HEALTH AND WELLBEING BOARD

TUESDAY 25 FEBRUARY 2020
10.00 AM

Council Chamber - Town Hall
Contact – Daniel.kalley@peterborough.gov.uk, 01733 296334

AGENDA

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Board Members:

Cllr J Holdich (Chairman), Dr G Howsam (Vice Chairman), V Moore, H Daniels, W Fitzgerald, W Ogle-Welbourn, L Robin, S Qayyum, I Walsh, J Bawden and Z Trent

Co-opted Members: Russell Wate and Claire Higgins

Substitute:

Further information about this meeting can be obtained from on telephone 01733 296334 or by email – daniel.kalley@peterborough.gov.uk

PETERBOROUGH CITY COUNCIL

MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING
HELD AT 1.00PM, ON
24 JUNE 2019
BOURGES/VIERSEN ROOM, PETERBOROUGH

Committee Members Present: Councillor Fitzgerald, (Chairman) Deputy Leader, Cabinet Member for Integrated Adult Social Care and Health
Councillor Walsh, Cabinet Member for Communities
Councillor Shabina Qayyum
Dr Liz Robin, Director for Public Health
Wendi Ogle-Welbourn, Executive Director People and Communities
Val Moore, Chair Cambridgeshire and Peterborough Healthwatch
Hilary Daniels, NHS South Lincolnshire CCG
Jessica Bawden, Director of External Affairs & Policy, Cambridgeshire & Peterborough Clinical Commissioning Group
Dr Anan Tariq

Officers Present: Caroline Townsend, Head of Commissioning Partnerships and Programmes
Alison Mayen, Social Worker
Iain Green, Senior Public Health manager, Environment and Planning
Ian Phillips, Head of Community and Safety Integration
Nikitta Vanterpool, Senior Transformation Adviser
Stuart Keeble, Consultant in Public Health
Pratigya Balaji, Senior Public Health Manager
Paulina Ford Senior Democratic Services Officer

1. ELECTION OF CHAIRPERSON

In the absence of the Chairman and Vice Chairman who had both submitted apologies for the meeting the Senior Democratic Services Officer sought nominations for a Chairman for the meeting. Councillor Walsh seconded by Dr Robin nominated Councillor Fitzgerald. There being no further nominations Councillor Fitzgerald was appointed as Chairman.

2. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Holdich, Dr Howsam, Russell Wate and Zephan Trent. Dr Adnan Tariq was in attendance as substitute for Dr Howsam.

3. DECLARATIONS OF INTEREST BY MEMBERS OF THE PETERBOROUGH HEALTH AND WELLBEING BOARD

Item 8. Annual Health Protection Report, Cambridgeshire and Peterborough 2018

Jessica Bawden declared an interest in that she was a member of the Cambridgeshire and Peterborough Combined Authority Board.

4. MINUTES OF THE PETERBOROUGH HEALTH AND WELLBEING BOARD MEETING HELD ON 28 MARCH 2019

The minutes of the meeting held on 28 March 2019 were agreed as a true and accurate record subject to the following correction. Hillary Daniels title had been listed incorrectly and wished it noted that her title should be listed as the NHS Representative South Lincolnshire CCG.

5. SEND PEER REVIEW FINDINGS

The report was introduced by the Executive Director, People and Communities. The purpose of the report was to provide the Board with an update on the delivery of the Local Government Association (LGA) Peterborough Special Educational Needs and Disabilities (SEND) Peer Review held in October 2018.

The Health and Wellbeing Board debated the report and in summary the key points raised and responses to questions included:

- Board Members were informed that Peterborough City Council had invited the Local Government Association (LGA) into the area to look at where the council was in terms of its progress with SEND since the 2014 reforms and to assist the area in preparing for an imminent Ofsted/Care Quality Commission inspection.
- This had not been a review of the local authority but of the way in which the local area: health, social care, education (including schools and settings) and other partners like voluntary groups, were working together to support children and young people with SEND and achieve independent, happy and fulfilled lives from the earliest years.
- One of the key themes explored was how children and young people who had special educational needs and/or disabilities were identified. It was acknowledged that a good amount of progress had been made and in particular with regard to pre-birth to 5 years and this was continuing to improve. The Best Start in Life Strategy which was in its early days had contributed to this.
- The report acknowledged that by working together processes had been refined and there was now a robust governance structure in place which included a SEND Partnership Board and a Joint Commissioning Unit SEND Group which provided oversight. SEND priorities and outcomes were now featured in local authority service plans.

The Peterborough Health and Wellbeing Board **RESOLVED** to note the report and consider the content and raise any questions.

6. SCHEME OF AUTHORISATIONS FOR NHS ENGLAND PHARMACY APPLICATIONS

The Senior Public Health Manager introduced the report. The purpose of the report was to request that the Board delegate responsibility to the Director of Public Health, in consultation with the Chairman/Vice Chairman for responding to notifications of pharmacy consolidations on behalf of the Health and Wellbeing Board, in order for the Board to fulfil its statutory duties.

The Peterborough Health and Wellbeing Board **RESOLVED** to:

1. Note the statutory duty of the Health and Wellbeing Board to respond to "Excepted Applications" termed a "Consolidated Application", and
2. Agreed to delegate authority to the Director of Public Health in consultation with the Chairman/Vice Chairman to respond to notifications from NHS England of "Excepted Applications" termed a "Consolidated Application" on behalf of the Board.

7. CREATION OF JOINT HWB BOARD SUB-COMMITTEE WITH CAMBRIDGESHIRE COUNTY COUNCIL

7a. FEEDBACK FROM THE JOINT DEVELOPMENT SESSION WITH PETERBOROUGH AND CAMBRIDGESHIRE HEALTH AND WELLBEING BOARDS

The report was introduced by the Director of Public Health and provided the Board with an update from the joint development session with Peterborough and Cambridgeshire Health and Wellbeing Boards held on 28 March 2019.

The Health and Wellbeing Board debated the report and in summary key points raised and responses to questions included:

- The development session had been facilitated by representatives from the Local Government Association (LGA) with the purpose of assisting members of the Boards to:
    - Understand the statutory role of the HWB Board.
    - Understand what the Joint Strategic Needs Assessment says about the health and wellbeing of Peterborough and Cambridgeshire residents.
    - Develop a joint vision for health and wellbeing
    - Understand how the organisational relationships operate in a complex system
- The Board supported the approach taken and noted the contents of the report.

The Peterborough Health and Wellbeing Board **RESOLVED** to note and comment on the content of the HWBB Joint Development session update report.

7b. PROPOSAL TO UPDATE THE TERMS OF REFERENCE FOR THE PETERBOROUGH HEALTH AND WELLBEING BOARD AND TO CREATE TWO JOINT SUB-COMMITTEE WITH THE CAMBRIDGESHIRE BOARD

The Director of Public Health introduced the report the purpose of which was to present the Board with a proposal to create two joint sub-committees of the Peterborough Health and Wellbeing Board and the Cambridgeshire Health and Wellbeing Board, a 'Whole System' Joint Sub-Committee and a 'Core' Joint Sub-Committee. It also proposed to amend the terms of reference of both the Peterborough and the Cambridgeshire Health and Wellbeing Boards so that they were aligned, which would then allow clear delegation of functions to the two Sub-Committees. The Health and Wellbeing Board was asked to endorse the proposals and the updated terms of reference which would then need to be referred to full Council for approval.

The Health and Wellbeing Board debated the report and in summary key points raised and responses to questions included:

- It was anticipated that the Whole System Joint Sub Committee would meet twice a year, the Core System Joint Sub Committee would meet four times a year and the individual HWBB's would meet two or more times a year depending on their work programme.
- It was recognised that sometimes the same report topics affected both the Cambridgeshire HWBB and the Peterborough HWBB and therefore the Whole System Joint Sub Committee was a practical solution in these instances.
- Creation of a 'Core' Joint Sub-Committee of the Health and Wellbeing Boards would enable joint commissioning. It would also assist Better Care Fund planning across Peterborough City Council, Cambridgeshire County Council and the Cambridgeshire and Peterborough Clinical Commissioning Group to be driven forward more effectively and efficiently, by providing a high level forum to provide strategic direction and un-block issues which are preventing progress.
- Members of the Board sought clarification as to where the outcomes and debate regarding the Better Care Fund sat. The Board were informed that the Better Care Fund would be monitored by the Integrated Commissioning Board which was chaired by the Chair of Cambridgeshire and Peterborough Healthwatch who would report back to the Whole System Joint Sub Committee.
- Members of the Board were concerned that reports that were being presented to the HWBB had not shown the impact on patients. The Executive Director, People and Communities suggested that reports being presented to the HWBB should also go to the Integrated Commissioning Board.

