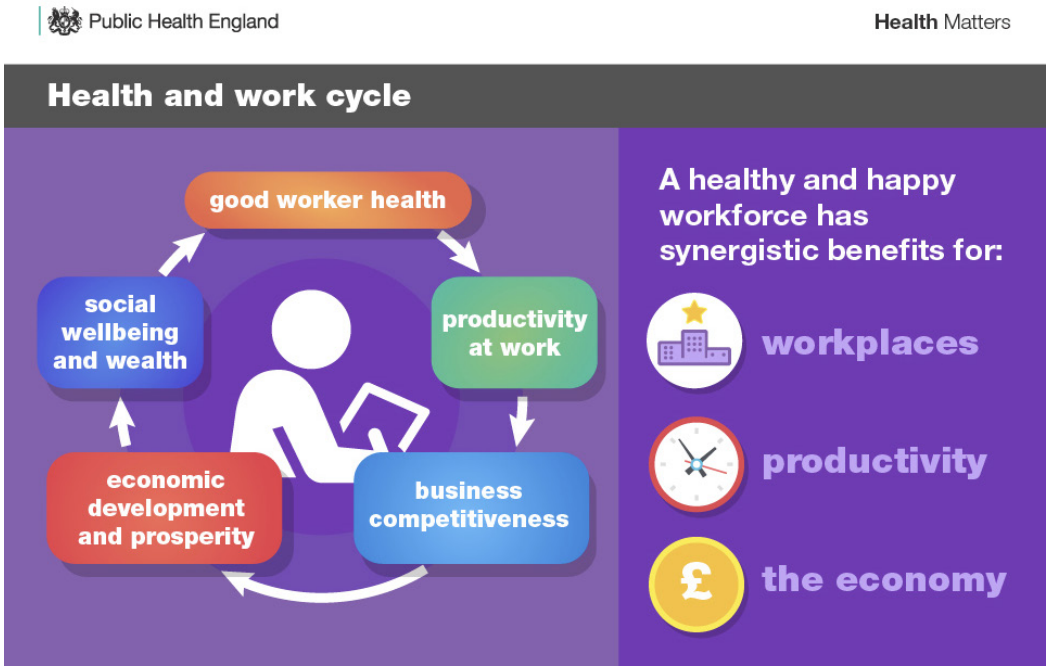
How are we working together already?

- The Combined Authority has approved an Industrial Strategy which recognises the different economic issues in Greater Cambridge, Peterborough and the Fens and which has as its first goal:
    - To scale growth further to benefit the whole area, building on Cambridge's world class assets to create INCLUSIVE growth across our economy.

  Inclusive economic growth means bringing local communities out of poverty - helping local people to gain the right skills, and access good quality jobs and income.
- There is a world leading life sciences and health technology sector in Cambridge and surrounding areas.
- We have a Combined Authority 'Work and Health' pilot, and a nationally funded Mental Health pilot, to help people with long term health problems back into work.

What can the Health and Wellbeing Board do?

- Endorse the Combined Authority Industrial Strategy goal for inclusive growth across the area. This will create good quality jobs which support people's health.
- Healthcare providers on the HWB Board can support the Combined Authority's aim to spread the economic benefits of a strong biomedical and health technology sector beyond Greater Cambridge.
- Public health and healthcare providers on the HWB Board can work with the Combined Authority Business Board to promote workplace health programmes in local businesses, which help staff stay healthy and productive.
- HWB Board member organisations can engage with and support the local pilot programmes to support people with long term health problems back into work.

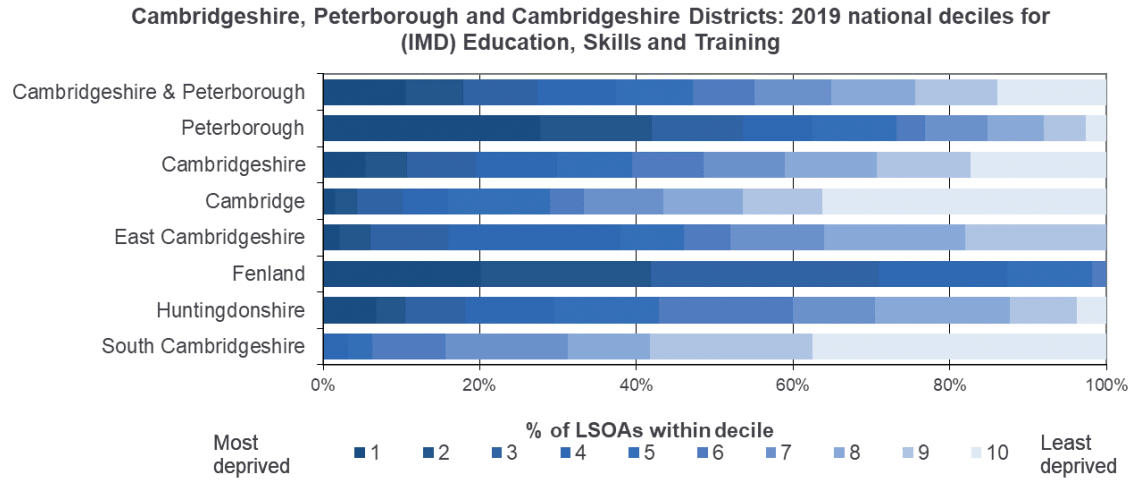


Source: Public Health England, Health Matters.
https://www.gov.uk/government/publications/health-matters-health-and-work/health-matters-health-and-work Downloaded 14/01/2020

ADULT EDUCATION AND SKILLS

What does the JSNA tell us?

People with higher education and skill levels generally have better health – both through higher incomes and a better understanding of how to stay healthy. The chart below shows that many communities in Peterborough and the Fens have low levels of education and skills (marked blue black), while communities in Cambridge and South Cambridgeshire often have very high education and skill levels (marked light blue). Some people need to regain confidence and skills after an illness to return to work. For migrant workers, English language skills are key to accessing a wider range of jobs.



Source: MHCLG https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015 Downloaded 14/01/2020

How are we working together already?

- The second theme of the recently approved Combined Authority Skills Strategy is 'Empower local people to access education and skills to participate fully in society, to raise aspirations and enhance progress into further learning or work.' It outlines several actions which will help to close the local skills gap including:
  - Improving Adult Education Budget Commissioning to link directly with apprenticeships and job progression.
  - Developing a University for Peterborough.
  - Creating a health and care sector work academy, working collaboratively with local care and health providers.

What can the Health and Wellbeing Board do?

- The Health and Wellbeing Board can endorse the Combined Authority Skills Strategy theme to 'Empower local people to access education and skills, to participate fully in society, to raise aspirations and enhance progress into further learning or work'.
- Health and care providers on the Health and Wellbeing Board can work with the Combined Authority to deliver a successful Health and Care sector work academy, supporting local people into jobs.

Outcomes for residents:

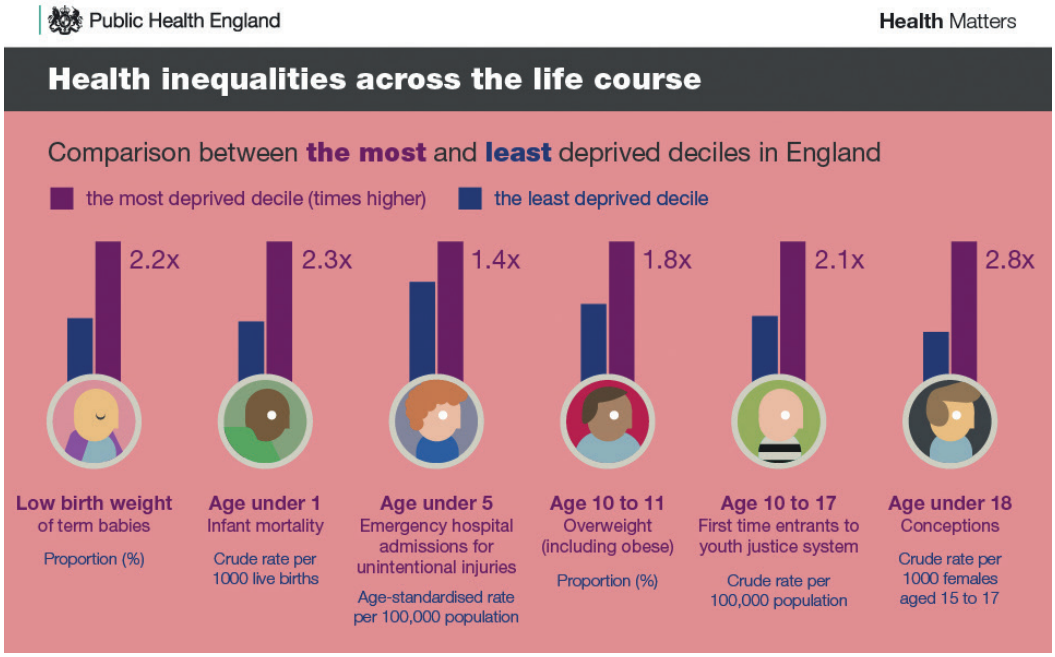
- Residents in all parts of Cambridgeshire and Peterborough have access to good quality training, jobs and incomes.
- Residents working locally are helped to stay healthy by their employers.
- More residents with long term health conditions are in work.

PRIORITY TWO:
HELPING CHILDREN ACHIEVE THE BEST START IN LIFE

What happens in pregnancy and childhood influences a person's health throughout their life.

Source: Health matters: giving every child the best start in life, Public Health England. https://publichealthmatters.blog.gov.uk/category/health-matters/ Downloaded 14/01/2020

Social and economic factors are important - health inequalities between the most and least deprived areas locally and nationally are evident from the earliest stage.



Source: Health matters: prevention – a life course approach, Public Health England. https://www.gov.uk/government/publications/health-matters-life-course-approach-to-prevention/health-matters-prevention-a-life-course-approach Downloaded 14/01/2020

Information from the JSNA and discussions with a range of local stakeholders about 'Helping Children achieve the Best Start in Life' have identified two areas for focus:

2.1 The Best Start in Life from pre-birth to age five

2.2 Developing an integrated approach for older children and adolescents

2.1 THE BEST START IN LIFE FROM PRE-BIRTH TO AGE FIVE

What does the JSNA tell us?

Both Peterborough and Fenland have more children living in poverty than the national average, and this is likely to affect their health and wellbeing.

In reception class, children are assessed for 'school readiness' – which covers their physical development, communication and social skills. Good 'school readiness' means a child is more likely to flourish at school, achieve good educational outcomes, and have good long term health. In Peterborough and Fenland, children are less likely to be ready for school than nationally, as shown for Peterborough in the chart below.

School Readiness: the percentage of children achieving a good level of development at the end of reception, 2017/18

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↑	458,847	71.8	71.7	71.9
East of England region	↑	51,915	72.3	72.0	72.6
Essex	↑	12,569	74.4	73.7	75.0
Southend-on-Sea	↑	1,610	74.0	72.1	75.8
Thurrock	→	1,782	73.7	71.9	75.4
Hertfordshire	↑	10,354	73.0	72.2	73.7
Central Bedfordshire	↑	2,610	72.5	71.0	73.9
Norfolk	↑	6,514	72.5	71.6	73.4
Cambridgeshire	↑	5,063	71.4	70.3	72.4
Suffolk	↑	5,589	70.7	69.7	71.7
Bedford	↑	1,598	69.1	67.1	70.9
Luton	↑	2,202	68.4	66.8	70.0
Peterborough	↑	2,024	67.0	65.3	68.6

Source: Public Health England. Fingertips https://fingertips.phe.org.uk/ Downloaded 14/01/2020

In Cambridgeshire, children experiencing poverty who are eligible for free school meals are less likely to be ready for school than children from similar backgrounds in other counties as shown in the chart below.

School Readiness: the percentage of children with free school meal status achieving a good level of development at the end of reception, 2017/18

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↑	50,732	56.5	56.2	56.9
East of England region	↑	4,460	54.6	53.6	55.7
Thurrock	→	203	67.0	61.5	72.0
Luton	↑	309	65.3	60.9	69.5
Southend-on-Sea	→	208	57.9	52.8	62.9
Peterborough	→	285	56.9	52.5	61.2
Essex	↑	1,004	56.3	54.0	58.6
Suffolk	→	415	54.7	51.1	58.2
Norfolk	→	677	54.6	51.8	57.3
Bedford	→	166	53.0	47.5	58.5
Hertfordshire	→	653	51.1	48.4	53.8
Cambridgeshire	→	434	47.5	44.3	50.7
Central Bedfordshire	→	106	44.4	38.2	50.7

Source: Public Health England. Fingertips https://fingertips.phe.org.uk/ Downloaded 14/01/2020

2.1 THE BEST START IN LIFE FROM PRE-BIRTH TO AGE FIVE

The child population in our main urban areas is rich in diversity – in both Peterborough and Cambridge, around half of all births in 2017 were to mothers who themselves were born outside the UK. In Peterborough, a third of schoolchildren speak a language other than English at home.

How are we working together already?

- Over the past year, a multi-agency Cambridgeshire and Peterborough 'Best Start in Life' Strategy has been developed, with the vision that "Every child will be given the best start in life supported by families, communities and high quality integrated services". The BSiL strategy covers the time from conception until children start school and is focussed on three key outcomes for local children.
    - Children live healthy lives.
    - Children are safe from harm.
    - Children are confident and resilient with an aptitude and enthusiasm for learning.

    A new 'Best Start in Life' service model is being developed, with increased focus on a place based approach, linking young families into local communities.
- There has been investment in a local 'Better Births' programme, including development of community hubs, improved peri-natal mental health services, and interventions to support pregnant women to stop smoking.

What can the Health and Wellbeing Board do?

- The Health and Wellbeing Board can endorse the Best Start in Life Strategy 2019-24, which is overseen by the Cambridgeshire and Peterborough Children's Health and Wellbeing Executive Board.
- NHS organisations on the Health and Wellbeing Board can make sure that 'Better Births' hubs and perinatal mental health services are fully integrated with the new 'Best Start in Life' service model.
- Local authority and voluntary sector organisations on the Health and Wellbeing Board can help develop the place based 'Best Start in Life' model, by supporting links with local communities.

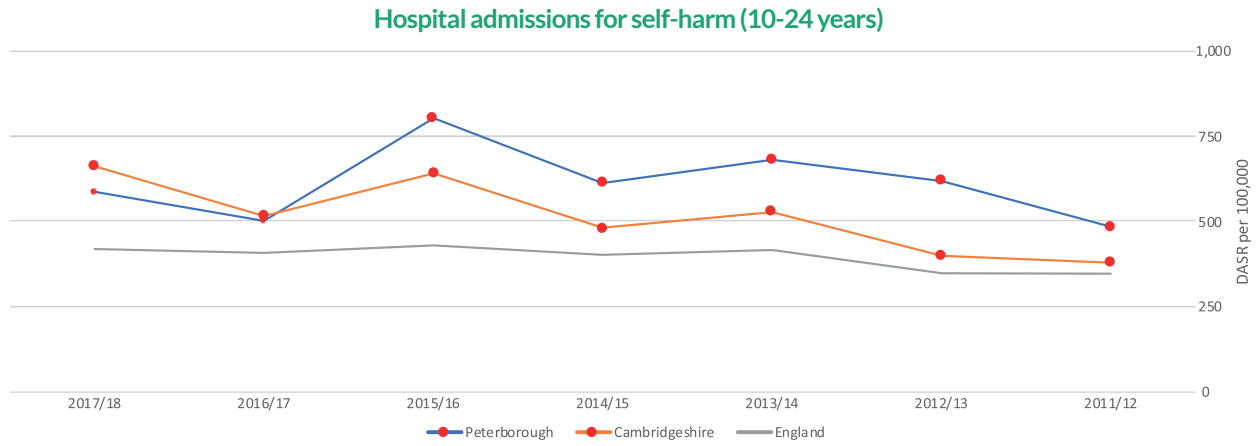
Outcomes for residents

- Babies and young children are healthier and safer.
- Parents and families can find the right information and support to help their children stay healthy.
- Young children are more confident, resilient and ready to start school.

2.2 DEVELOPING AN INTEGRATED APPROACH FOR OLDER CHILDREN AND ADOLESCENTS

What does the JSNA tell us?

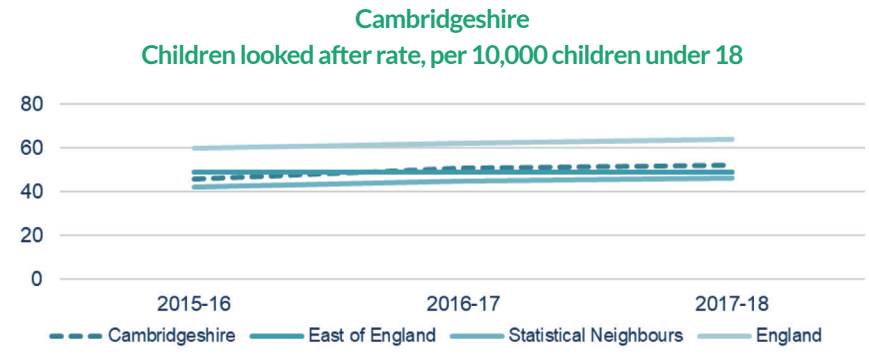
The JSNA shows that 10-24 year olds in Cambridgeshire and Peterborough are more likely to be admitted to hospital for self-harm (often an overdose) than the national average. This may be partly because hospitals around the country collect information in different ways, but it is still of concern.

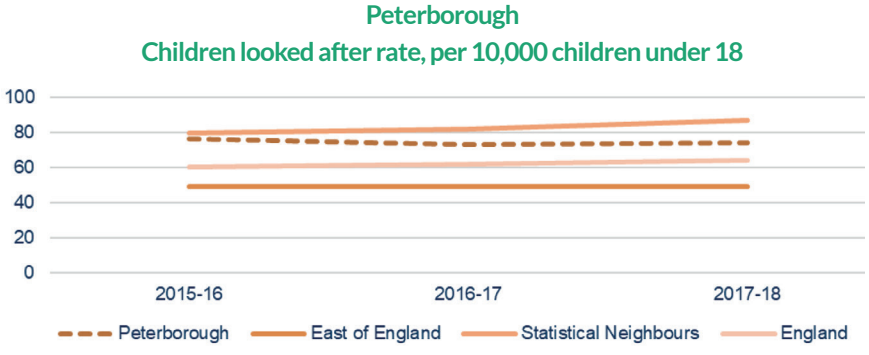


Source: Public Health England. Fingertips https://fingertips.phe.org.uk/ Graphic generated by Cambridgeshire & Peterborough Public Health Intelligence

Local 16-24 year olds are also more likely than the national average to be homeless, particularly in Peterborough. Young people in Peterborough are more likely than average to be admitted to hospital for injuries, asthma or diabetes, to be teenage mothers, and not to be in education, employment or training.

Nationally there have been rising rates of children taken into care, and these children are some of the most vulnerable people in our society. In Peterborough the numbers of children in care are in line with similar local authorities. In Cambridgeshire there are more children in care than in similar counties, and their rates of health checks and immunisations are low.





