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

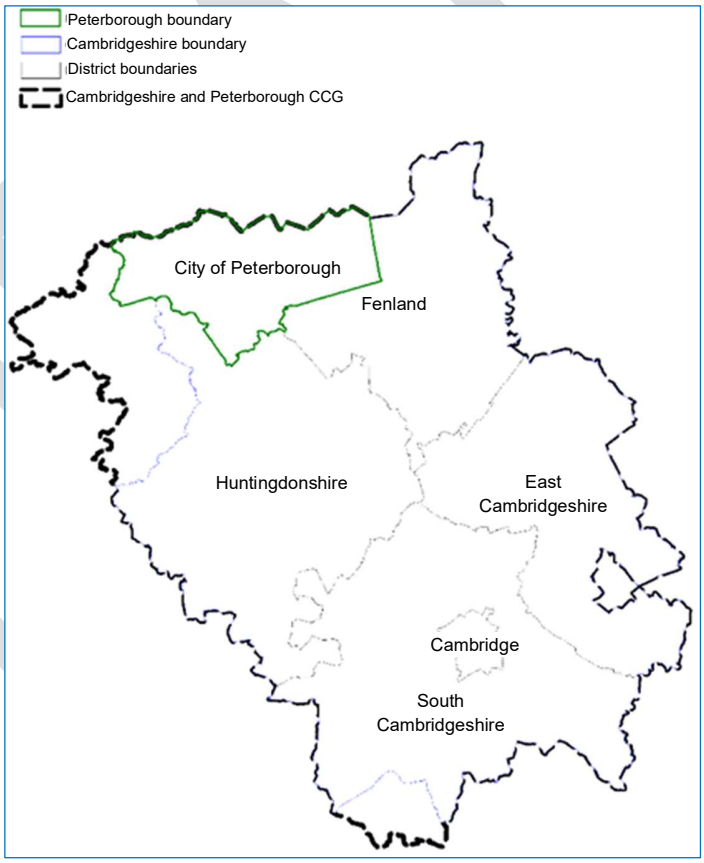
Chapter 1: Who we are

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

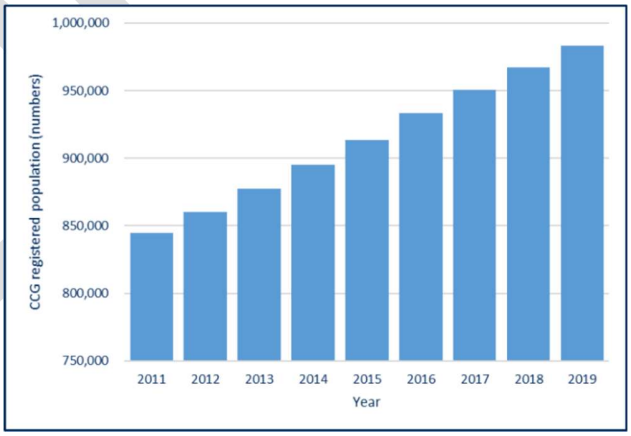


24. We have a population of over 980,000 patients[5]. Thriving industry means that this is increasing rapidly, putting pressure on housing availability, transport links and a range of public services. The rate of growth is highest for older people, placing particular pressure on health and care services. 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].

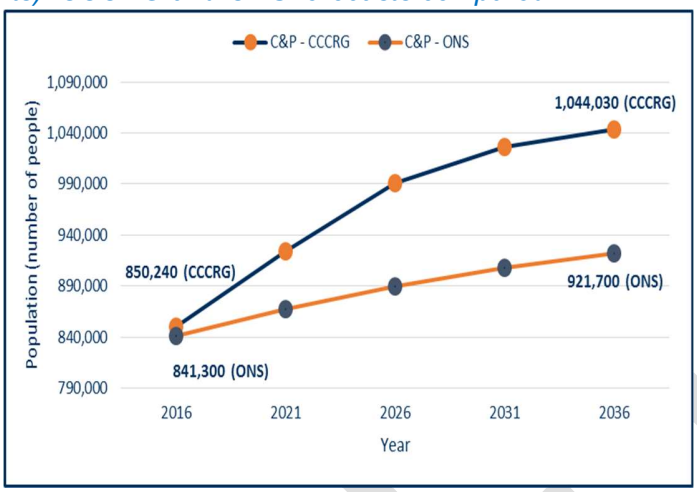
26. The local Cambridgeshire County Council Research Group (CCCRG), which forecasts population growth based on known housing developments, predicts that our population will be approximately 1,022,000 by 2021. This is 30,000 higher than the Office for National Statistics (ONS) prediction for the same 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.