The Peterborough Health and Wellbeing Board **RESOLVED** to:

1. Endorse the updated terms of reference for the Peterborough Health and Wellbeing Board and for the two new Joint Sub-Committees with the Cambridgeshire Health and Wellbeing Board and referred them to full Council for agreement subject to the following amendment:

    - Paragraph 2.8.3.12 of the Peterborough Health and Wellbeing Board Terms of Reference to be added to the Cambridgeshire and Peterborough Health and Wellbeing Board Core Joint Sub-Committee Terms of Reference and to replace the following paragraph:

      "*To keep under consideration, the financial and organisational implications of joint and integrated working across health and social care services across Cambridgeshire and Peterborough, and to make recommendations for ensuring that performance and quality standards for health and social care services to children, families and adults are met and represent value for money across the whole system."*

2. Review the functioning and effectiveness of the Joint Sub-Committees after one year

8. ANNUAL HEALTH PROTECTION REPORT, CAMBRIDESHIRE AND PETERBOROUGH

The report was introduced by a Consultant in Public Health. The purpose of the report was to provide an update on all key areas of health protection for Peterborough which included the following services:

- Communicable diseases – their prevention and management;
- Infection control;

- Routine antenatal, newborn, young person and adult screening programmes;
- Routine immunisation programmes;
- Sexual health;
- Environmental hazards; and
- Planning for public health emergencies.

The Health and Wellbeing Board debated the report and in summary key points raised and responses to questions included:

- This was the first joint Cambridgeshire and Peterborough Annual Health Protection Report.
- TB continued to be a priority for the Health Protection Steering Group.
- Cervical screening continued to have lower than acceptable uptake in Peterborough at 72% which could be improved. There was a better uptake in older women than in younger women. Public Health England had launched a 'Cervical Screening Saves Lives' campaign in March 2019 which was hoped would help to increase uptake. It was however a national issue and not just Peterborough. There had also been some targeted work with ethnic minority communities.
- Immunisation uptake was lower than needed in some programmes, including the pre-school vaccinations which was a national issue. A focus group was currently being run to try and understand the reasons for the lower uptake. The outcome would provide a better understanding of what the issues were so that they could be addressed. The World Health Organisation had also run a 'World Immunization Week' Campaign during the last week of April which aimed to promote the use of vaccines to protect people of all ages against disease. This was being promoted via social media.
- Board members referred to TABLE 26: Shingles vaccination, aged 70 & 78, Cambridgeshire & Peterborough, uptake July 2018 and wanted to know if the percentage of 46.3% of 70 year olds and 49.0% of 78 year olds who had received the vaccine since 2013 was correct. It was unclear if people knew that the singles vaccination was available and the low uptake since 2013 was worrying. The Director of Public Health advised that further enquiries would be made to establish if the figures were correct. The low uptake had been acknowledged and 70th birthday cards were being sent out with a reminder for the shingles vaccination.
- Board members noted that sexual health services access rates were lower in Peterborough than in Cambridgeshire and sought clarification as to whether there had been a change in service provision in Peterborough. The Director of Public Health advised when the clinic moved from the hospital to the city centre the demand went up for testing and contraceptive services. The activity increase in Peterborough has contributed to a decrease in the percentage of patients being offered and accessing the sexual health services within 48 hours to around 70% on average for both measures. Measures have been taken to address the increase in activity. From October 2018 there were six clinic closures but also additional ongoing funding was secured from Peterborough City Council to address the increase in demand that had created substantial funding issues for the provider. In addition the contractual key performance indicators for the access targets were changed from being a contractual mandatory requirement to a reporting requirement. This would be reviewed regularly.
- The top three priorities for Public Health were: TB Screening and assessment, childhood immunisation and cervical screening.

The Peterborough Health and Wellbeing Board **RESOLVED** to:

1. Note the contents of the Annual Health Protection Report and comment on future priorities for health protection in Peterborough, and

2. Requested that the Director of Public Health confirm if the 46.3% of 70 year olds and 49.0% of 78 year olds who had received the shingles vaccine since 2013 as stated in TABLE 26: Shingles vaccination, aged 70 & 78, Cambridgeshire & Peterborough, uptake July 2018 was correct.

9a. PETERBOROUGH HEALTH & WELLBEING STRATEGY 2016-19 FINAL ANNUAL REVIEW, JUNE 2019

The report was introduced by the Director for Public Health and provided the Board with an annual summary of progress against statistical targets and goals agreed by the Board on commencement of its 2016-19 Health & Wellbeing Strategy. The Board mandated that indicators and associated performance narratives be compiled at regular intervals for 11 key areas as noted below and the report summarised how health & wellbeing outcomes had developed in Peterborough over the course of the 2016-19 period.

Peterborough Health & Wellbeing Strategy 2016-19 themes:

a) children & young people's health
b) health behaviours & lifestyles
c) long term conditions & premature mortality
d) mental health for adults of working age
e) health & wellbeing of people with disability and/or sensory impairment
f) ageing well
g) protecting health
h) growth, health & the local plan
i) health & transport planning
j) tackling health inequalities
k) health & wellbeing of diverse communities

The Health and Wellbeing Board debated the report and in summary key points raised and responses to questions included:

- It was noted that the decline in cervical screening coverage appeared to have levelled off but was still below acceptable level.
- A number of childhood vaccination programmes were below optimal uptake rates and NHS England and NHS Improvement and the Council were working in partnership to address this, which included working with GP practices.
- NHS England and NHS Improvement had extended their project working with participating GP practices to improve uptake of the shingles vaccination.
- Members of the Board raised concern about inequalities and life expectancy. The disparity in life expectancy between the 80% of people living in the least deprived areas and the 20% living in the most deprived areas of Peterborough had increased from 1.6 years in 2011-15 to 2.1 years in 2013-17. Residents in the most deprived 20% of Peterborough electoral wards had a life expectancy of 78.9 years, compared to 81.0 years in the least deprived 80% of Peterborough electoral wards.
- The suicide rate was now similar to the national average having previously been statistically significantly higher (worse) as recently as 2010-12. The trend was positive.

The Peterborough Health and Wellbeing Board **RESOLVED to:**

1. Note the findings within the final 2016-19 Health & Wellbeing Strategy annual review, including data showing improvements in health and wellbeing outcomes for Peterborough residents over the course of the strategy as well as areas that may require further continued intervention.
2. Use the information contained within the document to inform preparations for the next Peterborough Health & Wellbeing Strategy with a view towards improving general health and wellbeing in Peterborough and reducing observed inequalities/inequities. This may apply to both healthcare outcomes and associated wider determinants of health and wellbeing.

9b. PETERBOROUGH HEALTH & WELLBEING STRATEGY UPDATE

The report was introduced by the Executive Director, People and Communities and provided the Board with a summary of progress against the future plans identified for each of the focus areas outlined in the Health & Wellbeing Strategy 2016-2019.

The Health and Wellbeing Board debated the report and in summary key points raised and responses to questions included:

- Following the Peterborough CC and Cambridgeshire CC Early Years Social Mobility Peer Review (July 2018), a Joint Best Start in Life (BSiL) strategy had been developed and would be presented to the Health & Wellbeing Board in September for consultation.
- Emotional wellbeing in young children was of particular interest and Members asked if work was being done with schools. The Director of Public Health responded that the Healthy Schools Support Service worked with schools using the National Institute for Health and Care Excellence (NICE) Guidance for social and emotional wellbeing in primary and secondary education.
- The Board were pleased to see positive improvements in areas such as housing standards which had been improved though the Selective Licencing scheme.
- The system was committed to the development of Place Based delivery and the Council had been working closely with NHS Partners to develop local Integrated Neighbourhoods which sat alongside the development of the Primary Care Networks. This in turn was being aligned to the Council led Think Communities programme.

The Peterborough Health and Wellbeing Board **RESOLVED** to note the report, consider the content and raise any questions, and to challenge performance and agree future actions which needed to be addressed. In doing so the Board wished to ensure that:

1. The Health and Wellbeing Strategy is aligned with Place Based Working and the Primary Care Networks, and
2. That the NICE Guidance was implemented throughout the strategy.

10. PLACED BASED WORKING - THINK COMMUNITIES, INTEGRATED NEIGHBOURHOODS AND PRIMARY CARE NETWORKS

The report was introduced by the Head of Community and Safety Integration accompanied by the Senior Transformation Adviser. The report provided the Board with an update on how placed based working between the council and the North Alliance

would be delivered through the Think Communities, Integrated Neighbourhoods and Primary Care Network (PCN) approaches.