Area	No.	%*	Rate per 10,000 of pop.
Cambridge	139	20%	60.2
East Cambridgeshire	60	8%	30.6
Fenland	163	23%	81.1
Huntingdonshire	165	23%	45.1
South Cambridgeshire	98	14%	27.9
Non-Cambridgeshire postcode	81	11%	-
Cambridgeshire	**706**	**66%**	**52.5**
Peterborough	**370**	**34%**	**74.6**
Cambridgeshire and Peterborough	**1,076**		**58.3**

Source: Public Health England. Fingertips https://fingertips.phe.org.uk/ Graphic generated by Cambridgeshire & Peterborough Public Health Intelligence

2.2 DEVELOPING AN INTEGRATED APPROACH FOR OLDER CHILDREN AND ADOLESCENTS

How are we working together already?

- The Cambridgeshire and Peterborough Children and Young People Emotional Wellbeing Board works jointly to improve services and outcomes for young people with mental health problems.
- The Clinical Commissioning Group receives national NHS funding to improve child and adolescent mental health services by delivering a 'Local Transformation Plan'.
- The Police and Crime Commissioner is funding work to promote young people's resilience through the local Healthy Schools Support Service.
- The Cambridgeshire and Peterborough Special Educational Needs and Disability (SEND) Strategy aims to provide joined up support for children and young people with disabilities across Education, Health and Social Care.
- Peterborough City Council has received national funding for a 'Family Safeguarding' pilot, in which adult mental health, drug and alcohol, and domestic abuse workers provide direct care and support to parents. This reduces the number of children who need to go into care. Cambridgeshire County Council is receiving similar funding to implement the 'Family Safeguarding' model.

What can the Health and Wellbeing Board do?

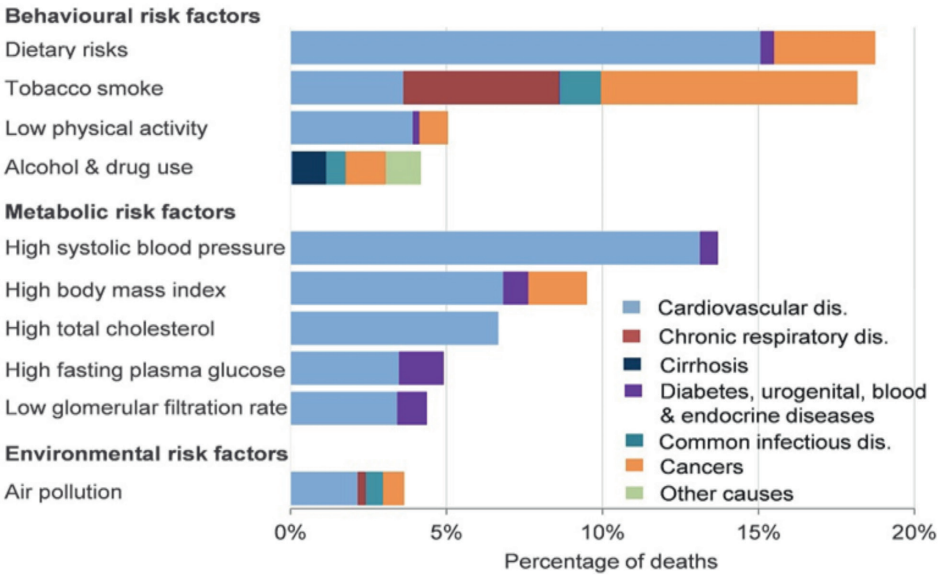
- The Health and Wellbeing Board can ask the Children's Health and Wellbeing Executive Board to bring together organisations and stakeholders, to develop an integrated outcomes framework and strategy for older children and adolescents across Cambridgeshire and Peterborough.
- Health and Wellbeing Board member organisations can help Children in Care to belong in local communities, by taking practical steps to include them and those who care for them in local activities and services.

Outcomes for residents

- Children and young people have better mental health.
- Fewer young people are homeless.
- Fewer young people are not in education training or work.
- Vulnerable young people are included in local communities and get help and support when they need it.
- Fewer young people are taken into care.

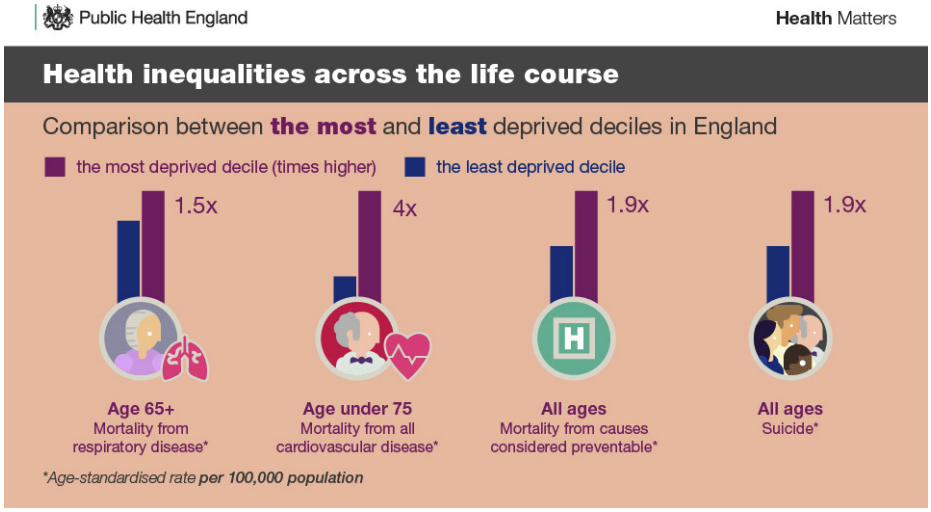
PRIORITY THREE: STAYING HEALTHY THROUGHOUT LIFE

Research shows that some lifestyle behaviours have a major impact on a person's risk of developing long term health conditions such as heart and lung disease, cancer and diabetes. The biggest risks are eating an unhealthy diet and smoking tobacco, each responsible for about 20% of deaths. Too little physical activity and alcohol and drug use are also significant.



Source: Global Burden of Disease Study 2013 in Health Profile for England 2017. Public Health England,

Social and economic factors remain relevant in adulthood, with big differences in health between the most and least deprived communities, locally and nationally.



Source: Health matters: prevention – a life course approach, Public Health England. https://www.gov.uk/government/publications/health-matters-life-course-approach-to-prevention/health-matters-prevention-a-life-course-approach Downloaded 14/01/2020

Information from the JSNA and discussions with a range of local stakeholders about 'Staying healthy throughout life' have identified four outcome areas for focus:

3.1 A joined up approach to healthy weight, obesity and diabetes
3.2 Reducing inequalities in heart disease and smoking
3.3 Improving mental health and access to services
3.4 Ageing Well – working with a growing older population

3.1 A JOINED UP APPROACH TO HEALTHY WEIGHT, OBESITY AND DIABETES

What does the JSNA tell us?

Obesity increases the risk of several diseases including diabetes, heart disease, cancer and arthritis. In Cambridgeshire and Peterborough, between one in three and one in four children are overweight or obese by the time they leave primary school. Both locally and nationally, some communities with high rates of poverty and deprivation, and some ethnic groups including South Asians, have higher childhood obesity rates.

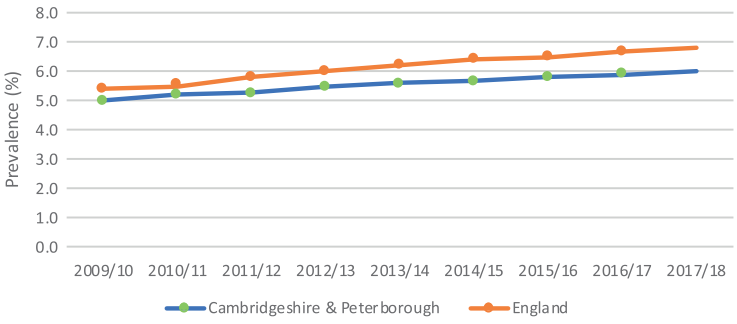
Around two in three adults are estimated to be overweight or obese, and in Peterborough and Fenland rates of overweight, obesity, and diabetes are all worse than the national average. The numbers of people with diabetes have been rising both locally and nationally and more than one in twenty adults now has diabetes.

NHS benchmarking statistics show that outcomes of treatment for patients with diabetes in Cambridgeshire and Peterborough are generally worse than the national average.

Recorded prevalence of obesity 18+ years, 2017/18

Area of GP Location	Percentage	Number of people
Cambridge	4.7	7,601
East Cambridgeshire	9.2	6,227
Fenland	13.2	12,353
Huntingdonshire	8.7	12,489
South Cambridgeshire	7.1	7,555
Cambridgeshire	8.1	46,225
Peterborough	10.1	16.916
Cambridgeshire and Peterborough CCG	**8.5**	**63.141**
England	9.8	4,530,447

Recorded diabetes prevalence, 17+ years



Source: Public Health England. Fingertips https://fingertips.phe.org.uk/ Downloaded 14/01/2020

How are we working together already?

- A local authority led Healthy Weight Strategy for Cambridgeshire was approved in 2017 and a Healthy Weight Strategy for Peterborough is in process of being produced. These include actions to promote both healthy eating and physical activity.
- The NHS led Sustainable Transformation Partnership (STP) has identified obesity and diabetes as a clinical priority, and is producing a local Diabetes and Obesity Strategy.
- The Cambridgeshire and Peterborough Public Health Reference Group (PHRG) have collated information on more than 50 fast food outlet policies from other UK local authorities.

What can the Health and Wellbeing Board do?

- The HWB Board member organisations can approve and adopt the Cambridgeshire and Peterborough Healthy Weight Strategies and the STP Obesity and Diabetes Strategy - and make sure they are implemented in a joined up way with consistent messages.
- Planning authorities on the HWB Board can use the PHRG review of local authority fast food policies, to consider what they could introduce locally.

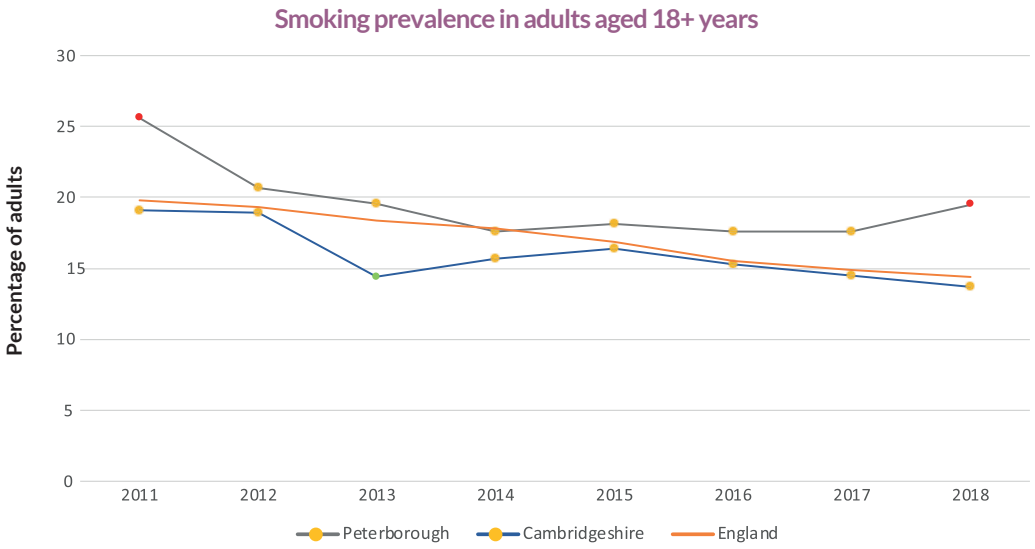
Outcomes for residents

- More children and adults have a healthy weight.
- Fewer residents develop obesity and diabetes.
- Residents with diabetes in all parts of Cambridgeshire and Peterborough have access to good care.

3.2 REDUCING INEQUALITIES IN HEART DISEASE AND SMOKING

What does the JSNA tell us?

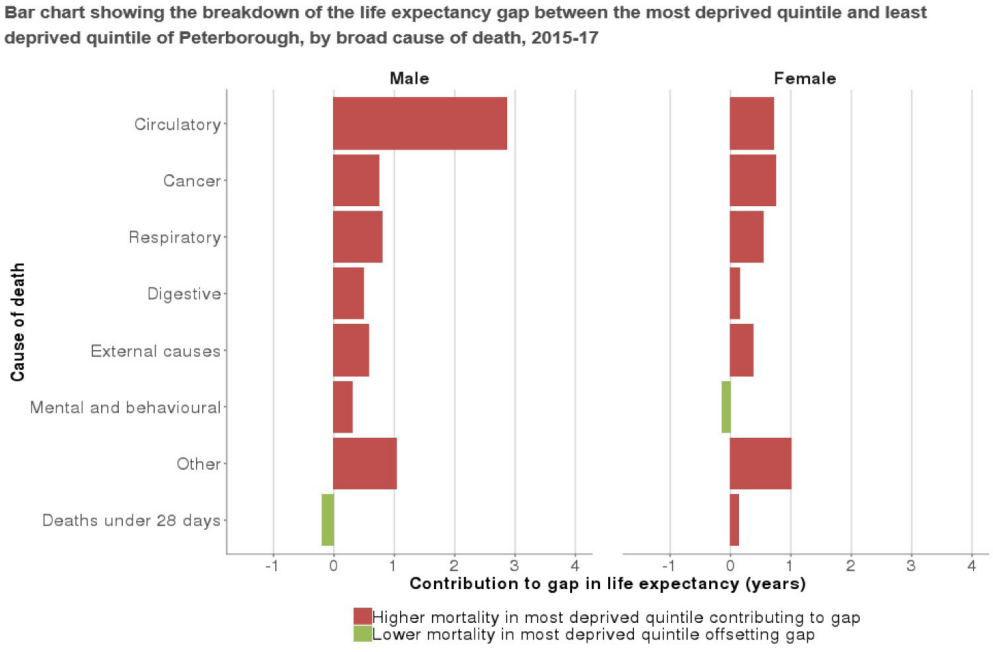
Local smoking rates haven't fallen as fast as elsewhere and are now above the national average in Peterborough and similar to average in Cambridgeshire. Almost one in four women in Wisbech smoke during pregnancy, which can affect the health of both mother and baby, compared with one in ten women nationally.



Source: Public Health England. Fingertips https://fingertips.phe.org.uk/ Graphic generated by Cambridgeshire & Peterborough Public Health Intelligence

Deaths under the age of 75 from circulatory disease (heart disease and stroke) are higher than average in both Peterborough and Fenland.

Both nationally and locally, heart disease is linked with social and economic deprivation and with ethnicity – there are higher rates in both South Asian and some Eastern European communities. Circulatory disease accounts for three years of the difference in life expectancy between men in the most and least deprived areas of Peterborough, and there are also high rates in Wisbech.



Public Health England. Segment Tool https://analytics.phe.gov.uk/apps/segment-tool/ Downloaded 14/01/2020

3.2 REDUCING INEQUALITIES IN HEART DISEASE AND SMOKING

How are we working together already?

- The Cambridgeshire and Peterborough Smoke Free Alliances have developed a local multi-agency strategy to prevent and reduce the harm caused by smoking and tobacco.
- The local Clinical Commissioning Group (CCG) has developed a Prevention Strategy, which focusses on the role of local NHS organisations in tackling smoking and high blood pressure.
- The NHS led Sustainable Transformation Partnership (STP) has identified cardiovascular disease as a clinical priority and is developing a local Cardiovascular Disease strategy.
- In Peterborough, public health staff are working with the South Asian communities to develop a healthy living programme to help prevent diabetes and heart disease.
- In Wisbech, addressing smoking has been identified as a priority for local work to improve health, across organisations.

What can the Health and Wellbeing Board do?

- Health and Wellbeing Board organisations can endorse and adopt the Cambridgeshire and Peterborough Smoking and Tobacco Strategy, led by the Smoke Free Alliances.
- The Health and Wellbeing Board can endorse the CCG Prevention Strategy, and the Clinical strategy for Cardiovascular Disease led by the STP.
- Health and Wellbeing Board member organisations and Primary Care Networks can focus resources on working together in the most deprived areas of Peterborough and Wisbech to prevent and effectively treat cardiovascular disease.

Outcomes for residents:

- Fewer residents die early as a result of smoking.
- Fewer residents die early from heart disease.
- Residents with heart disease in all parts of Cambridgeshire and Peterborough have access to good care.

3.3 IMPROVING MENTAL HEALTH AND ACCESS TO SERVICES

What does the JSNA tell us?

Around one in ten adults nationally have depression, according to information on GP practice records. Locally, it is more common for people to have depression in Fenland, and least common in Cambridge. In Cambridge the rates of serious mental illness such as schizophrenia and bipolar disorder are higher than average (about one in one hundred adults). Around one in two hundred adults are recorded on GP registers as having learning disabilities, and the rate is highest in Fenland.

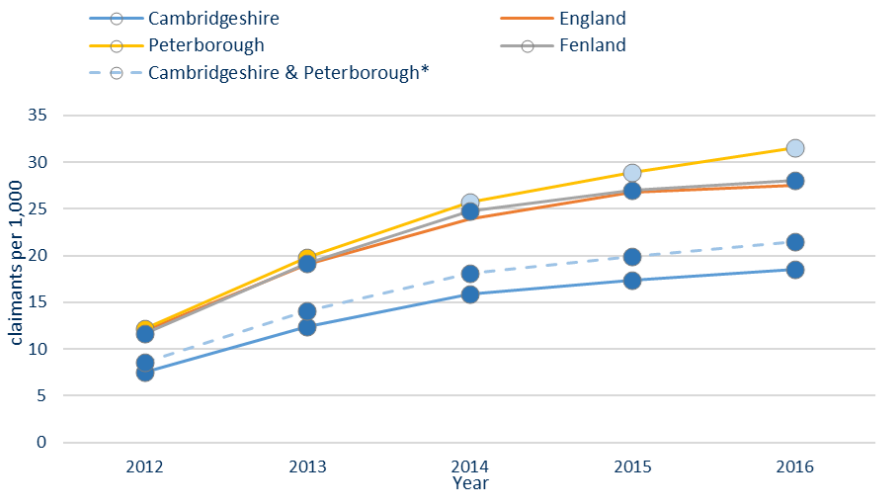
Recorded prevalence of mental health, dementia and learning disabilities, 2017/18

Area of GP Location	Schizophrenia, bipolar affective disorder and other psychoses		Depression (18+)		Dementia		Learning disabilities	
	%	Number	%	Number	%	Number	%	Number
Cambridge	1.0	2,013	7.0	11,410	0.5	922	0.3	584
East Cambridgeshire	0.7	609	9.4	6,368	0.7	599	0.4	364
Fenland	0.6	733	11.0	10,352	0.7	866	0.6	650
Huntingdonshire	0.7	1,249	9.7	13,897	0.8	1,420	0.5	837
South Cambridgeshire	0.8	1,045	8.6	9,197	0.7	892	0.3	451
Cambridgeshire	0.8	5,649	8.9	51,224	0.7	4,699	0.4	2,886
Peterborough	0.8	1,870	8.5	14,272	0.7	1,521	0.5	1,072
Cambridgeshire and Peterborough	0.8	7,519	8.8	65,496	0.7	6,220	0.4	3,958
England	0.9	550,918	9.9	4,589,213	0.8	446,548	0.5	284,422

Source: Public Health England. Fingertips https://fingertips.phe.org.uk/ Graphic generated by Cambridgeshire & Peterborough Public Health Intelligence. *Patients with a record of unresolved depression since April 2006.