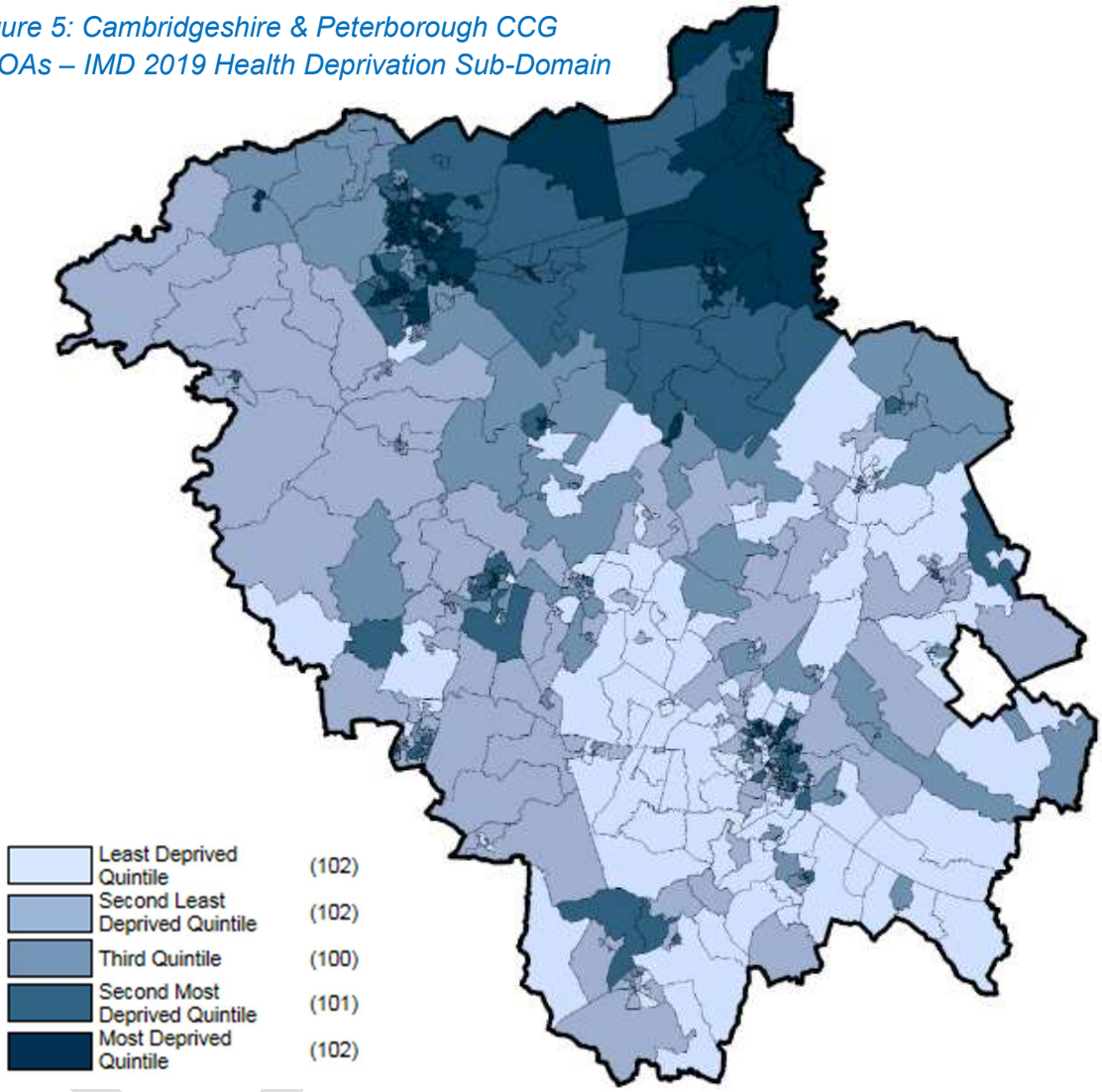
Indicator	Local Authority					
	Peterborough	Cambridge	East Cambridgeshire	Fenland	Huntingdonshire	South Cambridgeshire
Overall local authority rank	53	245	266	51	247	300
Income deprivation domain rank	59	245	259	56	250	302
Employment deprivation domain rank	73	270	274	54	245	304
Education, skills and 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].

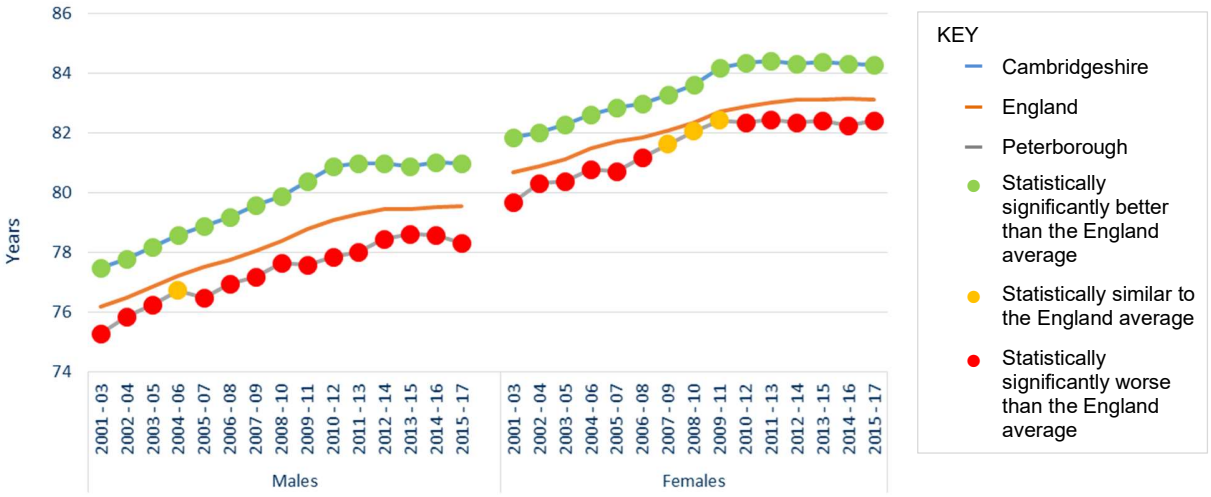
Figure 5: Cambridgeshire & Peterborough CCG LSOAs – IMD 2019 Health Deprivation Sub-Domain



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