The Health and Wellbeing Board debated the report and in summary key points raised and responses to questions included:

- The Cabinet Member for Communities commented that the Place Based model had so far been very positive and already seen dramatic results.
- There was a requirement of all GP practices to join a Primary Care Network covering a population of 30-50k. The proposal was that there would be five PCN's covering Peterborough. The PCN's were currently in the process of getting set up.
- There was currently one prototype area in Peterborough for the Think Communities approach and two in Cambridgeshire. It was hoped that there would be ten initially within the next few months.
- The Think Communities model was new in that it demanded a response from the residents. It was about reducing the demand for services and the population becoming self-serving.
- GP practices would gain resilience through being part of a PCN as they would have access to additional resources.
- To oversee the work of the service delivery areas, new Place Based Delivery Boards would be established and they would fulfil the responsibilities of the Safer Peterborough Partnership and the Living Well Partnership both of which would then cease.
- Public Health services would need to be commissioned in the Place Based way.
- Concern was raised with regard to the delivery of GP services and staffing levels at GP practices and the sharing of personal information.

The Peterborough Health and Wellbeing Board **RESOLVED** to note the contents of the report and endorsed the joint approach being taken by the North Alliance and Peterborough City Council for Place Based working through the Think Communities, Integrated Neighbourhoods and Primary Care Networks.

11. UPDATE ON HEALTH AND SOCIAL CARE INTEGRATION

The report was introduced by the Head of Commissioning Partnerships and Programmes and provided the Board with an update on the progress of local health and social care integration.

The Health and Wellbeing Board debated the report and in summary key points raised and responses to questions included:

- It was noted that in Peterborough A&E attendances of over 65s remained higher than the national average. Clarification was sought as to what was being done regarding admission avoidance. The Board were informed that various initiatives were being looked at including Joint Commissioning to support prevention and early intervention, supporting care homes to reduce avoidable hospital admissions and Neighbourhood Place Based Care. The CCG were looking at a whole range of initiatives including looking at how people were accessing care and the many ways to access care which could sometimes be confusing for people. The CCG were looking at how this could be made easier.

The Peterborough Health and Wellbeing Board **RESOLVED** to note the contents of the report which provided an update on the priorities and progress of health and social care integration.

12. BETTER CARE FUND UPDATE

The report was introduced by the Head of Commissioning Partnerships and Programmes and provided the Board with an update on the progress and performance of the local Better Care Fund plans.

There being no discussion the Peterborough Health and Wellbeing Board **RESOLVED** to note the contents of the report.

INFORMATION AND OTHER ITEMS

The remainder of the items on the agenda were for information only and the Health and Wellbeing Board **RESOLVED** to note them without comment.

13. DIVERSE ETHNIC COMMUNITIES JSNA – SOUTH ASIAN COMMUNITIES

14. SCHEDULE OF FUTURE MEETINGS AND DRAFT AGENDA PROGRAMME

The Board requested that the Think Communities Programme be added as an agenda item at the next meeting.

Chairman

1:00pm – 3.00pm

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HEALTH AND WELLBEING BOARD	AGENDA ITEM No. 4
25 FEBRUARY 2020	PUBLIC REPORT

Report of:	Dr Liz Robin, Director of Public Health	
Cabinet Member(s) responsible:	Cllr John Holdich, Leader of the Council and Chairman of the Health and Wellbeing Board	
Contact Officer(s):	Dan Kalley/Paulina Ford, Senior Democratic Services Officer	Tel. 296334/452508

UPDATED PETERBOROUGH HEALTH AND WELLBEING BOARD TERMS OF REFERENCE

RECOMMENDATIONS	
FROM: Dr Liz Robin, Director Public Health	**Deadline date:** N/A
It is recommended that the Health and Wellbeing Board note and agree the amended terms of reference as attached at Appendix A.	

1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Wellbeing Board following the appointment of Charlotte Black as the Director of Adult Social Services.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to seek the agreement of the Health and Wellbeing Board on the revised terms of reference of the Board. Namely the addition of the Director of Adult Social Services to the membership of the Board. Appendix A identifies the amendment.

2.2 This report is for the Health and Wellbeing Board to consider under its Terms of Reference No.2.8.4.2: The membership will be kept under review periodically.

3. TIMESCALES

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

4. BACKGROUND AND KEY ISSUES

4.1 Following the appointment of Charlotte Black to the position of Director of Adult Social Services the Board's terms of reference have been updated to include this position.

In addition members will note that the Service Director Communities and Safety reference has also been removed.

5. CONSULTATION

5.1 There is no consultation applicable.

6. ANTICIPATED OUTCOMES OR IMPACT

6.1 That the position of Director of Adult Social Services is added to the membership of the Board.

7. IMPLICATIONS

Financial Implications

7.1 There are none.

Legal Implications

7.2 There are none.

Equalities Implications

7.3 There are none.

8. BACKGROUND DOCUMENTS

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

8.1 Peterborough City Council Constitution, Part 3 Section 2

9. APPENDICES

9.1 Appendix A – Updated Terms of Reference

2.8 Peterborough Health and Wellbeing Board

Purpose and Terms of Reference

2.8.1. Background and context:

The Peterborough Health and Wellbeing Board has been established to provide a strategic leadership forum focussed on securing and improving the health and wellbeing of Peterborough residents.

2.8.2. The aims are:

2.8.2.1 To bring together the leaders of health and social care commissioners to develop common and shared approaches to improving the health and wellbeing of the community.

2.8.2.2 To actively promote partnership working across health and social care in order to further improve health and wellbeing of residents.

2.8.2.3 To influence commissioning strategies based on the evidence of the Joint Strategic Needs Assessment.

2.8.3. Its functions are:

2.8.3.1 Authority to prepare the Joint Health and Wellbeing Strategy for the city based on the needs identified in the Joint Strategic Needs Assessment and overseeing the implementation of the Strategy, which informs and influences the commissioning plans of partner agencies.

2.8.3.2 Authority to prepare the Joint Strategic Needs Assessment (JSNA): To develop a shared understanding of the needs of the community through developing and keeping under review the Joint Strategic Needs Assessment and to use this intelligence to refresh the Health & Wellbeing Strategy.

2.8.3.3 Authority to respond to consultations about commissioning plans issued by clinical commissioning groups in connection with Section 26 of the Health and Social Care Act 2012.

2.8.3.4 To keep under review the delivery of the designated public health functions and their contribution to improving health and wellbeing and tackling health inequalities.

2.8.3.5 To consider the recommendations of the Director of Public Health in their Annual Public Health report.

2.8.3.6 Authority to encourage persons who arrange for the provision of any health or social care services in the Council's area to work in an integrated manner.

2.8.3.7 Authority to provide any advice, assistance and support it thinks appropriate for the purpose of encouraging the making of arrangements under Section 75 of the National Health Service Act 2006.

2.8.3.8 To consider options and opportunities for the joint commissioning of health and social care services for children, families and adults in Peterborough

to meet identified needs (based on the findings of the Joint Strategic Needs Assessment) and to consider any relevant plans and strategies regarding joint commissioning of health and social care services for children and adults.

2.8.3.9 To identify areas where joined up or integrated commissioning, including the establishment of pooled budget arrangements would benefit improving health and wellbeing and reducing health inequalities.

2.8.3.10 By establishing sub groups as appropriate give consideration to areas of joint health and social care commissioning, including but not restricted to services for people with learning disabilities.

2.8.3.11 To oversee the development of Local HealthWatch for Peterborough and to ensure that they can operate effectively to support health and wellbeing on behalf of users of health and social care services.

2.8.3.12 To keep under consideration, the financial and organisational implications and impact on peoples' experience of joint and integrated working across health and social care services, and to make recommendations for ensuring that performance and quality standards for health and social care services to children, families and adults are met and represent value for money across the whole system.

2.8.3.13 Authority to prepare and provide Health and Wellbeing Board sign off for the Better Care Fund Plan.

2.8.3.14 To ensure effective working between the Board and the Greater Peterborough Partnership ensuring added value and an avoidance of duplication.

2.8.3.15 To establish a joint Cambridgeshire and Peterborough sub-committee in relation to issues that cross local authority boundaries.

2.8.3.16 Authority to discharge any other functions specifically reserved to be undertaken by the Health and Wellbeing Boards as set out in legislation, guidance, circulars and directives received from national government.