Since 2012, the numbers of people claiming benefits for mental health problems which make them unable to work has risen and is highest in Peterborough.

Employment Support Allowance (ESA) claimants for mental and behavioural disorders



Source: Public Health England. Fingertips https://fingertips.phe.org.uk/ Graphic generated by Cambridgeshire & Peterborough Public Health Intelligence

The Health Watch 'What would you do?' survey and focus groups identified some concerns about local mental health services in particular:

- Waiting times for both adults and children's mental health services.

3.3 IMPROVING MENTAL HEALTH AND ACCESS TO SERVICES

- Services sometimes seeming fragmented – with people either too ill or not ill enough to access them.
- Care can seem to be service centred rather than person centred.

How are we working together already?

- The local 'Mental Health Crisis Concordat' brings together NHS, police, local authority and voluntary sector services. The local 'Dial 111 option 2' mental health crisis service developed recently, is due to be rolled out nationally.
- A multi-agency Suicide Prevention Strategy approved in 2018 is being implemented.
- There have been several successful bids for national funding streams leading to local service developments. These include:
    - The child and adolescent mental health Local Transformation Plan.
    - National NHS funding to pilot waiting targets for mental health appointments.
    - NHS funded pilots for suicide prevention and for helping people with mental health issues into employment.
- The national 'Campaign to end Loneliness' is working with local stakeholders to produce a Cambridgeshire and Peterborough Loneliness toolkit, which aims to improve both mental and physical health outcomes.

What can the Health and Wellbeing Board do?

- Health and Wellbeing Board member organisations can support work through 'Think Communities' to address loneliness in Cambridgeshire and Peterborough.
- The Health and Wellbeing Board can work with the Sustainable Transformation Partnership (STP) Board and Crisis Care Concordat, to ensure that there is joined up governance and oversight for all aspects of mental health strategy.
- Health and Wellbeing Board member organisations can support pathways for vulnerable people with mental health problems into housing and employment.

Outcomes for residents

- More residents feel included in their communities and fewer experience loneliness.
- Residents with mental health problems can access the support they need from 'joined up' services which make sense to them.
- More people with severe mental health problems are in stable housing and employment.

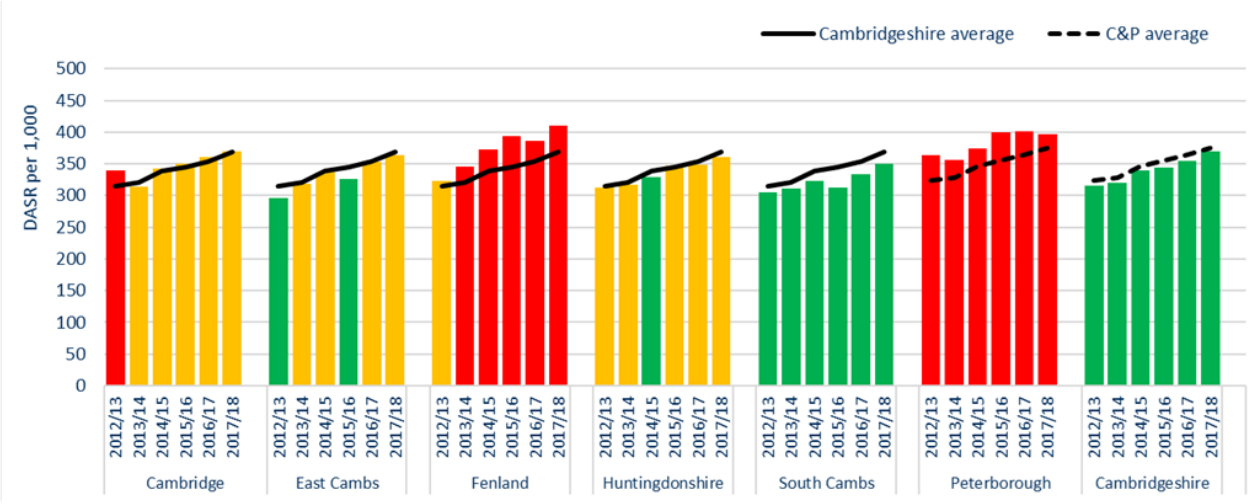
3.4 AGEING WELL – WORKING WITH A GROWING OLDER POPULATION

What does the JSNA show?

Older people make a huge and often unpaid contribution to society – for example through grandparents caring for children, and retired people continuing to use their skills through volunteering. The numbers of people in Cambridgeshire and Peterborough aged seventy-five or over are expected to increase by between 40% and 50% from 2016 to 2026.

The risk that a local resident aged 75 or over will be admitted to hospital as an emergency increased between 2012/13 and 2017/18 in all parts of Cambridgeshire and Peterborough. Emergency hospital admission rates for older people are highest in Fenland and Peterborough and lowest in South Cambridgeshire.

Directly age standardised emergency admission rate per 1000 population for people aged 75+ years



Source: NHS Digital Hospital Episode Statistics, ONS mid-year population estimates

Once in hospital, there is a history in Cambridgeshire of some older people staying in hospital for longer than they need to. This is called a 'delayed transfer of care'. The Sustainable Transformation Partnership (STP) has prioritised delayed transfers of care as an area for joint health and social care action, and there have been recent improvements, which need to be maintained.

The risk of developing dementia increases with age, and may increase the need for both health and care services. While many cases of dementia aren't preventable the risk can be reduced by lifestyle changes in mid to later life.

Source: Health matters: midlife approaches to reduce dementia risk, Public Health England. https://www.gov.uk/government/publications/health-matters-midlife-approaches-to-reduce-dementia-risk/health-matters-midlife-approaches-to-reduce-dementia-risk Downloaded 14/01/2020

3.4 AGEING WELL – WORKING WITH A GROWING OLDER POPULATION

A common reason for hospital admission, and sometimes for onward referral to residential care is a serious fall. Elderly residents of Cambridge City are more likely than those in other areas to be admitted to hospital for a fall.

Emergency hospital admissions, falls in people aged 65+ years, 2017/18

Indicator	Period	England rate per 100,000	C&P rate per 100,000	C&P Number	Pboro rate per 100,000	Pboro number	Cambs rate per 100,000	Cambs number	Cambridgeshire Districts				
									Cambridge	East Cambridgeshire	Fenland	Huntingdon-shire	S Cambs
People aged 65 & over (persons)	2017/18	2,170	2,140	3,261	2,041	602	2,164	2,659	2,591	2,014	2,177	2,056	2,123
People aged 65 & over (males)	2017/18	1,775	1,732	1,076	1,635	192	1,754	884	2,187	1,491	1,951	1,612	1,696
People aged 65 & over (females)	2017/18	2,453	2,437	2,185	2,320	410	2,465	1,775	2,860	2,400	2,355	2,361	2,469
People aged 65-79 (persons)	2017/18	1,033	935	982	897	179	943	803	1,263	752	951	956	876
People aged 65-79 (males)	2017/18	855	764	388	759	72	766	316	1,172	533	799	794	658
People aged 80 & over (persons)	2017/18	5,469	5,636	2,279	5,357	423	5,702	1,856	6,440	5,673	5,730	5,246	5,741
People aged 80 & over (female)	2017/18	6,115	6,345	1,591	6,082	303	6,410	1,288	7,243	6,570	6,031	6,008	6,521

Source: Public Health England. Fingertips https://fingertips.phe.org.uk/ Graphic generated by Cambridgeshire & Peterborough Public Health Intelligence

The HealthWatch 'What would you do?' survey of local people's views on health services asked 'What is most important to help you keep your independence and stay healthy for as long as possible?' The most highly rated answer was 'I want to be able to stay in my own home for as long as it is safe to do so'.

People also said they wanted 'seamless' health and social care services; access to appropriate and timely housing adaptions and wider, more varied range of housing options; access to their local community; access to better transport options; and that it was important to support carers in their caring roles. People valued their local support networks, and wanted better information about how health and care services worked and where to go for information or support.

How are we working together already?

- Local authorities and the NHS work together to prepare and deliver 'Better Care Fund' Plans using nationally allocated resources.
- The Sustainable Transformation Partnership (STP) has prioritised joint work on delayed transfers of care, and these are improving.
- The local authority 'Adults Positive Challenge Programme' is providing better information for older people and their families, and encouraging services to work flexibly with older people, building on their strengths and community networks - including two 'Neighbourhood Cares' pilots.
- The multi-agency 'Ageing Well' Board brings together joint preventive programmes for older people including falls prevention and a multi-agency dementia strategy.

What can the Health and Wellbeing Board do?

- Health and Wellbeing Board member organisations can work more closely with the Adults Positive Challenge and Ageing Well Board programmes to support older people in their homes and communities – helping people make sense of the services available to them and taking a 'Think Communities' approach (see p.26)
- The Health and Wellbeing Board can monitor how well we are working together to help older people receive their care outside hospital, using a system 'emergency bed days' measure.

Outcomes for residents

- Older residents are supported to stay healthy and independent in their homes and communities for as long as possible.
- Older residents spend less time in hospital.
- Older residents feel that health and social care services are 'joined up' and make sense to them.

PRIORITY 4: GOOD QUALITY HEALTH AND SOCIAL CARE

Views of local residents and patients

Good quality health and social care when you need it matters to everyone. One of the most up to date sources of information on local people's views of healthcare in Cambridgeshire and Peterborough is the **HealthWatch 'What would you do?'** report, published in May 2019. Over 800 people gave their views and there were some clear messages:

Source: HealthWatch Cambridgeshire & Peterborough. http://www.healthwatchcambridgeshire.co.uk/ Downloaded 14/01/2020

'We identified recurring and persistent themes in the comments people wrote in the surveys and when talking to us in the focus groups. These messages are very similar to what we hear in our routine collection of people's experiences of health care locally.

- People we heard from want faster, easier access to primary care services, particularly to GPs.
- People are interested in self-help and are asking for support to access information and appropriate services to help them keep well.
- Support is not always offered; people often look for support themselves sometimes whilst coping with illness or another's illness. They find that information is in lots of different places, often not current, and often not accessible.
- Carers with long-term conditions often have the additional challenges of caring for others. People often experience poor communication between services and as a patient. Often the patient / carer has to co-ordinate it themselves and chase to get anywhere.
- Patients want to be listened to, especially people with long-term conditions who are often 'experts' in their condition and able to recognise when their health changes.
- People with conditions over a long time told us they experienced worsening services.
- Care can seem to be service-centred rather than person-centred. We heard this particularly of autism and mental health services.
- Care is often not joined-up — especially for people with long-term or multiple conditions. People told us they wanted to be seen and treated holistically. The experience was of systems not 'talking' to each other, and people not understanding how the system works.
- There is a 'digital divide'. Not everyone does or can use the internet, but there is awareness of its potential.
- Travel and transport difficulties continue to be barriers to effective health care. There is some evidence of willingness to travel and the limits on this for some aspects of care and some groups.

PRIORITY 4: GOOD QUALITY HEALTH AND SOCIAL CARE

External quality inspections

External Care Quality Commission inspection reports for local NHS Trusts are variable, ranging from outstanding to 'requires improvement'. The Queen Elizabeth Hospital Trust in Norfolk, which is used by residents of Wisbech and North Fenland has recently been rated as 'inadequate'. Most GP practices are rated as good and some as outstanding, but some have been rated as 'inadequate' or 'requires improvement' and there is a higher proportion of these GP practices in Peterborough.

Trust	2014	2015	2016	2017	2018	2019
Cambridge University Hospital Foundation Trust		Inadequate	Requires improvement	Good		Good
Peterborough City Hospital	Requires improvement	Good			Good	Requires improvement
Hinchingbrooke Hospital	Inadequate		Good		Requires improvement	Requires improvement
Cambridgeshire and Peterborough Foundation Trust		Good			Good	
Cambridgeshire Community Services	Good				Good	Outstanding
Papworth Hospital		Good				Outstanding

Source: Care Quality Commission. https://www.cqc.org.uk/what-we-do/how-we-do-our-job/inspection-reports#cqc-solr-search-theme-form

Demand and financial pressures

The Cambridgeshire and Peterborough health system is one of the most financially challenged in the country – with the mid-2019 annual deficit across local NHS organisations totalling in the order of £190 million. A large part of this deficit sits with NHS hospitals which treat patients from outside the area – so not all of this funding is spent on Cambridgeshire and Peterborough residents. Local Council social care and public health services are also under pressure financially, and services face additional pressure from a growing and ageing population.

PRIORITY 4: GOOD QUALITY HEALTH AND SOCIAL CARE

Health inequalities

While local NHS Trusts are providing good quality services across Cambridgeshire and Peterborough, it's not always clear that services and staff are allocated proportionately to need. There are many differences in service provision which are historical, and which may not be related to current health needs and inequalities.

The Cambridgeshire and Peterborough Sustainable Transformation Partnership (STP)

The Cambridgeshire and Peterborough Health and Wellbeing Boards work alongside the Cambridgeshire and Peterborough Sustainable Transformation Partnership (STP). The STP Board is made up from the Chairs and Chief Executives of the main local NHS organisations, and Local Authority representation. It is accountable to regional and national NHS regulators.

The STP Board is preparing an STP Five Year Plan for NHS services in Cambridgeshire and Peterborough (2019-24), which also covers partnership working with local authority social care and public health services. This is the local version of the nationwide NHS Long Term Plan.

It aims to transform the local health and care system and ensure financial sustainability, while tackling deprivation related health inequalities and leveraging the benefits of local research and innovation expertise.

The STP Five Year Plan for Cambridgeshire and Peterborough will be available on weblink **www.fitforfuture.org.uk/** and is working toward five main priority programmes to transform local health and care services:

1. Develop a high quality, efficient integrated primary, community, mental health, acute and social care model, based around integrated neighbourhoods. This will build on the current integrated neighbourhood teams work and potentially leverage partnerships with industry.
2. Implement a full outpatient transformation programme looking at modernising the pathway end-to-end.
3. Redesign high volume and high cost healthcare pathways (starting with trauma/orthopaedics and ophthalmology) across community and through acute care, to reduce inefficiencies and variation and ensure quality.
4. Identify opportunities to make the best use of the existing fixed cost base in the local NHS, including estates and IT.
5. Leverage research and innovation, focused on responding to the challenges in the NHS Long Term Plan across the whole STP area and wider region.

It's essential that the Health and Wellbeing Board and the STP Board have a shared vision and fully aligned strategies for health and social care services. This section of the Health and Wellbeing Strategy reinforces the STP Board aims to tackle health inequalities, achieve financial sustainability, and develop new, high quality, care models based on neighbourhood teams. The four focus areas for the Health and Wellbeing Strategy are:

4.1 Embedding a 'Think Communities' approach to place based working

4.2 A joint approach to population growth

4.3 Addressing financial challenges together

4.4 Acting as a system to reduce health inequalities

4.1 EMBEDDING A 'THINK COMMUNITIES' APPROACH TO PLACE BASED WORKING

What does the JSNA tell us?

No two local communities are exactly the same and some are very different – for example in Doddington & Wimblington ward in rural Cambridgeshire, one in four residents is aged 65+ and only one in twenty was born outside the UK. In Central ward in Peterborough, only one in ten residents is aged 65+ and one in two was born outside the UK. The health needs and the skills and assets within different communities also vary widely.

How are we working together already?

Public sector bodies in Cambridgeshire and Peterborough are increasingly working together using a 'Think Communities' approach. This means freeing up local staff to work together across organisations and with communities to solve problems and achieve the outcomes local people want. The approach aims to build relationships locally and address situations where 'care is not joined up' and 'systems not talking to each other', described in the HealthWatch 'What would you do?' report. Small voluntary sector organisations can be key to the Think Communities approach – which aligns with the skills and assets already held within communities and neighbourhoods.

There are now several 'Think Communities' pilot areas across Cambridgeshire and Peterborough. Some are new and others are building on work which was already happening. Pilot areas include the Ortons in Peterborough, Oxmoor in Huntingdonshire, Wisbech in Fenland, 'Neighbourhood Cares' areas in Soham and St Ives, and the Southern Fringe in Cambridge/South Cambridgeshire.

At the same time, the NHS both locally and nationally is developing Primary Care Networks, based on groups of GP practices covering about 30,000-50,000 people. In Cambridgeshire and Peterborough, community health services and adult social care are creating integrated neighbourhood teams around these GP practice groups – aiming to build local relationships and 'joined up' care.

What can the Health and Wellbeing Board do?

- Health and Wellbeing Board organisations can endorse and adopt the 'Think Communities' approach, as the locally agreed way of working in partnership with each other and local communities.
- Health and Wellbeing Board organisations can actively promote joint working across 'Think Communities' pilots and Primary Care Network integrated neighbourhood teams – recognising the geography covered will sometimes, but not always, be the same.
- At district level, 'Living Well Partnerships' can consider joining wider 'Think Communities Delivery Boards',

Outcome for residents

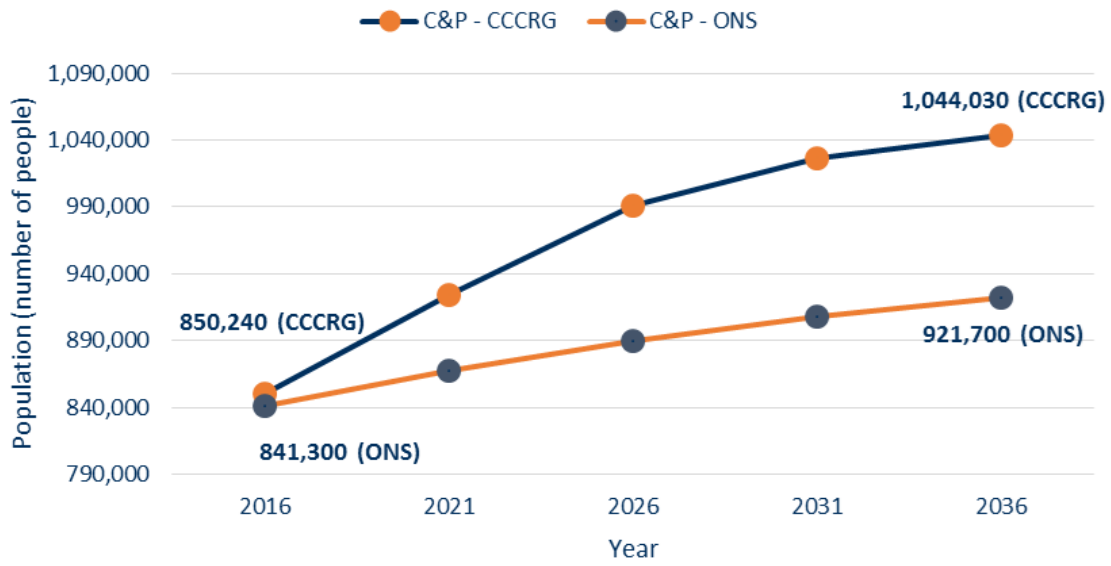
- Residents understand how they can help themselves and each other to stay healthy in their local communities.
- Residents experience 'joined up' local services which help them to solve problems and achieve the health and social care outcomes they want.

4.2 A JOINT APPROACH TO POPULATION GROWTH

What does the JSNA say?

We expect our population to grow alongside our growing economy, but forecasts from different sources vary. The nationally calculated population forecasts predict we will have around 900,000 people in Cambridgeshire and Peterborough by 2026, while our locally calculated forecasts predict we will have about 990,000 people. This is important because if more people live locally there is more demand on health and social care services. We need national funding for these services to keep up with local population growth.