2.8.4 Membership

2.8.4.1 Membership of the Health and Wellbeing Board will be composed of the following:

Peterborough City Council:
The Leader of the Council – Chairman of the Board
Deputy Leader and Cabinet Member for Adult Social Care, Health and Public Health
Cabinet Member Communities
An Opposition Councillor
Executive Director People and Communities Cambridgeshire and Peterborough Councils
~~Service Director Communities and Safety~~
The Director of Public Health
Director of Adult Social Services

Cambridgeshire and Peterborough Clinical Commissioning Group

Clinical Chair (GP) of Cambridgeshire and Peterborough Clinical Commissioning Group (Deputy Chair)
1 further GP representative from the Peterborough area to cover when Clinical Chair is unavailable
Nominated Director from Cambridgeshire and Peterborough Clinical Commissioning Group

Lincolnshire
1 GP representing South Lincolnshire CCG

NHS England
1 representative from NHS England

Cambridgeshire and Peterborough Healthwatch
1 member

The Board will also include as co-opted members the following:
Independent Chair of Peterborough and Cambridgeshire Safeguarding Children's and Adults Board
The Chair of the Safer Peterborough Partnership (Claire Higgins)

2.8.4.2 The membership will be kept under review periodically.

2.8.4.3 The Board shall co-opt other such representatives or persons in a non-voting capacity as it sees relevant in assisting it to undertake its functions effectively.

2.8.5 Meetings

2.8.5.1 The meetings of the Board and its decision-making will be subject to the provisions of the City Council's Constitution including the Council Procedure Rules and the Access to Information Rules, insofar as these are applicable to the Board in its shadow form.

2.8.5.2 The Board will meet in public.

2.8.5.3 The minimum quorum for the Board shall be 5 members which should include at least one elected member, one statutory director (DCS/DASS/DPH) and a CCG/LCG member.

2.8.5.4 The Board shall meet periodically and at least twice yearly. Additional meetings shall be called at the discretion of the Chairman where business needs require.

2.8.5.5 Administrative arrangements to support meetings of the Board shall be provided through the City Council's Governance team.

2.8.6 Governance and Approach

2.8.6.1 The Board will function at a strategic level, with priorities being delivered and key issues taken forward through the work of the partnership organisations.

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2.8.6.2 Decisions taken and work progressed will be subject to scrutiny of the City Council's Scrutiny Commission for Health Issues.

2.8.7 Wider Engagement

2.8.7.1 The Health and Wellbeing Board will develop and implement a communications engagement strategy for the work of the Board, including how the work of the Board will be influenced by stakeholders and the public.

2.8.7.2 The Board will ensure that its decisions and the priorities it sets take account of the needs of all of Peterborough's communities and groups are communicated widely.

2.8.8 Review

2.8.8.1 These Terms of Reference will be reviewed periodically.

HEALTH AND WELLBEING BOARD	AGENDA ITEM No. 5
25 FEBRUARY 2020	PUBLIC REPORT

Report of:	Adrian Chapman, Service Director: Communities and Partnerships	
Cabinet Member(s) responsible:	Cllr Irene Walsh, Cabinet Member for Communities	
Contact Officer(s):	Adrian Chapman, Service Director Communities and Safety	Tel. 07920 160441

THINK COMMUNITIES PROGRESS REPORT

R E C O M M E N D A T I O N S	
FROM: *Service Director for Communities and Partnerships*	**Deadline date:** *N/A*

It is recommended that the Health and Wellbeing Board:

1. Note and comment upon the progress being made towards delivery of the Think Communities approach.
2. Suggest further ideas for embedding the approach, particularly in relation to Health and Wellbeing Board priorities.

1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Wellbeing Board following a request from the Health and Wellbeing Board.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide members of the Health and Wellbeing Board with a progress report on the Think Communities approach.

2.2 This report is for the Health and Wellbeing Board] to consider under its Terms of Reference No. 2.8.3.4

To keep under review the delivery of the designated public health functions and their contribution to improving health and wellbeing and tackling health inequalities.

2.3 *How does this report link to the Children in care Pledge?*

Communities that are strong, resilient and cohesive, supported by a broad range of services and opportunities, provides the best opportunities for the whole population to succeed and for us and our partners to enable improved outcomes.

3. TIMESCALES

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

4. BACKGROUND AND KEY ISSUES

4.1 The principles of Think Communities are now firmly established across the public sector in Peterborough and Cambridgeshire, and they signal a new way of working – between public sector partners, with the voluntary, community and faith sectors, and with and alongside communities. Think Communities seeks to change traditional approaches to public service delivery by developing place-based teams that are responsive to local, evidenced needs. It will enable a sharp focus to be established on the things that matter most within communities, and for services, projects and programmes to be designed to best suit local need.

4.2 Think Communities is a new way of working – it is not a project or a programme with a limited lifespan, but instead aims to rethink the traditional ways we have collectively sought to address some of the biggest issues and take some of the biggest opportunities within our communities. Think Communities recognises that a place-based approach is best, rather than the current thematically-focussed service delivery arrangements: it is based on a model which creates the most appropriate teams to be based within and alongside our communities that can best respond to service demands, and find sustainable ways of tackling inequality.

4.3 The development of the Think Communities approach continues to be a collaborative one, and the recent launch of the new Think Communities Partnership Board signals another key milestone being reached. There is significant energy and enthusiasm across our partnerships to embrace the principles of Think Communities and to work differently.

4.4 We have also developed an integrated approach to delivery between Think Communities and the Health and Wellbeing Strategy, where Think Communities provides the basis on which delivery of the Strategy can be achieved. Having all of our key partners aligned to Think Communities will help to ensure that the Health and Wellbeing Strategy becomes a core part of all of our work and that of our partners.

4.5 Overall Progress

4.5.1 The Board will be aware, from previous reports, that significant effort has been made in securing the hearts and minds of colleagues right across the public sector. The Think Communities place-based, person-centred approach is now agreed as the best way to work together in response to the challenges our sector faces, most notably the increasing demand for our services and the challenges we have in reversing some declining outcomes. As Think Communities is not a project or a programme, it will require significant cultural and behavioural change if it is to have the impacts we require. The investment made in securing the support of our public sector partners prior to significant roll-out has been a key element in establishing a solid foundation from which to build.

4.5.2 The Cambridgeshire and Peterborough Public Services Board (CPSB), which comprises the chief executives (and equivalents) from the city council, county council, all district councils, the Clinical Commissioning Group, the Greater Cambridge Partnership, Police and Fire Service, has agreed to provide the strategic oversight and leadership required to truly embed Think Communities across and within their organisations. Although there is an agreement to provide a formal report to the CPSB each quarter, it is likely that we will follow the current pattern of providing a report at every CPSB meeting (currently around every 6-8 weeks).

4.5.3 The new Think Communities Partnership Board has now held two meetings; this Board will drive the delivery, at pace, of the Think Communities approach, unblocking issues or challenges and identifying opportunities wherever relevant. Membership mirrors that of the CPSB, but also includes voluntary sector representation via Hunts Forum, Peterborough Council for Voluntary Service, and Healthwatch. All parts of the health system are also represented, via representatives of the North and South Alliances of NHS and social care providers.

4.5.4 At a local level, productive discussions have continued relating to the ways in which Think Communities activity will be overseen and directed. It is likely that the existing community safety

partnership (a statutory partnership comprising representation from all sectors including the Director of Public Health) will be expanded to become the relevant place-based board to take on this role in Peterborough.

4.5.5 Think Communities seeks to respond at a local level to evidenced demand, and it is therefore vital that we establish recognised Think Communities service delivery areas and a framework through which data and intelligence can be shared and analysed in order to provide the evidence we need. Of at least equal importance is the requirement to create new ways to engage with citizens, working with them to build their own capacity and resilience, to support themselves and each other, and to help us to refine the priorities that the evidence suggests we should focus on. It is this range of important work that the Think Communities teams have been focussing on in recent months.