Cambridgeshire and Peterborough - absolute long term (20 year) population change, 2016 to 2036 (all ages)



Source: ONS 2016-based Subnational population projections and CCCRG mid-2015 based population forecasts (JSNA CDS figure 8)

How are we working together already?

- NHS organisations are aware of and use the Cambridgeshire County Council Research Group population forecasts for planning purposes.
- What can the Health and Wellbeing Board do?
- Health and Wellbeing Board member organisations can work together to make sure we present the same clear narrative to national government about how our population is growing, and the impact on infrastructure and services.

Outcomes for residents

- Residents are confident that enough health and social care services will be provided to meet the needs of a growing population.

4.3 ADDRESSING FINANCIAL CHALLENGES TOGETHER

In mid-2019, NHS organisations within Cambridgeshire and Peterborough were overspending by approximately £190 million per year compared to their baseline allocations from national NHS funding. This deficit is subsidised nationally and by other Sustainable Transformation Partnerships (STPs) within the Eastern Region. It's important to note that much of this overspend is at our hospitals, which treat many patients from outside Cambridgeshire and Peterborough as well as the local population.

In contrast, Local Authority adult social care and public health services in Cambridgeshire and Peterborough do not have a high spend compared to other areas.

Public health funding is allocated to local authorities through a national ring-fenced grant, and due to historical issues public health services in Peterborough are funded at 20% below the expected level for an area with its level of need. In Cambridgeshire, the funding is about 5% below the expected level.

Adult social care funding is locally generated through Council tax with some national grants in addition. In Peterborough and Cambridgeshire, spend has historically been lower than or similar to benchmark. Council finances are challenged both nationally and locally and social care budgets are experiencing severe financial pressures .Ongoing transformation is needed to remain within the available budgets.

How are we working together already?

- NHS and local authorities recognise the high level of financial constraints in the system, and that all organisations have significant financial pressures.
- NHS and local authority finance directors communicate and work together through a sub-group of the Sustainable Transformation Partnership (STP) Board.

What can the Health and Wellbeing Board do?

The Health and Wellbeing Board can

- Work with the STP to ensure that national lobbying on fair funding for Cambridgeshire and Peterborough is joined up and consistent.
- Engage with service transformations designed to bring the health system finances back into balance.
- Identify opportunities where integration across NHS and local authority services can improve prevention, join up care for service users and reduce overall costs.

Outcomes for residents

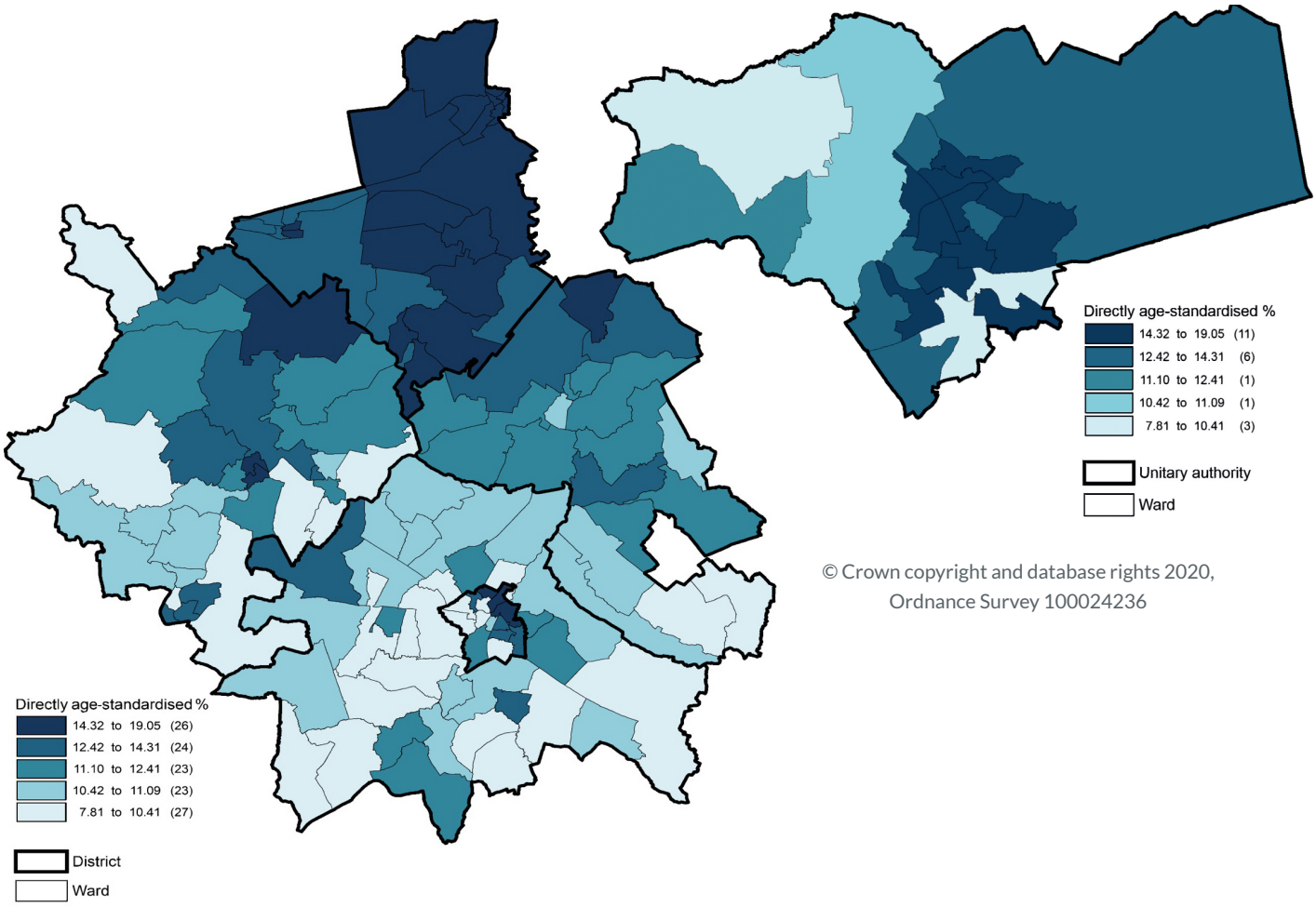
- Health and care services are financially sustainable.

4.4 ACTING AS A SYSTEM TO REDUCE HEALTH INEQUALITIES

What does the JSNA say?

Needs for health and social care services are not equally distributed across Cambridgeshire and Peterborough. People in Fenland and Peterborough are more likely to have long term illnesses which limit their activities in daily life. The maps below show that communities with the poorest health can be concentrated into small areas – including central Peterborough, north Fenland and north east Cambridge.

Long-term activity-limiting illness, ward, 2011



It is not always easy to provide health services in proportion to local needs – particularly in rural areas like Fenland which are some distance from the nearest hospital.

How are we working together locally?

- Some services have modelled their provision in relation to needs. For example local authority Child and Family Centres in both Cambridgeshire and Peterborough have remodelled their provision to provide more focus on areas with the highest needs, and health visiting services have use a workforce modelling tool – the 'Benson model' to allocate workforce where families and children's needs are highest. This is made easier by a Child Health Information System which provides good local data.
- Some public health contracts specify that services must see a higher proportion of their clients from areas of deprivation and this is performance monitored.
- Some place based community pilots in areas with higher deprivation take a holistic approach and include health and wellbeing alongside other community issues, for example Wisbech 2020 and Peterborough's Can Do area.

4.4 ACTING AS A SYSTEM TO REDUCE HEALTH INEQUALITIES

What can the Health and Wellbeing Board do?

- Health and care service providers on the Health and Wellbeing Board can use their own service data, together with wider population health data, to identify whether their services are reaching communities with the highest level of needs and whether their workforce is allocated proportionately. This can form part of a wider 'Population Health Management' approach.
- The Health and Wellbeing Board can encourage Primary Care Networks which look after communities with higher levels of deprivation and poorer health to develop joint preventive programmes with local authority public health services.
- Health and Wellbeing Board member organisations can consider their role as 'anchor organisations' in Cambridgeshire and Peterborough, including how their employment, workplace health and procurement practices can support good quality training and jobs for more disadvantaged communities.
- The Health and Wellbeing Board can endorse the Cambridgeshire & Peterborough Clinical Commissioning Group (CCG) Health Inequalities Strategy, currently in development.

Outcomes for residents

- More residents from socially disadvantaged communities have training and jobs in health and care services.
- Residents from communities with the worse health outcomes receive extra support to stay well and prevent health problems.
- Residents from communities where many people have health problems or disability experience good access to health and care support services.

GLOSSARY

Health and Wellbeing Board: A statutory partnership board which provides a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. It is a sub-committee of the local County or City Council.

Sustainable Transformation Partnership (STP): A non-statutory partnership of NHS organisations and local authority social care providers in an area, which works to run services in a more coordinated way, agree system-wide priorities, and plan collectively how to improve residents' day-to-day health.

Clinical Commissioning Group (CCG): Clinically led statutory NHS bodies, responsible for the planning and commissioning of health services for their local population.

HealthWatch: A statutory mechanism intended to strengthen the collective voice of users of health and social care services and members of the public, both nationally and locally. The aim of LHW is to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their locality.

Care Quality Commission (CQC): The independent regulator of all health and social care services in England. Its job is to make sure that care provided by hospitals, dentists, ambulances, care homes and services in people's own homes and elsewhere meets government standards of quality and safety.

Combined Authority (CA): A combined authority is a legal body set up using national legislation that enables a group of two or more councils to collaborate and take collective decisions across council boundaries. The Cambridgeshire and Peterborough CA has a directly elected Mayor.

Healthy New Towns: The Healthy New Towns Programme (**www.england.nhs.uk/ourwork/innovation/healthy-new-towns/**) was launched in 2015 with funding from NHS England to explore how the development of new places could provide an opportunity to create healthier and connected communities with integrated and high-quality services.

Think Communities: The Think Communities partnership approach (2018) has been developed in collaboration with partners to create a shared vision, approach and priorities for building Community Resilience across Cambridgeshire and Peterborough.

Cambridgeshire County Council

NHS
Cambridgeshire and Peterborough
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CONSULTATION DRAFT

CAMBRIDGESHIRE and PETERBOROUGH

JOINT HEALTH AND WELLBEING STRATEGY 2020-24 EXECUTIVE SUMMARY

The Health and Wellbeing Board is a place where politicians, health and social care professionals and other leaders across the system work together to solve problems and lead change to benefit our residents.

This year for the first time we have agreed to work together to create a joint Health and Wellbeing Strategy (2020-2024) across Cambridgeshire and Peterborough.

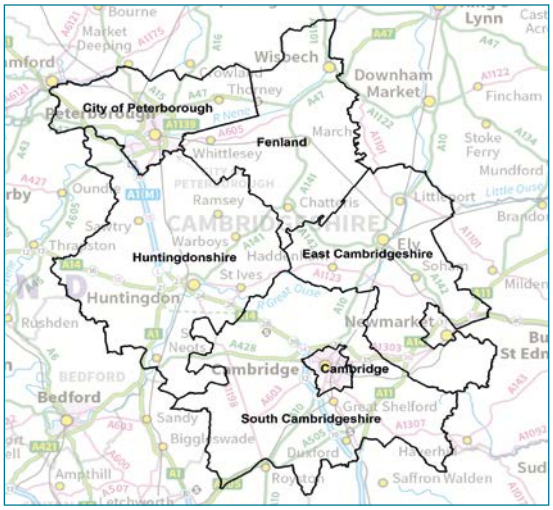
The Health and Wellbeing Strategy has four priorities:

Priority 1: Places that support health and wellbeing

Priority 2: Helping children achieve the best start in life

Priority 3: Staying healthy throughout life

Priority 4: Quality health and social care



PRIORITY 1: Places that support health and wellbeing

Focus area 1.1

Housing developments and transport which support residents' health and wellbeing

Outcomes for Residents:

- The design of new housing developments prioritises the health and wellbeing of residents
- Local transport infrastructure and access to public transport services helps all residents stay healthy and active
- Housing and transport infrastructure is designed to help tackle climate change

How will we work together?

- Adopt and implement the ten Healthy New Town principles for new developments
- Support local government planners and NHS estates planners to work together
- Endorse Cambridgeshire & Peterborough Local Transport Plan policies for 'creating healthy thriving communities'
- Endorse local organisations' Climate Change Strategies and Action Plans as they develop

Focus area 1.2

Preventing homelessness and improving pathways into housing for vulnerable people.

Outcomes for Residents:

- Fewer people with health problems and other vulnerabilities are homeless or in unsuitable housing
- Rough sleepers are helped to improve their physical and mental health

How will we work together?

- Support health and care providers to work with the sub-regional Housing Board, to prevent homelessness and develop pathways into housing for vulnerable people
- Implement the recommendations of the NHS health needs assessment for rough sleepers

PRIORITY 1: Places that support health and wellbeing (CONTINUED)

Focus area 1.3

Reducing inequalities in skills and economic outcomes across our area.

Outcomes for Residents:

- Residents in all parts of Cambridgeshire and Peterborough have access to good quality training, jobs and incomes
- Residents working locally are helped to stay healthy by their employers
- More residents with long term health conditions are in suitable work

How will we work together?

- Endorse the Combined Authority Industrial Strategy goal for inclusive growth across the area
- Promote workplace health programmes in local businesses
- Engage with local programmes to help people with long term health conditions back into work
- Endorse the Combined Authority Skills Strategy theme to 'Empower local people to access education and skills
- Deliver a successful Health and Care sector work academy, supporting local people into jobs

PRIORITY 2: Helping children achieve the best start in life

Focus area 2.1

The Best Start in Life from pre-birth to age five

Outcomes for residents

- Babies and young children are healthier and safer
- Parents and families can find the right information and support to help their children stay healthy
- Young children are more confident, resilient and ready to start school

How will we work together?

- Endorse and implement the Cambridgeshire and Peterborough Best Start in Life Strategy 2019-24
- Integrate community midwifery 'Better Births' Hubs and mental health services for new mothers with 'Best Start in Life' local teams
- Support 'Best Start in Life' local teams to develop links with the local voluntary sector and communities

Focus area 2,2

Developing an integrated approach for older children and adolescents

Outcomes for residents

- Children and young people have better mental health
- Fewer young people are homeless
- Fewer young people are not in education training or work
- Vulnerable young people are included in local communities and get help and support when they need it
- Fewer young people are taken into care

How will we work together?

- Bring together organisations and stakeholders, to develop an integrated outcomes framework and strategy for older children and adolescents across Cambridgeshire and Peterborough
- Take practical steps to include children in care, and those who care for them, in local activities and services

Priority 3: Staying healthy throughout life

Focus area 3.1

A joined up approach to healthy weight, obesity and diabetes

Outcomes for residents

- More children and adults have a healthy weight
- Fewer residents develop obesity and diabetes
- Residents with diabetes in all parts of Cambridgeshire and Peterborough have access to good care

How will we work together?

- Adopt the Cambridgeshire and Peterborough Healthy Weight Strategies
- Endorse the NHS Sustainable Transformation Partnership (STP) Obesity and Diabetes Strategy
- Consider adopting planning policies for fast food outlets

Focus area 3.2

Reducing inequalities in heart disease and smoking

Outcomes for residents

- Fewer residents die early as a result of smoking
- Fewer residents die early from heart disease
- Residents with heart disease in all parts of Cambridgeshire and Peterborough have access to good care

How will we work together?

- Adopt the Cambridgeshire and Peterborough Smoking and Tobacco Strategy
- Endorse the Clinical Commissioning Group (CCG) Prevention Strategy
- Endorse the STP Cardiovascular disease strategy
- Focus resources on areas of Peterborough and Wisbech with the highest deprivation, smoking and heart disease rates

Focus area 3.3

Improving mental health and access to services

Outcomes for residents

- More residents feel included in their communities and fewer experience loneliness
- Residents with mental health problems can access the support they need from 'joined up' services which make sense to them
- More people with severe mental health problems are in stable housing and employment

How will we work together?

- Support work through 'Think Communities' to address loneliness
- Work with the STP and the police and crime commissioner led 'Crisis Care Concordat' to join up oversight of mental health services
- Support pathways for vulnerable people with mental health problems into housing and employment

Focus area 3.4

Ageing Well – working with a growing older population

Outcomes for residents

- Older residents are supported to stay healthy and independent in their homes and communities for as long as possible
- Older residents spend less time in hospital
- Older residents feel that health and social care services are 'joined up' and make sense to them

How will we work together?

- Bring together work through the Ageing Well Board and Adults Positive Challenge programme to help older people stay well and independent
- Monitor how effectively the health and care system is helping older people receive their care outside hospital

PRIORITY 4: Quality health and social care

Focus area 4.1

Embedding a 'Think Communities' approach to place based working

Outcomes for Residents

- Residents understand how they can help themselves and each other to stay healthy in their local communities
- Residents experience 'joined up' local services which help them to solve problems and achieve the health and social care outcomes they want

How will we work together?

- Adopt a 'Think Communities' approach, with locally agreed ways of working in partnership with each other and local communities
- Promote joint working across 'Think Communities' pilots and Primary Care Networks/ integrated neighbourhood teams
- Review how Living Well Partnerships could integrate with a local Think Communities approach

Focus area 4.2

A joint approach to population growth

Outcomes for residents

- Residents are confident that enough health and social care services will be provided to meet the needs of a growing population

How will we work together?

- Ensure local organisations provide a consistent narrative to national government about how our population is growing, and the impact on infrastructure and services

Focus area 4.3

Addressing financial challenges together

Outcomes for residents

- Health and care services are financially sustainable

How will we work together?

- Engage with service transformations designed to bring the health system finances back into balance
- Identify opportunities to work across services to improve prevention, join up care for service users and reduce overall costs

Focus area 4.4

Acting as a system to reduce health inequalities

Outcomes for residents

- More residents from socially disadvantaged communities have training and jobs in health and care services
- Residents from communities with the worse health outcomes receive extra support to stay well and prevent health problems
- Residents from communities where many people have health problems or disability experience good access to health and care support services

How will we work together?

- Use data to allocate health and care resources in proportion to need
- Develop joint preventive programmes in communities with more deprivation and worse health
- Provide good training and jobs for people from disadvantaged communities
- Endorse the NHS Clinical Commissioning Group (CCG) Health Inequalities Strategy

Monitoring improvement

The Health and Wellbeing Board plans to monitor the actions proposed in the Strategy every six months, and to review changes in health outcomes for residents every year.