4.6 **Thematic Progress**

4.6.1 As mentioned above, we have invested significant time to date in securing the hearts and minds support of our partners, and we are now moving rapidly into delivery of positive change through Think Communities at the local level. To sharpen up even further this focus on delivery, the key themes being focussed on at present are:

1. Communications and Community Engagement
2. Data and Intelligence
3. Workforce Reform

These workstreams were also identified by partners at the Think Communities Partnership Board meeting as the most critical to the next stage of delivery

4.6.2 *Communications and Community Engagement*

Throughout the summer months, we engaged with citizens across Peterborough and Cambridgeshire as part of the Think Communities Challenge, which sought to identify what mattered most to residents, what they thought the council and partners should focus on, and what they could do for themselves. The headline results, which are shown below, will be used to shape and inform the development of the local delivery plans:

- The top 5 things the community should put their effort into:
  - to live in an area with good community spirit
  - to have enjoyable activities to do together, and not be lonely
  - children and young people to have fun
  - to live in a clean, green area, free of rubbish
  - to be part of a community, and feel valued whatever our differences

- The top 2 things an individual should put their effort into:
  - to be part of a community, and feel valued whatever our differences
  - for people to prepare for the future as they get old

- The top 1 thing the public sector should put their effort into:
  - for children and old people to be protected from danger

Think Communities also formed the key theme of the recent Local Councils Conferences in both Peterborough and Cambridgeshire, at which delegates were briefed on the approach, and ways to engage with parish and town councils through the Think Communities approach began to be explored. This collaboration with parish and town councils is a key requirement of Think Communities going forwards, and a number of follow-up meetings with delegates have been or will be held to explore how this will work at the local level.

Our NHS colleagues also recently consulted with residents as part of the Big Conversation (https://www.cambridgeshireandpeterboroughccg.nhs.uk/get-involved/the-big-conversation/). The Big Conversation sought to identify the priorities that our citizens have regarding health resources and funding choices. As key partners in the Think Communities approach, the data

collected through exercises such as this provide real opportunities to share learning and agree joined-up responses and funding choices.

4.6.3 *Data and Intelligence*

The data and intelligence workstream is fundamental to the success of Think Communities. If we are to make the scale of positive change we seek to make, it is vital that our place-based delivery plans and priorities are informed by data and intelligence that is shared between all Think Communities partners, including communities. This workstream is seeking to:

- understand barriers to data sharing and put in place effective governance procedures to resolve those barriers
- use data to better understand demand at a local level and inform service delivery
- develop a single view of place

Alongside the work to define service delivery areas using data and intelligence (described below), this workstream has also been focussing on the creation of area profiles. The structure of the area profiles has been established, making initial use of pre-existing information already held within the Cambridgeshire Insight data store – this includes topics relating but not limited to:

- Population including gender split
- Age group breakdown estimates and comparison to county and England
- Ethnicity and nationality
- Economically active population by gender
- Benefit claimant count
- Number of properties, proportion that are overcrowded, average household size
- Tenure, household size
- Educational attainment
- Deprivation
- Number of crimes, rate and types
- Self-reported health limiting conditions, including respiratory diseases, long term conditions, mental health and obesity
- Vehicle ownership
- Births and life expectancy

As the area profile work progresses, more and more information will be added, including details of public sector spend in each service delivery area. The profiles will seek to help our system to:

- Understand what demand challenges there are across particular communities / localities **(Segmentation)**
- Be informed about what the system could do collaboratively to meet the immediate needs of individual communities **(Utilisation)**
- Understand the future risks and needs of communities / localities **(Stratification)**

4.6.4 *Workforce Reform*

If we are to truly transform the way we work with and alongside our communities, our workforce needs to be equipped with the skills, knowledge and confidence to operate differently. Taking inspiration from the Neighbourhood Cares pilots in the County, where social care staff were supported to work very differently and to find the best ways to resolve challenges even if they were less traditional than the norm, we need our staff to become part of the community they are based within, forming close and effective relationships with, for example, citizens, local councillors, town and parish councils, community groups and organisations, and public sector partners. We need our staff to find creative and flexible solutions to some of the entrenched challenges our communities face, thereby improving outcomes and, in so doing, preventing or delaying demand for services. We also need our staff to find and pursue opportunities, and to adopt strengths-based approaches to engaging with and working within communities.

To signal this change of approach, we are developing a workforce development programme

that will see all public sector workers, at all levels, being immersed in the Think Communities approach. The current proposal is to develop a generic, half-day induction session for all staff. The induction sessions will contain generic information about Think Communities and the opportunities it brings to our staff to work differently, as well as being nuanced to the locality within which the staff being inducted are based. These sessions will run on a monthly basis and will continue for as long as necessary, with the sessions eventually being delivered by our own workforce.

In addition, we are developing a more thematic set of workforce development opportunities, to ensure that, where relevant, our staff develop a greater understanding of the wide range of issues that they will come across as part of their roles. This will include, for example, training and awareness raising relating to safeguarding, Prevent, hate crime, housing and homelessness, community engagement, and skills.

We have been running a set of discreet pilots to test and assess Think Communities approaches, and the learning from these as well as the Neighbourhood Cares pilots will inform the design of the workforce development programme.

4.7 **Service Delivery Areas**

4.7.1 A significant part of our place-based Think Communities approach is to identify and agree our service delivery areas – the geographical places within which our services, data and delivery plans will be aligned. We currently have a number of different boundaries – e.g. parish, division, ward, district, health, policing etc. Services between some of these boundaries often differ, making it difficult for communities to navigate or engage with, and Think Communities therefore provides the opportunity to agree a common set of boundaries across the system, that are:

- as natural as possible
- organised in a way that make sense to our citizens
- of the optimum size to have the biggest impact
- able to make the most of collective assets and resources, helping services to be affordable and sustainable
- respectful of boundaries defined by our partners

As the Board knows, we have worked closely over the past few months with our colleagues in the health system, to define and agree the Primary Care Network (PCN) areas. PCN's represent collections of GP practices who have agreed to work together as part of new NHS England contractual arrangements. It was agreed that these would, where possible, form the basis of defining what a cross-system, mutually agreed set of service delivery areas would be, which were both sensible and effective.

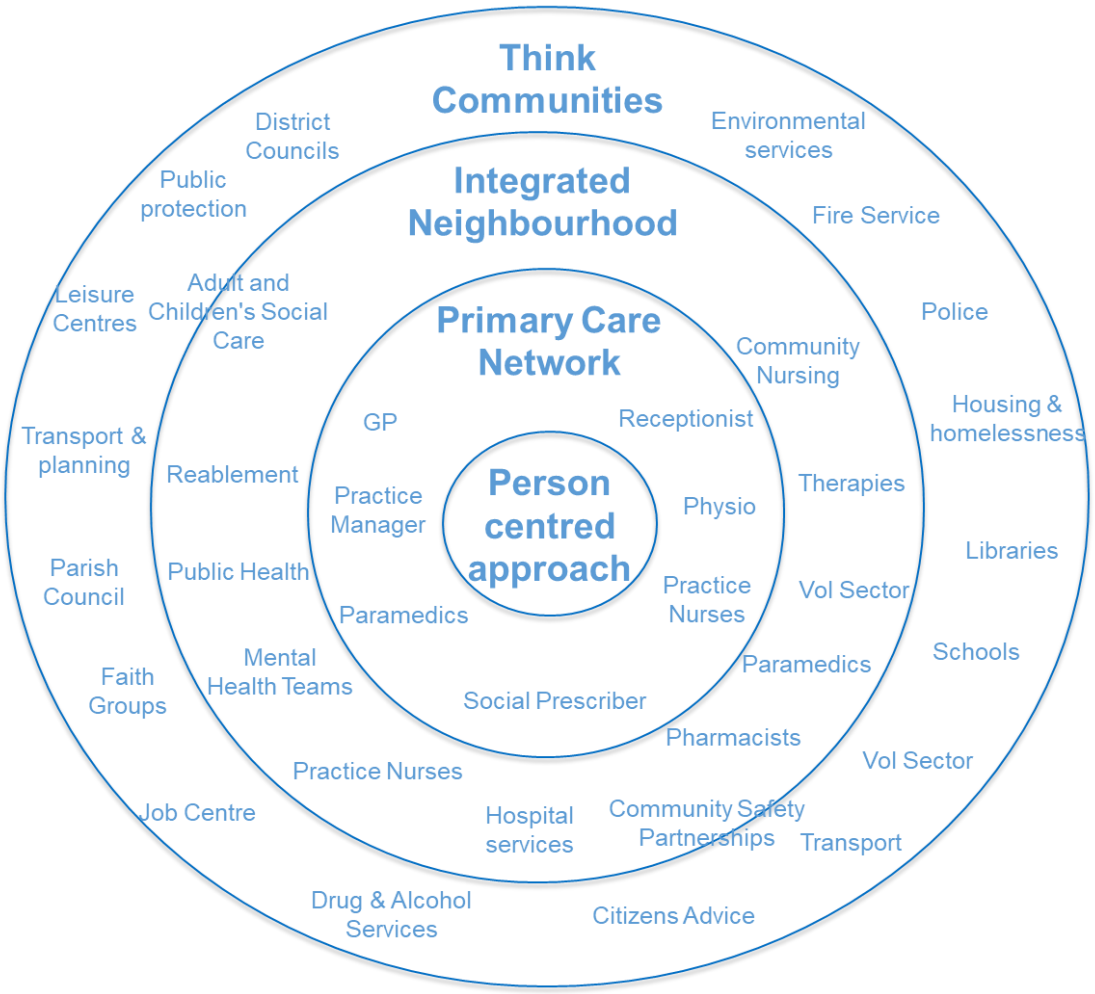
Although there are a number of approaches that could be taken to identify what an area *might* look like based on the Primary Care Networks, the approach taken was to group the PCN's and identify potential boundaries based on which Lower Super Output Areas* had the highest registered patient population – this is known as Dominant Lower Super Output Areas (LSOA's).