11. Do you have any other ideas on how the Health and Wellbeing Strategy should be monitored?

About you

The following questions will help us understand the spread of responses from across Cambridgeshire and Peterborough

12. How would you describe your gender?

☐ Female ☐ Male ☐ Prefer not to say ☐ Prefer to self-describe: (please specify)

13. Which age group do you fall in?

☐ Under 18 ☐ 18-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-64 ☐ 65-84 ☐ Prefer not to say

14. Do you have a disability or long-term health condition?

☐ Yes ☐ No ☐ Prefer not to say

15. What is your ethnic group?

BACK

☐ White ☐ Mixed/multiple ethnic group ☐ Asian/Asian British ☐ Black/African/Caribbean/Black British

☐ Other ethnic group (please specify)..... ☐ Prefer not to say

16. Would you say you are?

☐ Bi ☐ Gay Man ☐ Gay woman/Lesbian ☐ Heterosexual/Straight

☐ Prefer to self-describe: (please specify)..... ☐ Prefer not to say

17. What is the first half of your postcode? (This is optional but it will help us to check that we've received responses from all parts of Cambridgeshire and Peterborough)

Cambridgeshire County Council

NHS Cambridgeshire and Peterborough Clinical Commissioning Group

PETERBOROUGH CITY COUNCIL

https://consultcambs.uk.engagementhq.com/health-and-wellbeing-strategy-consultation

Please use the above link if you'd like to fill out the form online, or use the prepaid envelope provided to return the questionnaire

Cambridgeshire County Council

NHS Cambridgeshire and Peterborough Clinical Commissioning Group

PETERBOROUGH CITY COUNCIL

CAMBRIDGESHIRE and PETERBOROUGH

Joint Health and Wellbeing Strategy 2020-24 **QUESTIONNAIRE**

What do you think about our priorities?

The Health and Wellbeing Board brings together the organisations responsible for making decisions about health, wellbeing and care services in Cambridgeshire and Peterborough.

This includes local NHS organisations, elected Councillors, local authority public health, adult social care and children's services, and local Healthwatch.

The Board works together to plan how best to meet the needs of the local population and tackle inequalities in health. We have developed a draft Health and Wellbeing Strategy to help us do this.

We have chosen four priorities for the Strategy, in order to help the people in our communities live healthy lives. These are the things that it is most important for us to do.

PRIORITY ONE: places that support health and wellbeing

FRONT

The places where we live, work, learn and socialise have a big impact on our health. For this priority, we want to focus on:

- Build new homes and provide transport links that help people stay healthy and active, and support actions to reduce climate change.
- Work together to prevent homelessness, and provide support to vulnerable homeless people to move into stable housing.
- Help people with fewer qualifications access education and skills training to improve their employment chances. Help more people with long-term conditions into work.

1. Do you feel these are the right things to support the people in your community to be healthier?

☐ Strongly disagree ☐ Disagree ☐ Neither agree nor disagree ☐ Agree ☐ Strongly Agree

1b If you answered 'strongly disagree' or 'disagree', why do you feel these aren't the right things to support the people in your community to be healthier?

2. Are there any other things which should be done to make the place where you live healthier?

PRIORITY TWO: Helping children achieve the best start in life

Having a healthy and safe environment in early childhood and being ready to start school helps people have better health throughout their lives. For this priority we want to focus on:

- Support the families of children from pre-birth to five-years' old to give them the best start in life.
- Work together to improve mental health services and support for older children and adolescents.

3. Do you feel these are the right things to help children achieve a healthy start in life?

☐ Strongly disagree ☐ Disagree ☐ Neither agree nor disagree ☐ Agree ☐ Strongly Agree

3b If you answered 'strongly disagree' or 'disagree', why do you feel these aren't the right things to help children achieve a healthy start in life?

4. Is there anything else that could help children achieve the best start in life?

PRIORITY THREE: Helping people stay healthy throughout life

This means people having the opportunity to live a healthy lifestyle as well as having access to health services. For this priority we want to focus on:

- Work together to help people achieve a healthy weight.
- Support people to manage long-term conditions like diabetes and heart disease.
- Reduce smoking.
- Improve mental health and access to services
- Ensure services work together to meet the needs of people as they grow older.

5. Do you feel these are the right things to help people stay healthy throughout life?

☐ Strongly disagree ☐ Disagree ☐ Neither agree nor disagree ☐ Agree ☐ Strongly Agree

5b. If you answered 'strongly disagree' or 'disagree', why do you feel these aren't the right things to help people stay healthy?

6. Is there anything else that would help people stay healthy throughout life?

INSIDE FRONT

PRIORITY FOUR: good quality health and social care

Good quality health and social care when you need it matters to everyone. For this priority we want to focus on:

- Develop a local community approach to make sure that services and communities work together to help people when they need it. This is called 'Think Communities'.
- Work together to meet the needs for health and care services of a growing local population.
- Address financial challenges together
- Act as a system to reduce inequalities in health between communities.

7. Do you feel these are the right things to help improve the health and social care services?

☐ Strongly disagree ☐ Disagree ☐ Neither agree nor disagree ☐ Agree ☐ Strongly Agree

7b. If you answered 'strongly disagree' or 'disagree', why do you feel this plan won't help improve the quality of health and social care?

8. Is there anything else that would help improve health and social care services?

INSIDE BACK

Our draft Health and Wellbeing Strategy

Our draft Health and Wellbeing Strategy is available online. (If you don't have time to look at this, you can move straight to question 12.)

9. How far do you support our joint Health and Wellbeing Strategy to improve health and wellbeing for people in Cambridgeshire and Peterborough?

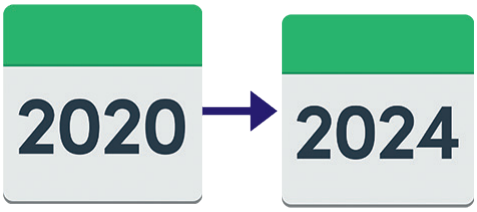
☐ Strongly disagree ☐ Disagree ☐ Neither agree nor disagree ☐ Agree ☐ Strongly Agree

10. Do you have any comments on the draft Strategy?

Staying healthy and happy

This document is to help you have your say on the **'Health and Wellbeing Strategy'.**

From **Cambridgeshire and Peterborough Health and Wellbeing Board.**



It says what they want to do in the next four years.

For people in **Cambridgeshire** and **Peterborough**.

About the Health and Wellbeing Board

They plan how **NHS** and **Council** services can work together.

To help people be healthy and happy.

And make services more equal.

The NHS helps you look after your health. Like seeing your doctor or going to hospital.

The Council

Councils provide important services to help you live your life. They are part of the **local government**.

Some of the things your council does

Plans new homes. And looks after roads.

Makes sure there are parks and leisure services.

And helps you to have a healthy lifestyle.

Gives help to families. And keeps children safe.

Helps people live independently at home.

Making services more equal

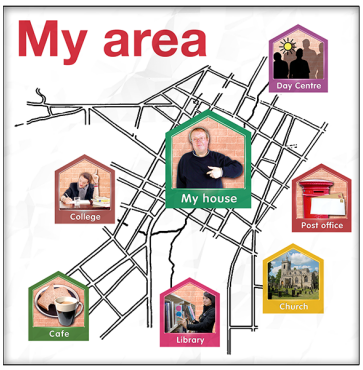
It can be harder for people from poor areas to be healthy and happy.

A poor area is where many people do not have much money. And can find it hard to get a good job.

People in poor areas do not always live as long as people in richer areas.

The Board wants to make the health of people in poor areas better.

Places that help you to stay happy and healthy



Your home and the area you live in can affect your health.

A bad house can make your health worse. Like if your house is cold or damp.

Having more skills and a job can help you stay healthy and happy.

Having friends and meeting people can help you stay healthy and happy.

What the Board wants to happen:

New homes are planned to help people stay healthy and happy.

And be more active.

People who have health or care problems have a home to live in.

It is easier to improve your skills. This will help you get a better job. And make healthy choices.

For 'places that help you stay happy and healthy'.

Do you agree with what the Board wants to do?

Tick the box you agree with.

Scale of 1 (**very bad**) to 5 (**very good**)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Help children have a good start in life

It can be harder for babies and children in poor areas to be healthy.

It can be hard for young people to get help with their mental health.

What the Board wants to happen:

Better care for new parents and babies.

Help for new parents to stop smoking. This is bad for them and for their babies.

Better information and help for parents and families.

Help young people look after their mental health.

For 'help children to have a good start in life'.

Do you agree with what the Board wants to do?

Tick the box you agree with.

Scale of 1 (**very bad**) to 5 (**very good**)

☐ 1 

☐ 2 

☐ 3 

☐ 4 

☐ 5 

Help to stay healthy as long as you can

You can make your health better by the choices you make. Like:

- Eating a healthy diet.

- Not drinking too much alcohol or taking drugs.

- Getting enough exercise.

- Not smoking.

The Board wants to make it easier for people to:

Make healthy choices to stay well.

Look after themselves if they have a health problem. Such as diabetes or a bad heart.

Look after their mental health. And not be lonely.

Stay independent at home for longer. Especially as they get older.

For 'Help to stay healthy as long as you can'.

Do you agree with what the Board wants to do?

Tick the box you agree with.

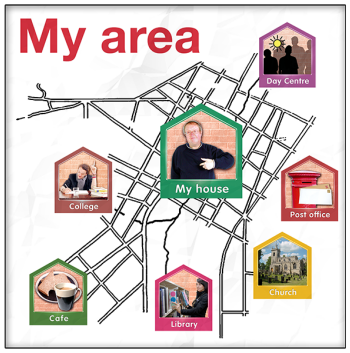
Scale of 1 (**very bad**) to 5 (**very good**)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Health and social care services are good

What the Board wants to happen:

People like doctors and social workers to work together more.



So it is easier to get help close to where you live. And look after your own health.

People from poor areas get extra help to stay healthy and happy

Health and social care services save some money.

For 'Health and social care services are good'.

Do you agree with what the Board wants to do?

Tick the box you agree with.

Scale of 1 (**very bad**) to 5 (**very good**)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

What do you think about our overall plan?

Tick the box you agree with.

Scale of 1 (**very bad**) to 5 (**very good**)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Is there anything else that the Health and Wellbeing Board should be doing?

You can write your answer in this box.

You can ask someone to help you do it if you want.

How to have your say

Website

- https://consultcambs.uk.engagementhq.com/health-and-wellbeing-strategy-consultation

Send this to us in the Freepost envelope that came with this form.

Or post to

Cambridgeshire County Council
Shire Hall
Castle Hill
Cambridge
CB3 0AP

You will need a stamp if you use your own envelope.

Send this back by 30 April 2020

Written by **Healthwatch Cambridgeshire and Healthwatch Peterborough.** We are part of the **Health and Wellbeing Board.**

Healthwatch speaks up for people who use health and social care services.

We use Photosymbols to help make the information easier to read.

Thank you to the **Access Champions** for helping to check it is easy to read.

Registered Company Number: 08516179

Think Communities Health Deal Agreement

Think Communities Approach

It is an approach to public services that will fundamentally evolve and change the relationship between the Public Sector and Communities.

It will transform the way the public sector delivers its services.

It will see the public sector have a much greater focus and understanding of working within place – joining up the system in innovative ways and delivering our services closer to communities to meet the needs.

It is about understanding the strengths and specific issues within specific areas and working with communities to improve lives.

Our System Ambition

A public sector workforce that listens, engages with and aligns to communities and each other, through mobilization of citizens and communities into positive action. The System commits to delivering services in ways that support communities to drive lasting change.

The Think Communities Health Deal Agreement requires the System partners to commit to working collaboratively with the focus on place /populations to aim to empower people to take responsibility to improve their health outcomes.

Why we have this ambition-

· **We need to do something fundamentally different**.

· Demand for public services is increasing at an alarming rate, often in the context of reducing budgets.

· Forecasts show that this is not likely to change anytime soon.

· Health Inequalities remain with some outcomes are not improving.

· And the system has become too complex.

Interdependencies across the System

Supporting the health and wellbeing of our communities is fundamental to Local Government, as well as to the NHS, we recognise that many of the most important factors which affect our residents' health are social, economic and environmental.

The Health and Wellbeing Board is the place where politicians, health and social care professionals and other leaders across the system work together to solve problems and lead change to benefit our residents. The Health and Well-being Boards signed Memorandum of Understanding (2018) by the Partners stating how they will work together.

The Cambridgeshire and Peterborough Sustainable Transformation Partnership (STP)has prepared their local Five-Year Plan as part of the wider NHS Long Term Plan. This will reflect national guidance from NHS England and local needs for health and care services. It is essential that the Health and Wellbeing Strategy and the STP response to the NHS Long Term Plan are aligned and complementary.

The Public Service Board has also set out its Four Grand Challenges for Cambridgeshire and Peterborough outlined below.

1. Giving people a good start in life.

2. Ensuring that people have good work.

3. Creating a place where people want to live.

4. Ensuring that people are healthy throughout their lives.

The Think Communities approach acknowledges the significant impact that housing, household income and employment, access / use of green space, and environmental issues have on a person's health .Partners know that local residents who present to health services are also the users of other public sector services, therefore the whole sector understands the importance of collective preventative activity to reduce poor health outcomes.

The Think Communities Health Deal Agreement recognises the need to focus on addressing the Wider Determinants of Health to improve health outcomes within our local communities. The Agreement outlines the transformation needed by Public Sector partners to work collaboratively with their Communities to create the conditions needed to enable Communities to take action.

The communities we live in are fundamental to our health outcomes and taking a 'Think Communities' approach based on place, rather than a silo approach based on organisations is at the core of the Strategy. The local health issues are often clear, while the actions we can take locally to address them can be more challenging therefore we need to adopt a much more holistic approach to delivering solutions with Communities.

What can the System do to deliver?

The System Partners recognises the impact on Health Outcomes caused through the Wider Determinants of health which can differ from community to community or geographical location.

Understanding the root causes maybe stemming from Housing, Employment, lack of Green Spaces, Family events / experiences, Education, Lifestyle choices etc.

The System recognises the contribution and resources that Partners can bring to help deliver change and improved outcomes.

Who are the Communities in need?

We need to be able to identify which Communities we are focusing on as System Partners these Communities maybe defined by -

Place – in that the Community belongs to a geographical area

Person – Individuals /families who are in contact with services on a frequent basis.

Community- which could be defined by people who have aspects in common such as Faith, Ethnicity, Longterm Conditions, Isolation, Falls

What are we agreeing to deliver moving forward?

Supporting a set of shared Values developed with our communities to -

Live in an area with good community spirit.

Have enjoyable activities and not be lonely.

Keep Children and young people safe and having fun.

Live in a clean, green and rubbish free area.

Be part of a Community and valued whatever their differences.

Culture change

As a System we will support cultural change through organisational development programmes designed to develop the capacity of our workforce to work across organisational boundaries. Leading to the purposeful creation of a shared culture across our workforce's where individuals can clearly see their role in supporting our communities to become resilient.

Collective delivery of Local priorities

To take some of the Priorities from the Health and Wellbeing Strategy and work at a Community Level to design and deliver improvements that address local health inequalities and improve health outcomes at an individual and Community level.

The Think Communities approach can support the delivery of some of the Health and Wellbeing Strategy priorities by utilising local data and intelligence

For example -

Promote Workplace Health Diabetes

Best start in Life Obesity/Lifestyles

Loneliness Mental wellbeing

Housing/ Homelessness Employment

What this will mean for Citizens and Communities?

Having more say on decisions that impact their lives and where they live and utilising Community Based Assets.

Understanding the community better by building clear area profiles to understand the opportunities, risks and challenges.

Building stronger local connections and community networks.

Working in partnership with the public sector and other organisations to focus on the issues most important in their area.

Focusing more on prevention than cure.

What does this mean for the System?

Letting go - people and communities do not always want and need services involved and can be empowered to take back responsibility for their lives.

Recognising that local places have different strengths and challenges and working through local System groups develop solutions with the Community.

Accepting that communities usually know best.

Working in a way that makes sense to communities, not offering one size fits all approaches and therefore build on the data and local intelligence.

Building greater collaboration with partners and local people equals better outcomes.

Developing a connection to a ‘place’ and really understanding the key issues for that area.

Training our workforce – so that they can work in new ways to support the local community.

HEALTH SCRUTINY COMMITTEE	AGENDA ITEM No. 9
9 MARCH 2020	PUBLIC REPORT

Report of:	Director of Law and Governance	
Contact Officer(s):	Paulina Ford, Senior Democratic Services Officer	Tel. 01733 452508

MONITORING SCRUTINY RECOMMENDATIONS

RECOMMENDATIONS	
FROM: Director of Law and Governance	**Deadline date:** *N/A*

It is recommended that the Health Scrutiny Committee:

1. Considers the responses from Cabinet Members and Officers to recommendations made at previous meetings as attached in Appendix 1 to the report and provides feedback including whether further monitoring of each recommendation is required.

1. ORIGIN OF REPORT

1.1 The Health Scrutiny Committee agreed at a meeting held on 19 June 2017 that a report be provided at each meeting to note the outcome of any recommendations made at the previous meeting held thereby providing an opportunity for the Committee to request further monitoring of the recommendation should this be required.

2. PURPOSE AND REASON FOR REPORT

2.1 The report enables the Scrutiny Committee to monitor and track progress of recommendations made to the Executive or Officers at previous meetings.

2.2 This report is for the Health Scrutiny Committee to consider under its Terms of Reference No. *Part 3, Section 4 - Overview and Scrutiny Functions, paragraph 3.3:*

The Scrutiny Committees will:

(a) Review and scrutinise the Executive, Committee and officer decisions and performance in connection with the discharge of any of the Council's functions;

(b) Review and scrutinise the Council's performance in meeting the aims of its policies and performance targets and/or particular service areas;

(c) Question Members of the Executive, Committees and senior officers about their decisions and performance of the Council, both generally and in relation to particular decisions or projects;

(d) *Make recommendations to the Executive and the Council as a result of the scrutiny process*.

3. TIMESCALES

Is this a Major Policy Item/Statutory Plan?	**NO**	If yes, date for Cabinet meeting	N/A

4. BACKGROUND

4.1 Appendix 1 of the report sets out the recommendations made to Cabinet Members or Officers at previous meetings of the Scrutiny Committee. It also contains summaries of any action taken by Cabinet Members or Officers in response to the recommendations.

4.2 The progress status for each recommendation is indicated and if the Scrutiny Committee confirms acceptance of the items marked as completed they will be removed from the list. In cases where action on the recommendation is outstanding or the Committee does not accept the matter has been adequately completed it will be kept on the list and reported back to the next meeting of the Committee. It will remain on the list until such time as the Committee accepts the recommendation as completed.

5. ANTICIPATED OUTCOMES OR IMPACT

5.1 Timelier monitoring of recommendations made will assist the Scrutiny Committee in assessing the impact and consequence of the recommendations.