Dominant Lower Super Output Areas take into account the proportion of each LSOA's residential population who is registered at a GP within each PCN. This was utilised to ensure potential Think Communities service delivery areas are as sympathetic and aligned as best as possible to PCN's to support integrated approaches to service delivery, particularly with our health partners.

**** Lower-Layer Super Output Areas (LSOA's)*** *are small areas designed to be of a similar population size, with an average of approximately 1,500 residents or 650 households. There are 32,844 Lower-layer Super Output Areas (LSOA's) in England.*
They were produced by the Office for National Statistics for improving the reporting of small area statistics and are a standard way of dividing up the country. For ease of communication, LSOA's are sometimes referred to as 'neighbourhoods' or 'small areas'

4.7.2 The joining-up of the development of the PCN's with our Think Communities approach has

enabled some ambitious shared plans to emerge around service delivery. Our health partners have developed the Integrated Neighbourhoods model of service delivery, which forms part of our broader Think Communities approach. The diagram below illustrates the type and nature of services that fall within this overall system-wide, place-based approach:



4.7.3 The Think Communities team have reviewed the GP catchment areas and patient footfall within each PCN area, and overlaid that information with other data about our places, including what might constitute a more natural community boundary through the eyes of our citizens. This has resulted in the proposal to create a number of Think Communities service delivery areas. Each area comprises a number of Lower Super Output Areas, which enables detailed data to be shared and analysed at a macro level (i.e. whole Service Delivery Area), a micro level (i.e. a specific LSOA), or somewhere in between (i.e. groups of LSOA's).

4.7.4 Officers will be discussing the proposed areas with colleagues across the public sector system, and with Members, to ensure that a final set of areas can be agreed. In the spirit of Think Communities, it will be important that these areas remain flexible, especially where communities themselves show a desire or need to work with others beyond their Think Communities-defined areas.

4.7.5 To support delivery in the Service Delivery Areas, place-based teams are being formed, including:

- Think Communities Co-ordinators (6 posts, one for Peterborough and each District Council area)
- Social Prescribing Link Workers – at least one worker for each PCN area
- Integrated Neighbourhood Managers

In addition, existing place-based staff from, for example, the police will also work as part of the

core team approach.

The role of this core team will be to provide the links between the citizen and the public sector, to help identify ways to support alternatives to sometimes inappropriate statutory interventions, to build resilience and capacity within communities, and to drive collaboration at a local level, across the system, in response to the locally agreed priorities and delivery plans.

4.8 Finally, work has progressed to develop and agree a 'Health Deal' between all those agencies focussed on improving the health and wellbeing of our population. The Think Communities approach acknowledges the significant impact that housing, household income and employment, access to and use of green space, and environmental issues all have on a person's health. Partners know that local residents who present to health services are also the users of other public sector services, therefore the whole sector understands the importance of collective preventative activity to reduce poor health outcomes.

The Think Communities Health Deal Agreement recognises the need to focus on addressing the Wider Determinants of Health to improve health outcomes within our local communities. The Agreement outlines the transformation needed by Public Sector partners to work collaboratively with their Communities to create the conditions needed to enable Communities to take action.

The Deal is close to be finalised, and will be shared as soon as possible.

5. CONSULTATION

5.1 The report describes the ways in which the views of partners and residents is being used to shape the overall direction of the Think Communities approach.

6. ANTICIPATED OUTCOMES OR IMPACT

6.1 Feedback from the Board will be directly fed into the delivery team and Partnership Board's work,

7. REASON FOR THE RECOMMENDATION

7.1 To ensure that Think Communities develops in complete alignment to the principles and priorities of the Health and Wellbeing Board.

8. ALTERNATIVE OPTIONS CONSIDERED

8.1 Not applicable.

9. IMPLICATIONS

Financial Implications

9.1 There are no significant implications within this category at this stage. It is anticipated that the Think Communities approach will make more effective use of existing mainstream spend in an area first and foremost to deliver its aims.

Legal Implications

9.2 Not applicable at this stage.

Equalities Implications

9.3 The Think Communities approach seeks to ensure that all of our communities have access to the most appropriate services and opportunities, regardless of their circumstances.

10. BACKGROUND DOCUMENTS

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

10.1 None

11. APPENDICES

11.1 None

HEALTH AND WELLBEING BOARD	AGENDA ITEM No. 6
25 FEBRUARY 2020	PUBLIC REPORT

Report of:	**Jessica Bawden – Director of External Affairs and Policy** Cambridgeshire and Peterborough Clinical Commissioning Group	
Contact Officer(s):	Jane Coulson - **Senior Engagement Manager**	Tel. 01733 847348

BIG CONVERSATION REPORT ON FEEDBACK

RECOMMENDATIONS	
FROM: Jessica Bawden – Director of External Affairs and Policy Cambridgeshire and Peterborough Clinical Commissioning Group	**Deadline date:**

It is recommended that the Health and Wellbeing Board:

1. Note and comment on the findings
2. Consider how to include this feedback in future Health and Wellbeing Board planning.

1. ORIGIN OF REPORT

1.1 This report is submitted to the Board following previous reports and information from Cambridgeshire and Peterborough Clinical Commissioning Group regarding their plans and proposals for the BIG conversation engagement exercise. This report gives the Health and Wellbeing Board the feedback received during the BIG conversation which ran from 27 September to 20 December 2019.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to inform Cambridgeshire Health and Wellbeing Board of the responses and feedback received during the BIG conversation from 27 September 2019 to 20 December 2019. All feedback is contained in Annex 1.

2.2 This report is for the Board to consider under its Terms of Reference No. 2.8.3.4

To keep under review the delivery of the designated public health functions and their contribution to improving health and wellbeing and tackling health inequalities.

3. BACKGROUND AND KEY ISSUES

3.1 The CCG is facing an unprecedented financial challenge in 2019/20 and beyond. To meet this challenge, we needed to garner support from our key stakeholders, providers and importantly the wider public. This required a new approach, so we developed the BIG conversation to talk to the wider public and our stakeholders about how we use our valuable NHS resources and how we take more responsibility for our own health

4. REASON FOR THE RECOMMENDATION

4.1 It is recommended that the Health and Wellbeing Board:

1. Note and comment on the findings
2. Consider how to include this feedback in future Health and Wellbeing Board planning.

5. APPENDICES

5.1 Annex 1 BIG conversation report on feedback
Appendix 1 – Community Values Panel report 1
Appendix 2 – Community Values Panel Report 2
Appendix 3 – Healthwatch Big conversation response

Annex 1

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

The BIG Conversation

27 September 2019 to 20 December 2019

End of conversation report

29 January 2020

Version 7

Jane Coulson

Contents

Annex 1

1. Purpose of the report

This report is to inform Cambridgeshire and Peterborough Clinical Commissioning Group's (CCG) Governing Body of the responses and feedback received during the BIG conversation from 27 September 2019 to 20 December 2019.

2. Background to the BIG Conversation

The CCG is facing an unprecedented financial challenge in 2019/20 and beyond. To meet this challenge, we needed to garner support from our key stakeholders, providers and importantly the wider public. This required a new approach, so we developed the BIG conversation to talk to the wider public and our stakeholders about how we use our valuable NHS resources and how we can take more responsibility for our own health.

The BIG conversation was launched on 27 September 2019 and ran until 20 December 2019. It was designed to help the CCG better understand what matters most to the local community, as well as asking for ideas from the community and clinicians that could help us to make savings in the future.

The BIG conversation was an important engagement activity, but not a formal consultation. It was designed to support the financial recovery plan and future commissioning, decommissioning, investment and disinvestment decisions and provide an insight into what matters most to our local people. It was also an important exercise in raising awareness of the costs of certain services, treatments and medications. We also wanted to help inform people of the options available to them when they need advice or treatment.