6. REASON FOR THE RECOMMENDATION

6.1 To assist the Committee in assessing the impact and consequence of recommendations made at previous meetings.

7. BACKGROUND DOCUMENTS

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

7.1 Minutes of meetings held on 18 September 2019 and 7 January 2020.

8. APPENDICES

8.1 Appendix 1 – Recommendations Monitoring Report

RECOMMENDATION MONITORING REPORT 2019/20
APPENDIX 1

HEALTH SCRUTINY COMMITTEE

Meeting date Recommendations Made	Portfolio Holder / Directorate Responsible	Agenda Item Title	Recommendation Made	Action Taken	Progress Status
18 September 2019	Director of Public Health	**BEST START IN LIFE STRATEGY AND CHILDREN'S PUBLIC HEALTH SERVICES**	The Health Scrutiny Committee **RECOMMENDED** that a letter be sent to the Local MP's asking them to lobby the Secretary of State for Health for an increase in the Public Health Grant for Peterborough.	A letter to the two local MP's asking them to lobby the Secretary of State for Health for an increase in the Public Health Grant for Peterborough had been sent on 18 Dec 2019	Complete
7 January 2020	Director of External Affairs & Policy, Cambridgeshire and Peterborough Clinical Commissioning Group / Chief Executive, North West Anglia NHS Foundation Trust	**NORTH WEST ANGLIA NHS FOUNDATION TRUST - WINTER PREPARATIONS 19/20**	The Health Scrutiny Committee considered the report and **RECOMMENDED** that the pilot scheme currently being used at Hinchingbrooke Hospital was progressed further and implemented at Peterborough City Hospital.	Update from CCG – 27/2/2020 The 111 pilot at Hinchingbrooke remains ongoing and as such, our evaluation of the effectiveness of the model has not yet concluded. We have multiple phases to the pilot designed to understand the most effective and efficient method of delivery. Our plan remains to complete the initial pilot at Hinchingbrooke and review the evidence base before entering into conversations with system partners, as part of the urgent care collaborative, on whether the model can be adopted	Ongoing

				long term at all relevant NWAngliaFT sites. The model requires quite a lot of training to establish appropriate rotas and as such isn't suitable for a quick 'lift and shift' approach. If we believe that this is the right approach moving forward, then there will need to be system investment in building the 111 workforce who can deliver this across multiple sites. As an alternative, and to support Peterborough City Hospital through the winter period, we have put in place a nurse-led streaming model in the Emergency Dept at PCH. Patients are reviewed on arrival to ED and, if appropriate for primary care see and treat and / or other services, are then assessed and streamed by an Advanced Nurse Practitioner. While the Advanced Nurse Practitioners are not able to directly book into GP appointments, they are able to offer alternative advice on self-care, redirect to other urgent treatment centre facilities or recommend routine GP follow up as appropriate. This came into effect at the end of January, is supported by winter monies and is intended to run until the end of March. This has supported the trust to maintain its A&E four hour waiting time performance for minor injuries, with the trust achieving the standard in January and February to date.	

7 January 2020	Director of External Affairs & Policy, Cambridgeshire and Peterborough Clinical Commissioning Group / Chief Executive, North West Anglia NHS Foundation Trust	**NORTH WEST ANGLIA NHS FOUNDATION TRUST FINANCIAL UPDATE**	The Health Scrutiny Committee considered the report and **RECOMMENDED** that a report be presented to the Committee in the next Municipal Year on public transport access at the hospital and the progress made on the green transport plan.	Report to be programmed into the 2020/2021 Health Scrutiny Committee work programme	Ongoing
7 January 2020	Director of Public Health / Chairman of Health Scrutiny Committee	**UPDATE ON QUALITY IN PRIMARY CARE SERVICES**	It is **RECOMMENDED** that the Committee write to the Health Secretary and the local MP's outlining concerns that the national contract for GP surgeries was not specific enough. The letter to include specific examples of inconsistencies within the system, including the 8 o'clock appointment system.	Letter currently being drafted. (28/02/2020)	Ongoing

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HEALTH SCRUTINY COMMITTEE	AGENDA ITEM No. 9
9 MARCH 2020	PUBLIC REPORT

Report of:	Fiona McMillan, Director of Law and Governance	
Cabinet Member(s) responsible:	Councillor Mohammed Farooq, Cabinet Member for Digital Services and Transformation	
Contact Officer(s):	Paulina Ford, Senior Democratic Services Officer	Tel. 01733 452508

FORWARD PLAN OF EXECUTIVE DECISIONS

RECOMMENDATIONS	
FROM: Senior Democratic Services Officer	**Deadline date:** *N/A*

It is recommended that the Health Scrutiny Committee:

1. Considers the current Forward Plan of Executive Decisions and identifies any relevant items for inclusion within their work programme or request further information.

1. ORIGIN OF REPORT

1.1 The report is presented to the Committee in accordance with the Terms of Reference as set out in section 2.2 of the report.

2. PURPOSE AND REASON FOR REPORT

2.1 This is a regular report to the Health Scrutiny Committee outlining the content of the Forward Plan of Executive Decisions.

2.2 This report is for the Health Scrutiny Committee to consider under its Terms of Reference No. Part 3, Section 4 - Overview and Scrutiny Functions, paragraph 3.3:

The Scrutiny Committees will:

(f) Hold the Executive to account for the discharge of functions in the following ways:

ii) By scrutinising Key Decisions which the Executive is planning to take, as set out in the Forward Plan of Executive Decisions;

3. TIMESCALES

Is this a Major Policy Item/Statutory Plan?	**NO**	If yes, date for Cabinet meeting	N/A

4. BACKGROUND AND KEY ISSUES

4.1 The latest version of the Forward Plan of Executive Decisions is attached at Appendix 1. The

Forward Plan contains those Executive Decisions which the Leader of the Council believes that the Cabinet or individual Cabinet Member(s) can take and any new key decisions to be taken after 30 March 2020.

4.2 The information in the Forward Plan of Executive Decisions provides the Committee with the opportunity of considering whether it wishes to seek to influence any of these executive decisions, or to request further information.

4.3 If the Committee wished to examine any of the executive decisions, consideration would need to be given as to how this could be accommodated within the work programme.

4.4 As the Forward Plan is published fortnightly any version of the Forward Plan published after dispatch of this agenda will be tabled at the meeting.

5. CONSULTATION

5.1 Details of any consultation on individual decisions are contained within the Forward Plan of Executive Decisions.

6. ANTICIPATED OUTCOMES OR IMPACT

6.1 After consideration of the Forward Plan of Executive Decisions the Committee may request further information on any Executive Decision that falls within the remit of the Committee.

7. REASON FOR THE RECOMMENDATION

7.1 The report presented allows the Committee to fulfil the requirement to scrutinise Key Decisions which the Executive is planning to take, as set out in the Forward Plan of Executive Decisions in accordance with their terms of reference as set out in Part 3, Section 4 - Overview and Scrutiny Functions, paragraph 3.3.

8. ALTERNATIVE OPTIONS CONSIDERED

8.1 N/A

9. IMPLICATIONS

Financial Implications

9.1 N/A

Legal Implications

9.2 N/A

10. BACKGROUND DOCUMENTS

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

10.1 None

11. APPENDICES

11.1 Appendix 1 – Forward Plan of Executive Decisions

PETERBOROUGH CITY COUNCIL'S FORWARD PLAN OF EXECUTIVE DECISIONS

PUBLISHED: 28 FEBRUARY 2020

FORWARD PLAN

PART 1 – KEY DECISIONS

In the period commencing 28 clear days after the date of publication of this Plan, Peterborough City Council's Executive intends to take 'key decisions' on the issues set out below in **Part 1**. Key decisions relate to those executive decisions which are likely to result in the Council spending or saving money in excess of £500,000 and/or have a significant impact on two or more wards in Peterborough.

If the decision is to be taken by an individual Cabinet Member, the name of the Cabinet Member is shown against the decision, in addition to details of the Councillor's portfolio. If the decision is to be taken by the Cabinet, this too is shown against the decision and its members are as listed below:
Cllr Holdich (Leader); Cllr Fitzgerald (Deputy Leader); Cllr Ayres; Cllr Cereste; Cllr Hiller; Cllr Seaton; Cllr Walsh; Cllr Allen and Cllr Farooq.

This Plan should be seen as an outline of the proposed decisions for the forthcoming month and it will be updated on a fortnightly basis to reflect new key-decisions. Each new Plan supersedes the previous Plan and items may be carried over into forthcoming Plans. Any questions on specific issues included on the Plan should be included on the form which appears at the back of the Plan and submitted to philippa.turvey@peterborough.gov.uk, Democratic and Constitutional Services Manager, Legal and Governance Department, Town Hall, Bridge Street, PE1 1HG (fax 08702 388039). Alternatively, you can submit your views via e-mail to or by telephone on 01733 452460. For each decision a public report will be available from the Democratic Services Team one week before the decision is taken.

PART 2 – NOTICE OF INTENTION TO TAKE DECISION IN PRIVATE

Whilst the majority of the Executive's business at the Cabinet meetings listed in this Plan will be open to the public and media organisations to attend, there will be some business to be considered that contains, for example, confidential, commercially sensitive or personal information. In these circumstances the meeting may be held in private, and on the rare occasion this applies, notice will be given within **Part 2** of this document, 'notice of intention to hold meeting in private'. A further formal notice of the intention to hold the meeting, or part of it, in private, will also be given 28 clear days in advance of any private meeting in accordance with The Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012.

The Council invites members of the public to attend any of the meetings at which these decisions will be discussed (unless a notice of intention to hold the meeting in private has been given).

PART 3 – NOTIFICATION OF NON-KEY DECISIONS

For complete transparency relating to the work of the Executive, this Plan also includes an overview of non-key decisions to be taken by the Cabinet or individual Cabinet Members, these decisions are listed at **Part 3** and will be updated on a weekly basis.

You are entitled to view any documents listed on the Plan, or obtain extracts from any documents listed or subsequently submitted to the decision maker prior to the decision being made, subject to any restrictions on disclosure. There is no charge for viewing the documents, although charges may be made for photocopying or postage. Documents listed on the notice and relevant documents subsequently being submitted can be requested from Philippa Turvey, Democratic and Constitutional Services Manager, Legal and Governance Department, Town Hall, Bridge Street, PE1 1HG (fax 08702 388038), e-mail to philippa.turvey@peterborough.gov.uk or by telephone on 01733 452460.

All decisions will be posted on the Council's website: www.peterborough.gov.uk/executivedecisions. If you wish to make comments or representations regarding the 'key decisions' outlined in this Plan, please submit them to the Democratic and Constitutional Services Manager using the form attached. For your information, the contact details for the Council's various service departments are incorporated within this Plan.

PART 1 – FORWARD PLAN OF KEY DECISIONS

KEY DECISIONS FROM 30 MARCH 2020

KEY DECISION REQUIRED	*DECISION MAKER*	*DATE DECISION EXPECTED*	*RELEVANT SCRUTINY COMMITTEE*	**WARD**	*CONSULTATION*	*CONTACT DETAILS / REPORT AUTHORS*	*DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER INCLUDING EXEMPT APPENDICES AND REASONS FOR EXEMPTION*
Leasehold acquisition of property for temporary accommodation – KEY/30MAR20/01 - Approval to lease up to 68 flats in Orton at Local Housing allowance rates.	**Councillor Peter Hiller, Cabinet Member for Strategic Planning and Commercial Strategy and Investments**	**March 2020**	Growth, Environment and Resources Scrutiny Committee	Orton	Relevant internal and external stakeholders. Consultation has yet to be addressed with ward members	Tristram Hill NPS Peterborough Email:tristram.hill@nps.co.uk Tel: 07849 079787	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.

KEY DECISION REQUIRED	*DECISION MAKER*	*DATE DECISION EXPECTED*	*RELEVANT SCRUTINY COMMITTEE*	**WARD**	*CONSULTATION*	*CONTACT DETAILS / REPORT AUTHORS*	*DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER INCLUDING EXEMPT APPENDICES AND REASONS FOR EXEMPTION*
Disposal Of Plots 7 & 8 Fletton Quays [Whitworth Mill] - KEY/30MAR20/02 - Approve the disposal of the Whitworth Mill site (plot 7) and the adjacent site (plot 8) to Samsons Property Limited	**Councillor Peter Hiller, Cabinet Member for Strategic Planning and Commercial Strategy and Investments**	**March 2020**	Growth, Environment and Resources Scrutiny Committee	Central	There will be community consultation once the developer brings forward a detailed planning application	Dave Anderson , Interim Development Director – Email: dave.anderson@peterborough.gov.uk Tel: 07810 839 657	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.

PREVIOUSLY ADVERTISED KEY DECISIONS								
KEY DECISION REQUIRED		***DECISION MAKER***	***DATE DECISION EXPECTED***	***RELEVANT SCRUTINY COMMITTEE***	**WARD**	***CONSULTATION***	***CONTACT DETAILS / REPORT AUTHORS***	***DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER INCLUDING EXEMPT APPENDICES AND REASONS FOR EXEMPTION***
1.	**Affordable Warmth Strategy 2019 – 2021 - KEY/17APR17/03** Recommendation to approve the Affordable Warmth Strategy 2019 – 2021	**Councillor Walsh, Cabinet Member for Communities**	**March 2020**	Adults and Communities Scrutiny Committee	All wards	Relevant internal and external stakeholders. The draft strategy will be placed on PCC Consultation pages for 3 week consultation period	Sharon Malia, Housing Programmes Manager, Tel: 01733 863764 Email: sharon.malia@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. BRE Integrated Dwelling Level Housing Stock Modelling Report July 2016 Housing Renewals Policy 2017 – 2019

KEY DECISION REQUIRED		*DECISION MAKER*	*DATE DECISION EXPECTED*	*RELEVANT SCRUTINY COMMITTEE*	**WARD**	*CONSULTATION*	*CONTACT DETAILS / REPORT AUTHORS*	*DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER INCLUDING EXEMPT APPENDICES AND REASONS FOR EXEMPTION*
2.	**ICT Infrastructure works for Fletton Quays – KEY/13NOV17/02** To agree to the procurement of ICT infrastructure works for Fletton Quays	**Councillor Seaton, Cabinet Member for Finance**	**March 2020**	Growth, Environment & Resources Scrutiny Committee	N/A	Relevant internal and external stakeholders	Peter Carpenter, Acting Corporate Director, Resources Tel: 07920160122 Email: Peter.carpenter@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. The decision will include an exempt annexe. By virtue of paragraph 3, information relating to the financial or business affairs of any particular person (including the authority holding that information).
3.	**Expansion and Remodelling of Marshfields School – KEY/11DEC17/03** To approve the proposed expansion and remodelling of Marshfields school	**Cabinet Member for Children's Services and Education, Skills and University**	**March 2020**	Children and Education Scrutiny Committee	Dogsthorpe Ward	Relevant internal and external stakeholders. Public Consultation Meeting	Sharon Bishop, Capital Projects & Assets Officer Tel: 01733 863997 Email: Sharon.bishop@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. School Organisational Plan

DECISION REQUIRED		*DECISION MAKER*	*DATE DECISION EXPECTED*	*RELEVANT SCRUTINY COMMITTEE*	**WARD**	*CONSULTATION*	*CONTACT DETAILS / REPORT AUTHORS*	*DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER INCLUDING EXEMPT APPENDICES AND REASONS FOR EXEMPTION*
4.	**Extension to the Section 75 Agreement for Learning Disabilities Services - KEY/30APR18/01** Extension of the existing staff and commissioned arrangements for a period of 12 months	**Councillor Fitzgerald, Deputy Leader and Cabinet Member for Adult Social Care, Health & Public Health**	**March 2020**	Health Scrutiny Committee	All wards	Consultation with key stakeholders to agree this interim approach	Cris Green Tel: 01733 207164 Email: cris.green@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.
5.	**Disposal of freehold in Centre of the City - KEY/12JUN18/01** To delegate authority to the Corporate Director of Growth and Regeneration to sell the property	**Councillor Seaton, Cabinet Member for Finance**	**March 2020**	Growth, Environment and Resources Scrutiny Committee	Central	Relevant internal and external stakeholders	Peter Carpenter, Acting Corporate Director, Resources Tel: 07920160122 Email: Peter.carpenter@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. **The decision will include an exempt annexe. By virtue of paragraph 3, information relating to the financial or business affairs of any particular person (including the authority holding that information).**

DECISION REQUIRED		*DECISION MAKER*	*DATE DECISION EXPECTED*	*RELEVANT SCRUTINY COMMITTEE*	**WARD**	*CONSULTATION*	*CONTACT DETAILS / REPORT AUTHORS*	*DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER INCLUDING EXEMPT APPENDICES AND REASONS FOR EXEMPTION*
6.	**To approve the awarding of contracts to external providers following a competitive tender exercise led by Cambridgeshire County Council - KEY/25JUNE18/02** Cambridgeshire County has recently conducted a tendering exercise to establish a Dynamic Purchasing System for the provision Supported Living Services for Adults with a Learning Disability (Reference number: DN311905). Peterborough City Council is the named authority under this arrangement and would want to commission care and support packages (call-off).	**Councillor Fitzgerald, Deputy Leader and Cabinet Member for Adult Social Care, Health & Public Health**	**March 2020**	Adults and Communities Scrutiny Committee	All Wards	Relevant internal and external stakeholders Relevant consultations has been carried out with the service users, family carers, Health colleagues and care and support providers across Cambridgeshire and Peterborough.	Mubarak Darbar, Head of Integrated Commissioning, Tel: 07718654207, Email: mubarak.darbar@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.

DECISION REQUIRED		*DECISION MAKER*	*DATE DECISION EXPECTED*	*RELEVANT SCRUTINY COMMITTEE*	**WARD**	*CONSULTATION*	*CONTACT DETAILS / REPORT AUTHORS*	*DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER INCLUDING EXEMPT APPENDICES AND REASONS FOR EXEMPTION*
7.	**University Delivery Vehicle – KEY/3SEP18/02** Approval and setting up of an appropriate delivery vehicle with University project partners to move council assets to enable the delivery of the university.	**Councillor Hiller, Cabinet Member for Strategic Planning and Commercial Strategy and Investments**	**March 2020**	Growth, Environment and Resources Scrutiny Committee	Central	Relevant internal and external stakeholders	Peter Carpenter, Acting Corporate Director, Resources Tel: 07920160122 Email: Peter.carpenter@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. **The decision will include an exempt annexe. By virtue of paragraph 3, information relating to the financial or business affairs of any particular person (including the authority holding that information).**

KEY DECISION REQUIRED		*DECISION MAKER*	*DATE DECISION EXPECTED*	*RELEVANT SCRUTINY COMMITTEE*	**WARD**	*CONSULTATION*	*CONTACT DETAILS / REPORT AUTHORS*	*DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER INCLUDING EXEMPT APPENDICES AND REASONS FOR EXEMPTION*
8.	**Adoption of the "Dynamic Purchasing System" (DPS) procedure for Public Health contracts with Primary Care providers – KEY/10DEC18/01** To seek the approval to adopt the "Dynamic Purchasing System" (DPS) procedure for contracts with Primary Care providers for the duration of up to five years. The proposals have been approved by the Cambridgeshire and Peterborough Joint Commissioning Board.	**Councillor Fitzgerald, Deputy Leader and Cabinet Member for Adult Social Care, Health & Public Health**	**March 2020**	Health Scrutiny Committee	All Wards	Relevant internal and external stakeholders.	Claire-Adele Mead Commissioning Team Manager-Primary care and Lifestyles Claire-Adele.Mead@cambridgeshire.gov.uk 07884 250909 Val Thomas, Consultant in Public Health Val.Thomas@cambridgeshire.gov.uk 01223 703264/ 07884 183374	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.

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9.	**Recommissioning of the Unpaid Carers Contract – KEY/01APR19/01** The procurement of the unpaid carers service in collaboration with Cambridgeshire County Council and Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) for the unpaid carers service across Cambridgeshire and Peterborough.	**Councillor Fitzgerald, Deputy Leader and Cabinet Member for Adult Social Care, Health & Public Health**	**March 2020**	Adults and Communities Scrutiny Committee	All Wards	Relevant internal and external stakeholders.	Lee McManus, Commissioner, Cambridgeshire County Council & Peterborough City Council. Tel: 07785 721092. Email: lee.mcmanus@cambridgeshire.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. The decision will include an exempt annexe. By virtue of paragraph 1, Information relating to any individual

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10.	**Vehicle removal for Parking contravention – KEY/15APR19/02** To ask the Cabinet Member to approve the policy to implement a scheme to remove vehicles of persistent offenders in breach of parking restrictions in the City and to appoint the Local Authority Trading Company to act as the authorised agent of the policy.	**Councillor Walsh, Cabinet Member for Communities**	**March 2020**	Growth, Environment and Resources Scrutiny Committee	All Wards	Details of any consultation to be decided. Relevant internal and external stakeholders.	Adam Payton, PES Senior Officer, Parking Lead, 01733 452314 adam.payton@peterborough.gov.uk	Prevention and Enforcement Service Vehicle Removal For Parking Contraventions Policy and Guidance
11.	**Award of contract for the refurbishment of the Town Hall North - KEY/29APR19/04 -** Award of construction design and build contract with regard to the refurbishment of the Peterborough Town Hall North	**Councillor Seaton, Cabinet Member for Finance**	**March 2020**	Growth, Environment and Resources Scrutiny Committee	N/A	Relevant internal and external stakeholders.	Stuart Macdonald. Head of Property. Email: stuart.macdonald@peterborough.gov.uk Tel: 07715802489.	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.

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12.	**Approval for contract to be awarded to Skanska to deliver design of Eastern Industries Access Phase 1 scheme - KEY/10JUN19/01** Approval for contract to be awarded to Skanska to deliver design of Eastern Industries Access Phase 1 scheme. The council has received funding (£550k) from the Cambridgeshire and Peterborough Combined Authority to deliver the scheme.	**Councillor Hiller, Cabinet Member for Strategic Planning and Commercial Strategy and Investments**	**March 2020**	Growth, Environment and Resources Scrutiny Committee	East Ward	Relevant internal and external stakeholders. Consultation will take place with residents and key stakeholders at the relevant stage of the scheme.	Lewis Banks, Principal Sustainable Transport Planning Officer, 01733 317465, lewis.banks@peterborough.gov.uk	Cambridgeshire and Peterborough Combined Authority meeting notes confirming grant funding allocation. Also CMDN for award of contract to Skanska for provision of Professional Services under Peterborough Highway Services partnership.

KEY DECISION REQUIRED		*DECISION MAKER*	*DATE DECISION EXPECTED*	*RELEVANT SCRUTINY COMMITTEE*	**WARD**	*CONSULTATION*	*CONTACT DETAILS / REPORT AUTHORS*	*DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER INCLUDING EXEMPT APPENDICES AND REASONS FOR EXEMPTION*
13.	**Approval for contract to be awarded to Skanska to deliver design of A1260 Nene Parkway Junction 15 Improvement scheme – KEY/10JUN19/02** Approval for contract to be awarded to Skanska to deliver design of A1260 Nene Parkway Junction 15 Improvement scheme. The council has received funding (£500k) from the Cambridgeshire and Peterborough Combined Authority to deliver the scheme.	**Councillor Hiller, Cabinet Member for Strategic Planning and Commercial Strategy and Investments**	**March 2020**	Growth, Environment and Resources Scrutiny Committee	West Ward	Relevant internal and external stakeholders Consultation will take place with residents and key stakeholders at the relevant stage of the scheme.	Lewis Banks, Principal Sustainable Transport Planning Officer, 01733 317465, lewis.banks@peterborough.gov.uk	Cambridgeshire and Peterborough Combined Authority meeting notes confirming grant funding allocation. Also CMDN for award of contract to Skanska for provision of Professional Services under Peterborough Highway Services partnership.

KEY DECISION REQUIRED		*DECISION MAKER*	*DATE DECISION EXPECTED*	*RELEVANT SCRUTINY COMMITTEE*	**WARD**	*CONSULTATION*	*CONTACT DETAILS / REPORT AUTHORS*	*DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER INCLUDING EXEMPT APPENDICES AND REASONS FOR EXEMPTION*
14.	**Sign-off on Pseudo Framework - KEY/22JUL19/02** - It is required for the Cabinet member to sign off tender documents prior to Invitation To Tender being published (ITT). The ITT is for Better Care Fund and Hancock-funded services for better integration of health and social care, winter pressures and Prevention services.	**Councillor Fitzgerald, Deputy Leader and Cabinet Member for Integrated Adult Social Care and Health and Public Health**	**March 2020**	Adults and Communities Scrutiny Committee	All Wards	Relevant internal and external stakeholders. Equality Impact Assessment	Graeme Hodgson, Commissioner. Tel. 07448 379944 Email: graeme.hodgson@cambridgeshire.gov.uk"	Service Specifications, Terms and Conditions of Pseudo Framework ITT.
15.	**Approval of invest to save expenditure - KEY/22JUL19/03 -** The decision required will enable the Council to purchase suitable homes within the local housing market for use as temporary accommodation for households at risk of homelessness. This proposal is predicated on an invest to save proposition based upon an attached business case.	**Councillor Steve Allen, Cabinet Member for Housing, Culture and Recreation**	**March 2020**	Adults and Communities Scrutiny Committee	All Wards	Relevant internal and external stakeholders and Ministry of Housing Communities and Local Government	David Anderson Interim Development Director Tel: 01733 452468 Email: Dave.Anderson@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.

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16.	**Award of 9 Large Tail lift school transport routes to Aragon Direct Services - KEY/19AUG19/02 -** Replacement routes due to current operator terminating contract to transport pupils with complex needs to Phoenix, Heltwate and Marshfields School	**Councillor Lynne Ayres, Cabinet Member for Children's Services and Education, Skills and University**	**March 2020**	Children and Education Scrutiny Committee	All Wards	Relevant internal and external stakeholders. Parents of those currently receiving transport advised there will be a change of operator due to current operator terminating routes.	Bryony Wolstenholme - Team Manager, Passenger Transport Operations, Tel: 01733 317453, Email: bryony.wolstenholme@peterborough.gov.uk	Other documentation to follow once final costs confirmed and decision made on external testing of market

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17.	**Contract for remedial works by PCC to the Stanground Bypass – KEY/2SEP19/02** To approve works to the Stanground bypass and authorise the associated package of work to be issued to Skanska Construction UK Limited under the Council's existing agreement with SKANSKA dated 18th September 2013 (the Highways Services Agreement).	**Councillor Peter Hiller, Cabinet Member for Strategic Planning and Commercial Strategy and Investments**	**March 2020**	Growth, Environment and Resources Scrutiny Committee	Stanground South and Hargate and Hempsted	Relevant internal and external stakeholders Standard consultation for highway schemes.	Charlotte Palmer, Group Manager – Transport and Environment, charlotte.palmer@peterborough.gov.uk	To be determined.

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18.	**Uncollectable Debts in Excess of £10,000 – KEY/16SEPT19/01** To authorise the write-off of uncollectable debts shown as outstanding in respect of non-domestic rates, council tax, housing benefit overpayments and accounts receivable (sundry debt) accounts. All cases requested for write-off follow a lengthy process to recover the outstanding money, sometimes dating back many years. Only once all avenues have been exhausted will the council consider writing off debt.	**Councillor Seaton, Cabinet Member for Finance**	**March 2020**	Growth, Environment, & Resources Scrutiny Committee	All Wards	Relevant internal and external stakeholders.	Peter Carpenter, Acting Corporate Director Of Resources, Tel: 01733 452520, Email: peter.carpenter@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.

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19.	**Approval of funding for the provision of accommodation to reduce homelessness KEY/14OCT19/01** – Following Cabinet Decision JAN18/CAB/18 this is a new project to increase the supply of housing and address the demand for accommodation resulting from the increase in homelessness.	Councillor Steve Allen, Cabinet Member for Housing, Culture and Recreation	**March 2020**	Growth, Environment and Resources Scrutiny Committee	All	Relevant internal and external stakeholders. The issues associated with homelessness in Peterborough have been subject to significant discussion in various forums, including the Council's Adults and Communities Scrutiny, Cabinet and Full Council	Peter Carpenter, Acting Corporate Director of Resources Email: peter.carpenter@peterborough.gov.uk Tel: 01733 452520	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. The decision will include an exempt annexe. By virtue of paragraph 3, information relating to the financial or business affairs of any particular person (including the authority holding that information).

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20.	**Sale of the freehold of the London Road Stadium and the Allia Business Centre - KEY/14OCT19/04** – Delegate the Authority to the Corporate Director of Growth and Regeneration to sell the property (this item is a resubmission of KEY/24JUN19/01).	**Councillor Seaton, Cabinet Member for Finance**	**March 2020**	Growth, Environment & Resources Scrutiny Committee	Fletton and Stanground	Relevant internal and external stakeholders.	Peter Carpenter, Acting Corporate Director, Resources Tel: 07920160122 Email: Peter.carpenter@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. The decision will include an exempt annexe. By virtue of paragraph 3, information relating to the financial or business affairs of any particular person (including the authority holding that information).

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21.	**Enforcement of householder duty of care – KEY/11NOV19/01** To approve enforcement of householder duty of care by issue of Fixed Penalty Notice if an individual failed to comply with their duty of care under Section 34 (2A) of the Environmental Protection Action 1990 in England. To set the fixed penalty amount in line with current fine for environmental crime offences.	**Councillor Irene Walsh, Cabinet Member for Communities**	**March 2020**	Adults and Communities Scrutiny Committee	All Wards	Relevant internal and external stakeholders.	Clair George - Acting Head of Prevention and Enforcement Service Tel: 01733 453576 Email: clair.georgepes@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. Government paper - Guidance for local authorities on household waste duty of care fixed penalty notices

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22.	**Enforcement of the Minimum Levels of Energy Efficiency in Domestic Private Rented Properties - KEY/25NOV19/01** The Energy Performance of Buildings (England and Wales) Regulations 2012 introduced the prohibition on letting privately rented domestic properties that have an Energy Performance Rating of F or G from 1 April 2018. The decision required is to authorise the use of this legislation and the level of fines imposed.	**Councillor Irene Walsh, Cabinet Member for Communities**	**March 2020**	Adults and Communities Scrutiny Committee	All Wards.	Relevant internal and external stakeholders.	Jo Bezant, PES Manager - Housing, 01733 863785, jo.bezant@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.
23.	**Decision required to approve changes to the current street lighting policy - KEY/09DEC19/01** Decision is required to approve a programme of dimming regimes to the Council's street lighting.	**Councillor Peter Hiller, Cabinet Member for Strategic Planning and Commercial Strategy and Investments**	**March 2020**	Growth, Environment and Resources Scrutiny Committee	All Wards	Relevant internal stakeholders. No formal consultation required, there will be liaison with key stakeholders such as the emergency services and disability groups.	Amy Petrie, Principal Programme and Project Officer Tel: 01733 452272 Email: amy.petrie@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.

KEY DECISION REQUIRED		*DECISION MAKER*	*DATE DECISION EXPECTED*	*RELEVANT SCRUTINY COMMITTEE*	*WARD*	*CONSULTATION*	*CONTACT DETAILS / REPORT AUTHORS*	*DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER*
24.	**Introduction of Civil Enforcement of Bus Lane and Bus Gate contraventions pursuant to the Transport Act 2000 - KEY/09DEC19/02** To ask the Cabinet Member to authorise the council to exercise its powers as an approved local authority under The Bus Lane Contraventions (Approved Local Authorities)(England) Order 2005 to issue civil penalties for breaches of Traffic regulation orders in relation to Bus Lanes or Bus Gates in Peterborough. Set the level of penalty charge payable for such an offence at £60, reduced to £30 if paid within 14 days. Join the Bus Lane Adjudication Service Joint Committee so arrangements are in place for an individual to appeal against the issue of a penalty charge notice. Authorise the use of approved devices (cameras) to carry out enforcement at sites where it is deemed necessary and the required infrastructure has been put in place.	**Councillor Irene Walsh, Cabinet Member for Communities**	**March 2020**	Growth, Environment and Resources Scrutiny Committee	All Wards	Relevant internal stakeholders. Cabinet member for Strategic Planning and Commercial Strategy and Investments will be consulted, as will members from any ward where a bus lane or bus gate is to be enforced.	Adam Payton, Senior PES Officer - Parking Lead, Tel: 01733 452314, Email: adam.payton@peterborough.gov.uk.	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.

KEY DECISION REQUIRED		*DECISION MAKER*	*DATE DECISION EXPECTED*	*RELEVANT SCRUTINY COMMITTEE*	*WARD*	*CONSULTATION*	*CONTACT DETAILS / REPORT AUTHORS*	*DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER*
25.	**To enter into a lease of 50 new houses to be used by PCC for temporary accommodation for the homeless – KEY/23DEC19/01** PCC have been investigating ways in which the numbers of leasehold properties used to accommodate the homeless could be increased due the significant costs of B & B which costs the Council £386 per room per week. There is a programme of finding property to lease on the basis of 5 year leases at local housing allowance rates which is ongoing, however the supply is relatively limited. An opportunity has arisen to 'bulk lease' fifty properties for a period of 20 years (subject to a break option after ten years) which would substantially increase the supply of accommodation in a relatively short timeframe.	**Councillor Peter Hiller, Cabinet Member for Strategic Planning and Commercial Strategy and Investments**	**March 2020**	Adults and Communities Scrutiny Committee	Dogsthorpe Ward and Gunthorpe Ward	Relevant internal and external stakeholders.	Tristram Hill, Strategic Asset Manager, Tel: 07849 079787 Email: tristram.hill@nps.co.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.

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26.	**To approve the extension for the Peterborough City Council contract for Integrated Sexual and Reproductive Health (SRH) service that is due to end on 31st March 2020 for an additional six months to 30th September 2020 – KEY/23DEC19/03** To approve the extension for the Peterborough City Council contract for Integrated Sexual and Reproductive Health (SRH) service that is due to end on 31st March 2020 for an additional six months to 30th September 2020.	**Councillor Fitzgerald, Deputy Leader and Cabinet Member for Integrated Adult Social Care and Health and Public Health;**	**March 2020**	Health Scrutiny Committee	All Wards	Not applicable but there has been a full consultation as part of the procurement process for the new service	Charlene Elliott, Sexual Health Commissioner for Peterborough and Cambridgeshire, charlene.elliott@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published
27.	**Award of Food Waste Treatment Contract – KEY/23DEC19/05** Approval of award of food waste treatment contract which has been undertaken through an OJEU procurement process.	**Councillor Marco Cereste, Cabinet Member for Waste, Street Scene and Environment;**	**March 2020**	Growth, Environment and Resources Scrutiny Committee	All wards	OJEU procurement process	Amy Nebel, Senior Waste and Recycling Officer. 01733864727, amy.nebel@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.

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28.	**Disposal of land at 7-23 London Road, Peterborough - KEY/06JAN20/01** Approval to dispose of surplus land to a registered provider for redevelopment to social housing The disposal will be conditional on a successful planning consent; the application has yet to be made.	**Councillor Peter Hiller, Cabinet Member for Strategic Planning and Commercial Strategy and Investments**	**March 2020**	Growth, Environment and Resources Scrutiny Committee	Central	Relevant internal and external stakeholders.	Tristram Hill, Strategic Asset Manager, Tel: 07956 929198 Email: tristram.hill@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. There will be an exempt annex with details of the commercial transaction.

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29.	**The disposal of former playing fields at Angus Court, Westown, Peterborough - KEY/06JAN20/02** Approval to dispose of former playing fields and Angus Court	**Councillor Peter Hiller, Cabinet Member for Strategic Planning and Commercial Strategy and Investments**	**March 2020**	Growth, Environment and Resources Scrutiny Committee	West	A number of consultation events for local residents have been held for both the proposed disposal of land at Angus Court and the creation of new facilities at Thorpe Lea Meadows. Planning approval was secured for the new facilities at Thorpe Lea Meadows. These works are now completed. Consultation and information events to discuss the Council's plans to dispose of land at Angus Court and the creation of a new public play area, were held at West Town Academy took place on 1 November 2018 and 7 March 2019	Tristram Hill, Strategic Asset Manager, Tel: 07956 929198 Email: tristram.hill@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.

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30.	**20 year Lease of 9 three bedroom properties in Walton - KEY/06JAN20/05** Agreement to lease 9 three bedroom properties to be used for temporary housing in Walton. These properties are yet to be built and subject to developer financing would be completed by January 2021	**Cabinet Member for Strategic Planning and Commercial Strategy and Investments**	**March 2020**	Adults and Communities Scrutiny Committee	Paston and Walton Ward	Relevant internal and external stakeholders	James Price, Estate Surveyor, Tel: 07733003178 Email: james.price@nps.co.uk	The decision will include an exempt annexe. By virtue of paragraph 3, information relating to the financial or business affairs of any particular person (including the authority holding that information).
31.	**Contract Award for the Provision of Children and Family Centres in Cambridgeshire and Peterborough - KEY/20JAN19/01 -** Approval to award a contract to the successful supplier following a compliant tender process	**Councillor Lynne Ayres, Cabinet Member for Children's Services and Education, Skills and University**	**March 2020**	Children and Education Scrutiny Committee	All Wards.	Relevant internal and external stakeholders.	Pam Setterfield Children's, Commissioner 07920 160394	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.
32.	**Heltwate Expansion – KEY20JAN19/03** Expansion of Heltwate Primary School	**Councillor Lynne Ayres, Cabinet Member for Children's Services and Education, Skills and University**	**July 2020**	Councillor Lynne Ayres, Cabinet Member for Children's Services and Education, Skills and University	Bretton	Public Consultation to be held March 2020 prior to planning submission in April 2020	Sharon Bishop, Capital Projects and Assets Officer, 01733 863997, sharon.bishop@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.

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33.	**Review of Fixed Penalty Notice Charging – KEY/20JAN19/04** Peterborough's PSPO (Public Spaces Protection Order) areas have now been in place for two years. When PCC began levying FPN's via Kingdom Ltd. it was decided to implement a limited discounted payment period. Currently via Kingdom Ltd. an offense incurs a financial penalty of £80.00. The proposal is to raise this to £100.00 which will end the discount period and align Peterborough with other local authorities. The financial aspect of the rationale agreed for bringing environmental enforcement in house has been predicated on fines of £100.00	**Councillor Irene Walsh, Cabinet Member for Communities**	**March 2020**	Adults and Communities Scrutiny Committee	All Wards	Relevant internal and external stakeholders.	Clair George, Head of Prevention and Enforcement Service, 07920 160733, clair.george@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.

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34.	**Refurbishments to a Peterborough City Council owned building – KEY/17JAN20/01** The decision is to proceed with refurbishments to a PCC owned building; this building was previously Ofsted Registered as a Children's Home providing Short Breaks/Respite to children and young people with disabilities and complex needs. The in-house provision was re-designated in November 2018. The premises will now be redeveloped to enable single occupancy residency for a child/young person. This item has been added to the Forward Plan so we are able to proceed with the plans, if/when funding is received from NHSE. The procurement, and the works, need to progress as expediently as possible to allow transition of the child/young person into a residence which has been specifically designed to meet need.	**Councillor Lynne Ayres, Cabinet Member for Children's Services and Education, Skills and University**	**March 2020**	Children and Education Scrutiny Committee	Dogsthorpe	Relevant internal and external stakeholders. As a formal tender process has not commenced, a formal consultation with the nearby residents has not yet been undertaken.	Zoe Redfern-Nichols, Commissioner - Zoe.Redfern-Nichols@peterborough.gov.uk 07583 040523	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.