Before we began the BIG conversation with the public, we ran a BIG conversation with our clinicians to find out what areas they could identify as working well and working not so well. Where they could see waste and duplication. We had a good response from our clinicians to this survey.

3. Raising awareness of the BIG Conversation

Before we launched the BIG conversation, we shared an outline of our plans and the timelines for this work with Peterborough Health Scrutiny Committee, Cambridgeshire Health Committee, Cambridgeshire and Peterborough Healthwatch, CCG Patient Reference Group, and other key stakeholder groups around our area, and bordering areas. As we developed our plans and early drafts of our documents, we shared them with these groups and their feedback and views helped to shape the final versions.

We knew that we needed to be challenging with the questions and avoid giving too many choices as we really needed people to have to think hard about the difficult decisions faced by the CCG.

To signify this new approach to engagement, we wanted to develop a new brand that whilst embodying the spirit of the NHS, also looked fresh and distinct from campaigns that had run before.

We developed the branding to reinforce the fact that we were asking questions and opening a two-way dialogue. We needed to ensure the branding was eye catching as this was an awareness raising campaign as well as a BIG conversation.

The refreshed branding has received positive feedback throughout the campaign from partner organisations and others.

4. The Big Conversation 27 September to 20 December

4.1. Documents and other materials

The BIG conversation document was developed with feedback from key stakeholders, we included as much information as possible to ensure that people understood the issues faced by the CCG in making tough decisions for the future of the NHS in our area. We were very clear that this was not a consultation but was designed to gather views and understand what was important to people about their local NHS services.

Alongside this full document we produced a shorter summary version with links to the full document. We also developed posters advertising our range of public meeting dates.

On our website we created a separate page with a text only version of the full BIG conversation document to ensure that people who use text readers could access the document. We also printed larger font format versions, and on different coloured paper on request.

An Easi-read version was produced with feedback from the Healthwatch Access champions. The Easi-read version was made up of photo symbols and short easy to read text for people who have learning disabilities.

To support the BIG conversation, we created a marketing toolkit to make it as easy as possible for key partners and stakeholders to help support the engagement activity. The toolkit included wording for websites and internal newsletters, suggested social media posts and posters promoting the BIG conversation events. This was distributed to all GP practices and all local NHS trusts.

4.2. Distribution

We had a print run of 2,000 full documents and 20,000 summary documents, both included paper copies of the survey and contact information. The majority of the printed documents were for distribution to GP practices, pharmacies, local trusts and libraries, with the remainder being kept for any public meetings and local groups. We also sent the BIG conversation documents/or a link to the website via email to save on printing and distribution costs.

We distributed our documents to the following stakeholders either in hard copy or by email:

- Local MPs

- Local councillors, county, city, district and town
- Parish councils
- Patient Reference Group
- Patient Forums (Cambridge/Huntingdon/East Cambs/Greater Peterborough) - email
- All local Libraries
- Key Stakeholder database
- All GP practices
- All pharmacies
- Local trusts
    - Cambridge University Hospitals NHS Foundation Trust
    - Hinchingbrooke Health Care NHS Trust
    - North West Anglia NHS Foundation Trust (all sites)
    - Queen Elizabeth Hospital NHS Trust
    - North Cambridgeshire Hospital, Wisbech
    - Princess of Wales Hospital, Ely
    - Doddington Community Hospital
    - Peterborough Urgent Treatment Centre
    - St. Neots Walk-in Centre
    - Brookfields Hospital, Cambridge
- Healthwatch organisations for Cambridgeshire and Peterborough, Northamptonshire, Hertfordshire
- Local Medical Committee
- Local Pharmaceutical Committee
- Unions
- Local media outlets
- Local charities
- Local support groups
- Local voluntary organisations
- Local Councils for Voluntary Services
- Local businesses and large employers
- All local school sixth form departments.

4.3. Marketing

The BIG conversation was heavily reliant on a strong, integrated marketing campaign that would enable us to reach the broadest cross section of our local community as possible.

Based on low and no cost marketing activities we put in place a plan to focus on a different aspect of the BIG conversation each week to ensure fresh PR and social media content. This plan had to be amended during the pre-election period to scale back new communication.

Our main activities focused on:

- **Facebook** – promotion via our own Facebook page, including specific short polls, but more importantly via local Facebook groups. We are members of over 230 local community Facebook groups, who allow us to share information about the NHS to their members. By carefully targeting these groups with BIG conversation messages we managed to secure a significant uplift in responses.
- **Instagram** – we promoted BIG conversations messages, video and event reminders via our grid and Instagram stories.
- **LinkedIn** – to reach out to our business audience we both posted on our own LinkedIn page and encouraged members of staff at the CCG to post via their own pages as well.
- **Twitter** – we delivered a sustained Twitter campaign to promote key BIG conversation messages.
- **Hard copy distribution** – as noted above, we distributed hard copies of the survey and promotional posters to all GP practices and pharmacies within the CCG area, as well as all local libraries.
- **Advocacy** – as well as mobilising our NHS communications network (Comms Cell) and local authority colleagues, we contacted the top 100 businesses in our local area, along with a wide range of other groups including the WI, FSB, Chamber of Commerce, local charities (such as CamSight) and others to ask them to share the news of the BIG conversation with their members and followers.
- **Events** – as mentioned above, we held local events across the CCG area, as well as proactively seeking out opportunities to attend other events. This included the opportunity to speak at a Sikh Festival in Peterborough, attend Friday Prayers at Cambridge Central Mosque, talk to two dementia support groups, and meet with outpatients being cared for at Arthur Rank Hospice. As part of Self-Care Week, we also took a BIG conversation stand to each of our hospitals to encourage patients and visitors to share their views. On a hyperlocal level, members of the CCG team also shared the survey at children's football training clubs, Rainbows (young girl guides), in local pubs and more.
- **Medical students** – the Cambridge GP Soc were incredibly supportive of the BIG conversation and went out 12 times to speak to members of the public, their future potential patients, about the BIG conversation. This included visits to Cambridge train station at key commuter times and key business districts.
- **PR** – the BIG conversation was supported by a traditional PR campaign, which included the launch of lifestyle research in the last week of the campaign (once the pre-election period had passed). If we have not been in a pre-election period, we would have carried out more PR to support the campaign.
- **Internal communications** – staff were encouraged to complete the BIG conversation (if they live within Cambridgeshire and Peterborough) and encourage their networks (family, friends, business contacts etc…) to get involved as well.

- **Toolkit and digital assets** – a digital marketing toolkit was created and shared with key system partners, plus a range of videos and social media graphics were created to raise awareness of how to get involved in the BIG conversation.

4.4. BIG Conversation meetings

Ten meetings were held in total across a number of locations in Cambridgeshire and Peterborough, over several months and at different times of the day. Two meetings were held in each of Cambridge and Peterborough, in the afternoon and evenings, to ensure that people who worked had more opportunities to attend. Overall 91 people attended and these included members of the public, Healthwatch, members of staff, local councillors and representatives from voluntary organisations. The meetings were as follows:

Public meetings		
Peterborough, The Fleet	16 October	1:30 – 3:00pm
Cambridge, The Arbury Community Centre	22 October	6:00 – 7:30pm
Huntingdon, The George Hotel	29 October	6:00 – 7:30pm
Cambridge, The Central Library	31 October	1:30 – 3:00pm
Wisbech, The Boathouse Business Centre	7 November	6:00 – 7:30pm
Cambourne, The Hub	12 November	6:00 – 7:30pm
Peterborough, The Fleet	21 November	6:00 – 7:30pm
Ely, The Cathedral Centre	26 November	6:00 – 7:30pm
St Neots, Priory Centre	28 November	6:00 – 7:30pm
March, The Community Centre	10 December	6:00 - 7:30pm

Other meetings and venues attended	
Greater Peterborough Patient Forum	7 October
Cambridgeshire Public Service Board	11 October
Cambridgeshire Area Patient Forum	17 October
Healthwatch, Peterborough Area Health and Care Community Forum	24 October

Healthwatch, Hunts Area Health and Care Community Forum	5 November
Self-care week – Moat House Surgery, Warboys	18 November
Self-care week – Peterborough City Hospital	19 November
Self-care week – Addenbrooke's Hospital	21 November
Self-care week – Hinchingbrooke Hospital	22 November
Peterborough Sikh Gurdwara, celebration event	23 November
Arthur Rank Hospice	2 December
Healthwatch, Fenland Area Health and Care Community Forum	12 December
Peterborough Dementia Network Group	13 December
Cambridge Mosque	13 December
St Ives Alzheimer's Society	17 December

The Healthwatch Community Values Panels

The CCG commissioned Healthwatch Cambridgeshire and Peterborough to run two community values panels to explore some of the issues in the BIG conversation in more detail.