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35.	**A605 Whittlesey Access Phase 2 - Stanground Access: Contract exemption for Cadent Gas works – KEY/17JAN20/02** Following a CMDN to approve the budget for the A605 Whittlesey Access Phase 2 - Stanground Access highway scheme (DEC19/CMDN/63); a further CMDN is required to seek an exemption from the Council's contract rules to contract with Cadent Gas in order for them to undertake essential works associated with the highway scheme.	**Councillor Peter Hiller, Cabinet Member for Strategic Planning and Commercial Strategy and Investments**	**March 2020**	Growth, Environment and Resources Scrutiny Committee	Stanground South	Relevant internal and external stakeholders. Appropriate level consultation will take place with all relevant stakeholders. This will take place alongside Skanska to ensure consultation details align with delivery programmes and final design details	Lewis Banks, Principal Sustainable Transport Planning Officer, 01733 317465, lewis.banks@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. A605 Whittlesey Access Phase 2 - Stanground Access - DEC19/CMDN/63 - https://democracy.peterborough.gov.uk/ieDecisionDetails.aspx?ID=1680

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36.	**Recommendation to approve the local transport plan programme of capital works for 2020/21 - 2022/23 – KEY/17JAN20/03** The programme of capital works includes: Integrated Transport Programme (small to medium highway improvement works), Highway Maintenance Programme, Street Lighting Maintenance Programme, and Bridge Maintenance Programme.	**Councillor Peter Hiller, Cabinet Member for Strategic Planning and Commercial Strategy and Investments**	**March 2020**	Growth, Environment and Resources	All wards	Relevant internal and external stakeholders. A briefing note will be submitted for consideration to the Growth, Environment and Resources Scrutiny Committee before 1 April 2020 along with the proposed programmes of works. Appropriate consultation will be undertaken on individual schemes in the programme as required.	Lewis Banks, Principal Sustainable Transport Planning Officer, 01733 317465, lewis.banks@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.
37.	**Approval for spend of Concessionary Fares Budget 2020/21 - KEY/2MAR20/01 -** PCC has a statutory duty to reimburse bus operators in accordance with the national concessionary fare bus pass scheme. Each time a bus pass is used on a bus, PCC must reimburse the operator for this, at an agreed rate.	**Councillor Peter Hiller, Cabinet Member For Strategic Planning And Commercial Strategy And Investments**	**March 2020**	Growth, Environment and Resources Scrutiny Committee	All	N/A	Andy Bryan, Passenger Transport Officer, Email: Andrew.Bryan@Peterborough.Gov.Uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.

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38.	**Section 75 agreement between PCC and the CCG for commissioning of health and social care services under the Better Care Fund (BCF) 2019-2020 - KEY/2MAR20/02** An updated and amended agreement is necessary to reflect key changes to the Better Care Fund in 2019-20, including The financial effect of the extended Section 75 Agreement will be an increased contribution into the pooled fund from Peterborough City Council of an additional £4,027,686 in 2017/18 and £5,548,853 in 2018/19	**Councillor Fitzgerald, Deputy Leader and Cabinet Member for Integrated Adult Social Care and Health and Public Health**	**March 2020**	Health Scrutiny Committee	All	In the developing and drafting of the bcf plan, there were detailed discussions and workshops with system partners to create the vision, goal, objectives and scope of the strategic level plan and the specific delivery projects/schemes.	Graeme Hodgson, Commissioner, Graeme.hodgson@cambridgeshire.gov.uk 07448 379944	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. 1. CMDN BCF 17-19; 2. Better Care Fund Plan 2017-19; 3. Better Care Fund Plan 2019-20

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39.	**Review and re-implementation of the City Centre Public Spaces Protection Order - KEY/2MAR20/03** The current PSPO for the City Centre expires in April 2020. Orders can be extended for a further 3 years provided that they are reviewed and extended prior to the order expiring. This decision request will consider the enforcement levels of the current order carried out in the last 3 years, current crime and anti-social behaviour levels for the order area and the outcomes of the consultation with the public and interested parties.	**Councillor Irene Walsh, Cabinet Member for Communities**	**March 2020**	Adults and Communities Scrutiny Committee	Central	A consultation will be carried out with the Police & Crime Commissioner, Chief Constable, Ward Councillors, Key Interested Parties directly. A 28 day public consultation will be made available to the public and all other interested parties online on the council's website, with hard copies available on request.	Laura Kelsey, Senior Prevention & Enforcement Officer, Tel: 01733 453563, Email: laura.kelsey@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. Cabinet Member Decision Notice. No exempt documents anticipated.

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40.	**Amendment to Loan Facility - KEY/2MAR20/04 -** A decision is required to amend the terms of an existing loan facility	**Councillor David Seaton, Cabinet Member for Finance**	**March 2020**	Growth, Environment and Resources Scrutiny Committee	All Ward	Detailed consultation was undertaken in the original decision to offer the loan facility.	Peter Carpenter, Acting Corporate Director of Resources. Email: peter.carpenter@peterborough.gov.uk Tel: 07920160122	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. The decision will include an exempt annexe. By virtue of paragraph 3, information relating to the financial or business affairs of any particular person (including the authority holding that information).

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41.	**Award of Utility Contracts (Gas, Electricity, HH and NHH) to either suppliers under the ESPO or CCS Frameworks – KEY/16MAR20/01** The Council has currently got contracts under the CCS Framework with EDF (Electricity HH, NHH) and Corona Energy (Gas). The contracts expire on 31st March 2020. In order not to incur additional unnecessary budget pressures on the utility budget a decision is required to award a contract to a supplier under the ESPO or CCS Frameworks. A cost comparison is currently being undertaken and a decision is expected to be made shortly after.	**Councillor Seaton, Cabinet Member for Finance**	**March 2020**	Growth, Environment and Resources Scrutiny Committee	All Wards	Relevant internal and external stakeholders.	Andy Cox, Senior Contracts and Partnerships Manager, 01733 452465, andy.cox@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.
42.	**Lyons Gardens (Hereward Care Services Ltd) 12-month contract – KEY/16MAR20/02** Agreement sought for a 12 month contract with Hereward Care Services Ltd to continue to provide respite services (Lyons Gardens) for adults with a Learning Disability. The overall cost for the contract £787,000.00 with 50% funded by the CCG.	**Councillor Fitzgerald, Deputy Leader and Cabinet Member for Integrated Adult Social Care and Health and Public Health**	**March 2020**	Adults and Communities Scrutiny Committee	All Wards	Relevant internal and external stakeholders Relevant meetings between the CCG, Commissioners and Operational colleagues continue to occur to look at reshaping the future of the service.	Cris Green, Commissioner for Learning Disabilities & Autism, 07932612266419, cris.green@peterborough.gov.uk	Legal Advice

PART 2 – NOTICE OF INTENTION TO TAKE DECISIONS IN PRIVATE

KEY DECISIONS TO BE TAKEN IN PRIVATE

KEY DECISION REQUIRED	*DECISION MAKER*	*DATE DECISION EXPECTED*	*RELEVANT SCRUTINY COMMITTEE*	*WARD*	*CONSULTATION*	*CONTACT DETAILS / REPORT AUTHORS*	*DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER*
Peterborough Investment Partnership LLP	**Shareholder Cabinet Committee**	**2 March 2020**	Growth, Environment and Resources	All	Relevant internal and external stakeholders	Steve Cox Executive Director, Place Economy Email: steve.cox@peterborough.gov.uk	The decision will include an exempt annexe. By virtue of paragraph 3, information relating to the financial or business affairs of any particular person (including the authority holding that information).

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Aragon Direct Services	**Shareholder Cabinet Committee**	**2020**	Growth, Environment and Resources	All	Relevant internal and external stakeholders	James Collingridge, Head of Environmental Partnerships, Tel: 01733 864736 Email: james.collingridge@peterborough.gov.uk	The decision will include an exempt annexe. By virtue of paragraph 3, information relating to the financial or business affairs of any particular person (including the authority holding that information).
Embankment, University Site - KEY/30MAR20/03 - To enter a Subscription and Project Management Agreement with the Combined Authority	**Cabinet**	**30 March 2020**	Growth, Environment and Resources Scrutiny Committee	Central	Relevant internal and external stakeholders	Dave Anderson , Interim Development Director Email: dave.anderson@peterborough.gov.uk Tel: 07810 839 657	The decision will include an exempt annexe. By virtue of paragraph 3, information relating to the financial or business affairs of any particular person (including the authority holding that information).

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North Westgate Development - KEY/30MAR20/04 - Collaboration Agreement	**Cabinet**	**30 March 2020**	Growth, Environment and Resources Scrutiny Committee	Central	Relevant internal and external stakeholders	Dave Anderson , Interim Development Director Email: dave.anderson@peterborough.gov.uk Tel: 07810 839 657	The decision will include an exempt annexe. By virtue of paragraph 3, information relating to the financial or business affairs of any particular person (including the authority holding that information).

PART 3 – NOTIFICATION OF NON-KEY DECISIONS

NON-KEY DECISIONS							
DECISION REQUIRED	***DECISION MAKER***	***DATE DECISION EXPECTED***	***RELEVANT SCRUTINY COMMITTEE***	***WARD***	***CONSULTATION***	***CONTACT DETAILS / REPORT AUTHORS***	***DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER INCLUDING EXEMPT APPENDICES AND REASONS FOR EXEMPTION***
No new items.							

PREVIOUSLY ADVERTISED DECISIONS								
DECISION REQUIRED		***DECISION MAKER***	***DATE DECISION EXPECTED***	***RELEVANT SCRUTINY COMMITTEE***	***WARD***	***CONSULTATION***	***CONTACT DETAILS / REPORT AUTHORS***	***DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER INCLUDING EXEMPT APPENDICES AND REASONS FOR EXEMPTION***
1.	**A Lengthmans to be deployed on Lincoln Road Millfield -** There will be a daily presence along Lincoln Road, the operative will litter pick, empty bins as well as report fly-tips and other environmental issues.	**Councillor Cereste, Cabinet Member for Waste, Street Scene and Environment**	**March 2020**	Growth, Environment & Resources Scrutiny Committee	Central Ward	Relevant internal and external stakeholders. Cross party task and finish group report which went to the Growth, Environment and Resources Scrutiny Committee and it was also approved at Full Council as part of the 2017-18 Budget.	James Collingridge, Head of Environmental Partnerships, Tel: 01733 864736 Email: james.collingridge@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.
2.	**Approval of Additional Powers to the Combined Authority (Transfer of Powers) -** Approve additional powers for the Combined Authority via a Statutory Instrument for Adult Skills Commissioning.	**Councillor Holdich, Leader of the Council and Deputy Mayor of the Cambridgeshire and Peterborough Combined Authority**	**March 2020**	Growth, Environment and Resources Scrutiny Committee	All	All Councils in Peterborough and Cambridgeshire have to agree to the transfer	Peter Carpenter, Acting Corporate Director, Resources Tel: 07920160122 Email: Peter.carpenter@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. Combined Authority Statutory Instrument Request

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3.	**Disposal of former Barnack Primary School caretaker house -** Delegate authority to the Corporate Director of Growth and Regeneration to dispose of the property.	**Councillor Seaton, Cabinet Member for Finance**	**March 2020**	Growth, Environment & Resources Scrutiny Committee	N\A	Relevant internal and external stakeholders.	Stuart Macdonald, Property Manager. Tel: 07715 802 489. Email: stuart.macdonald @peterborough.gov.uk Bill Tilah (Bill.Tilah@nps.co.uk)	It is not anticipated that there will be any documents other than the report and relevant appendices to be published. **The decision will include an exempt annexe. By virtue of paragraph 3, information relating to the financial or business affairs of any particular person (including the authority holding that information).**

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4.	**Amendment to Environmental Enforcement Contact -** Amendment is required to the current environmental enforcement contract	**Councillor Irene Walsh, Cabinet Member for Communities**	**March 2020**	Adults and Communities Scrutiny Committee	N/A	Relevant internal and external stakeholders	Clair George Acting Head of Service - Prevention and Enforcement Service Tel: 01733 453576 Email: clair.georgepes@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.
5.	**Approval of the leasehold disposal of a brownfield site to a care provider –** A site has been found for a care home and the Council are currently looking into a leasehold disposal to a care provider who will build a care facility and then contract to provide services to the Council.	**Councillor Peter Hiller, Cabinet Member for Strategic Planning and Commercial Strategy and Investments**	**March 2020**	Growth, Environment and Resources Scrutiny Committee	Park Ward	Relevant internal and external stakeholders. A forum has been set up by the Combined Authority involving representatives from finance, legal, property and social care.	Tristram Hill - Strategic Asset Manager, 07849 079787, tristram.hill@nps.co.uk	The decision will include an exempt annexe. By virtue of paragraph 3, information relating to the financial or business affairs of any particular person (including the authority holding that information).

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6.	**Approval of Funding for the BID project -** To approve the provision of funding for the BID project	**Councillor Seaton, Cabinet Member for Finance**	**March 2020**	Growth, Environment and Resources Scrutiny Committee	Central Ward	No formal consultation has been done, a programme of business consultation is planned to take place	Jay Wheeler, Economic Development Manger and Dave Anderson Interim Development Director Tel: 01733 452468 Email: dave.anderson@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.
7.	**Modern Slavery Statement** To review and agree for publication an updated Statement in compliance with the Modern Slavery Act 2015.	**Cabinet**	**30 March 2020**	Adults and Communities Scrutiny Committee	All wards	Relevant internal and external stakeholders.	Rob Hill, Assistant Director: Public Protection, rob.hill@peterborough.gov.uk Amy Brown, Senior Lawyer and Deputy Monitoring Officer, Amy.brown@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.

DECISION REQUIRED		*DECISION MAKER*	*DATE DECISION EXPECTED*	*RELEVANT SCRUTINY COMMITTEE*	*WARD*	*CONSULTATION*	*CONTACT DETAILS / REPORT AUTHORS*	*DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER INCLUDING EXEMPT APPENDICES AND REASONS FOR EXEMPTION*
8.	**Peterborough Limited Articles of Association –** To alter Peterborough Limited's Articles of Association, and to delegate the power under the Articles.	**Cabinet**	**30 March 2020**	Growth, Environment and Resources Scrutiny Committee	All wards	Relevant internal and external stakeholders.	James Collingridge, Head of Environmental Partnerships, 01733864376, james.collingride@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published
9.	**Approval to enter into a Section 256 agreement with Cambridgeshire and Peterborough's Clinical Commissioning Group -** Approval to enter into a Section 256 agreement with Cambridgeshire and Peterborough Clinical Commissioning Group, for receipt of funding to deliver health and wellbeing support to children and young people and their families	**Councillor Lynne Ayres, Cabinet Member for Children's Services and Education, Skills and University**	**March 2020**	Children and Education Scrutiny Committee	All	Relevant internal and external stakeholders	Pam Setterfield, Children and Families Commissioner, Tel 07920 160394, Email: pam.setterfield@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.

DECISION REQUIRED		*DECISION MAKER*	*DATE DECISION EXPECTED*	*RELEVANT SCRUTINY COMMITTEE*	*WARD*	*CONSULTATION*	*CONTACT DETAILS / REPORT AUTHORS*	*DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER INCLUDING EXEMPT APPENDICES AND REASONS FOR EXEMPTION*
10.	**To authorise the Council to enter into a Section 76 agreement with Cambridgeshire and Peterborough Clinical Commissioning Group -** To authorise the Council to enter into a Section 76 agreement with Cambridgeshire and Peterborough Clinical Commissioning Group, relating to financial contribution to the Speech and Language Services.	**Councillor Lynne Ayres, Cabinet Member for Children's Services and Education, Skills and University**	**April 2020**	Children and Education Scrutiny Committee	All	Relevant internal and external stakeholders	Pam Setterfield, Children and Families Commissioner, Tel 07920 160394, Email: pam.setterfield@peterborough.gov.uk	It is not anticipated that there will be any documents other than the report and relevant appendices to be published.

PART 4 – NOTIFICATION OF KEY DECISIONS TAKEN UNDER URGENCY PROCEDURES

DECISION REQUIRED	*DECISION MAKER*	*DATE DECISION EXPECTED*	*RELEVANT SCRUTINY COMMITTEE*	*WARD*	*CONSULTATION*	*CONTACT DETAILS / REPORT AUTHORS*	*DOCUMENTS RELEVANT TO THE DECISION SUBMITTED TO THE DECISION MAKER INCLUDING EXEMPT APPENDICES AND REASONS FOR EXEMPTION*
None.							

DIRECTORATE RESPONSIBILITIES

RESOURCES DEPARTMENT Sand Martin House, Bittern Way, Fletton Quays, Peterborough, PE2 8TY

City Services and Communications (Markets and Street Trading, City Centre Management including Events, Regulatory Services, Parking Services, Vivacity Contract, CCTV and Out of Hours Calls, Marketing and Communications, Tourism and Bus Station, Resilience)
Strategic Finance
Internal Audit
Schools Infrastructure (Assets and School Place Planning)
Waste and Energy
Strategic Client Services (Enterprise Peterborough / Vivacity / SERCO including Customer Services, ICT and Business Support)
Corporate Property

PEOPLE AND COMMUNITIES DEPARTMENT Sand Martin House, Bittern Way, Fletton Quays, Peterborough, PE2 8TY

Adult Services and Communities (Adult Social Care Operations, Adult Social Care and Quality Assurance, Adult Social Care Commissioning, Early Help – Adults, Children and Families, Housing and Health Improvement, Community and Safety Services, Offender Services)
Children's Services and Safeguarding (Children's Social Care Operations, Children's Social Care Quality Assurance, Safeguarding Boards – Adults and Children's, Child Health, Clare Lodge (Operations), Access to Resources)
Education, People Resources and Corporate Property (Special Educational Needs and Inclusion, School Improvement, City College Peterborough, Pupil Referral Units, Schools Infrastructure)
Business Management and Commercial Operations (Commissioning, Recruitment and Retention, Clare Lodge (Commercial), Early Years and Quality Improvement)
Performance and Information (Performance Management, Systems Support Team)

LAW AND GOVERNANCE DEPARTMENT Sand Martin House, Bittern Way, Fletton Quays, Peterborough, PE2 8TY

Democratic Services (Town Hall, Bridge Street, Peterborough, PE1 1HG)
Electoral Services **(**Town Hall, Bridge Street, Peterborough, PE1 1HG)
Human Resources (Business Relations, HR Policy and Rewards, Training and Development, Occupational Health and Workforce Development)
Information Governance, (Coroner's Office, Freedom of Information and Data Protection)

PLACE AND ECONOMY DEPARTMENT Sand Martin House, Bittern Way, Fletton Quays, Peterborough, PE2 8TY

Development and Construction (Development Management, Planning Compliance, Building Control)
Sustainable Growth Strategy (Strategic Planning, Housing Strategy and Affordable Housing, Climate Change and Environment Capital, Natural and Built Environment)
Opportunity Peterborough
Peterborough Highway Services (Network Management, Highways Maintenance, Street Naming and Numbering, Street Lighting, Design and Adoption of Roads, Drainage and Flood Risk Management, Transport Policy and Sustainable Transport, Public Transport)

PUBLIC HEALTH DEPARTMENT Sand Martin House, Bittern Way, Fletton Quays, Peterborough, PE2 8TY
Health Protection, Health Improvements, Healthcare Public Health.

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