Healthwatch recruited the community panels to ensure that they were fully reflective of the diverse demographic characteristics of the county. The panels were made up of 30 people and met on two separate occasions to explore in depth two issues.

Community Values panels		
Prescribing and over the counter medicines	24 October	St Ives
Urgent and emergency care.	19 November	St Ives

Healthwatch produced two independent reports that describe the work of the community panels and the outcomes of the is work. They are attached as appendix 1 and appendix 2

4.5. Media coverage

We briefed local media about the BIG conversation via a media event on 25 September 2019, supported by an embargoed press release issued on 26 September 2019 in advance of the public launch on 27 September 2019. The CCG Chair Dr Gary Howsam also gave media interviews with the BBC, the Cambridge News and the Fenland Citizen on 25 September 2019, as well as Huntingdon Community Radio on 17 December 2019.

Due to the pre-election period, which was put in place as a result of the snap election called for 12 December 2019, the CCG was not able to publicise the BIG conversation as much as it would have done outside the pre-election period. A last-minute PR push was organised for the days immediately following the election, and several more news articles were published during this final push.

Over the course of the BIG conversation campaign, it was picked up by ten local and regional media outlets including radio and print, reaching a potential audience of 2,498,299[1].

4.6. CCG website and social media

Website

The BIG conversation had a dedicated area within the CCG's website, along with a prominent banner on the homepage of the website which remained for the duration of the project. The BIG conversation also had a separate text only page which also held the easy read version of the summary document. There was also a page for the BIG conversation toolkit which contained all the assets (posters/images/videos/documents) for partner organisations to download and use on their own websites and social media. When publicising the BIG conversation, we used shortened url links (Bit.ly) to make it easier to remember.

Website visits	
Get-involved/the-big-conversation	4826
Get-involved/the-big-conversation/text-only-	64
Get-involved/the-big-conversation/big-conversation-toolkit	255
Bit.ly/NHSBigConversation	2143

Downloads		
The BIG conversation	full document.pdf	450
The BIG conversation	summary.pdf	885

[1] Based on monthly visitor figures for web outlets, monthly users where this figure was the only one available, print circulation figures and monthly listeners

The BIG conversation	Easi read.pdf	50
The BIG conversation	general video.mp4	71
The BIG conversation	toolkit poster.pdf	87

Social media

During the BIG conversation we used four social media platforms to engage with the public and staff; Facebook, Twitter, Instagram and LinkedIn. All the profile pictures and banners were changed to images with the BIG conversation branding during the engagement and regular updates were posted.

Facebook

We launched the BIG conversation with a video and link encouraging people to visit our website. This post received 163 shares and reached around 25,500 people.

In addition, we received 128 comments on our Facebook posts, 529 shares and reached 99,666 people via posts on our own page.

We didn't just post links to the survey on our Facebook page, we also:

- Ran a weekly poll asking a different question from the BIG conversation. This generated a lot of engagement, comments and shares from local residents.
- At Halloween, we took some of the stats from the BIG conversation document to highlight these 'scary stats' encouraging people to take part in the online survey – these posts alone reached 12,500 people in one day.
- We also added all our public events to our Facebook page reaching 15,450 people.

Facebook groups

Across Cambridgeshire and Peterborough, we have an active network of hyperlocal Facebook groups, where people discuss issues that matter most to their city, town or village. As part of the BIG conversation we reached out to our local community via these groups – going to the places where conversations about local issues are discussed, rather than expecting people to come to us.

In total, there are around 300 Facebook groups across Cambridgeshire and Peterborough, which connect hundreds of thousands of people.

On three separate occasions we specifically posted information about the BIG conversation into all these groups.

1. On this first post we included a link to our website, and this meant people had to look to find the link to the survey.

2. Much more successful post with a call to action to fill in a quick survey about local NHS services with a direct link to the survey. In two days, we had over 1000 responses.
3. By using a unique url we could see that over 850 people had filled in the survey as a result of this post.

Twitter

We sent messages to lots of local businesses and third sector organisations asking them for their support and to share the information about the BIG conversation to their followers to expand the reach of the campaign.

Activity	Retweets	Reach
We launched the BIG conversation with a video and link encouraging people to visit our website	21	12,400
BIG conversation tweets across the whole campaign, combination of encouraging people to take part in the survey and promoting the public events	80	47,405

Instagram

For Instagram we used a mix of promoting the events, the link to the survey and videos encouraging people to take part. These posts achieved 105 likes and reached 3,676 people, whilst our Insta Stories (of which we posted 22) were viewed 1,171 times.

LinkedIn

LinkedIn was used to reach local people, as well as our own staff. During the engagement we made nine posts, reaching 3,426 people via the CCG page, which was also supported by a range of posts by other members of the CCG team.

4.7. Response details

Activity	Responses
Survey responses	5,732
Public meeting attendance	91
Organisation responses	1
Community values panels	30
Facebook comments	128
TOTAL	5,982

4.8. Responses from other organisations

We received one response from an organisation, Healthwatch Cambridgeshire and Peterborough. The full response is attached as appendix 3

4.9. Feedback from the BIG Conversation responses

We received a huge amount of feedback during the BIG conversation, through our public meetings, responses to the online survey and through social media channels.

In the following sections you will see the responses to the questions asked during the BIG conversation as well as themes that were collated from all of the responses we received. We have not reported each individual response but have read them all and reported on the common themes and the most common responses that we received. We have also raised any particular issues of concern to the appropriate teams internally.

The responses reported below are a combination of feedback we received at meetings we attended during the BIG conversation as well feedback through social media, in person, and on the returned surveys. Forty-six percent of people who replied to the survey took the opportunity to share their views with us through the free text option.

Our survey software gave us feedback on the most common words used in the free text responses and it is important to note that the top five words given in feedback were:

1. Needs
2. Patients
3. Services
4. NHS
5. Appointments

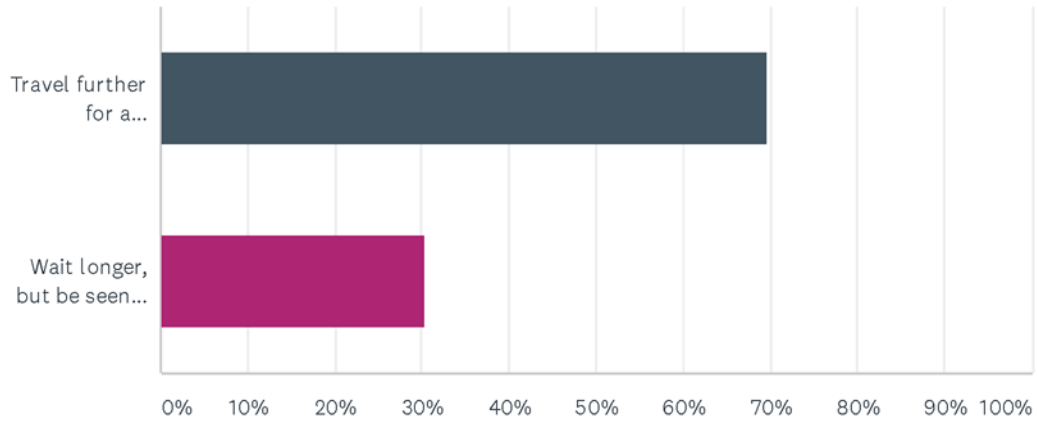
Q11 Do you have any other ideas or insights you'd like to share with us?

Fig 1. Word cloud graphic exported from SurveyMonkey

At the public meetings and in survey responses we heard that some people did not like the binary nature of the questions and found them difficult to answer as they wanted more options, or to give a nuanced response. Some people chose not to answer the questions at all and just give us their views in the free text area at the end. Others told us that the nature of the questions made them realise what difficult decisions the NHS organisations were having to make. People also appreciated being asked for their views even if they didn't like the questions.

Q1 If you needed to be seen by a healthcare professional, would you rather…

Answered: 5,619 Skipped: 113



Annex 1

ANSWER CHOICES	RESPONSES	
Travel further for a specialist appointment, but be seen quicker	69.73%	3,918
Wait longer, but be seen locally	30.27%	1,701
TOTAL		5,619

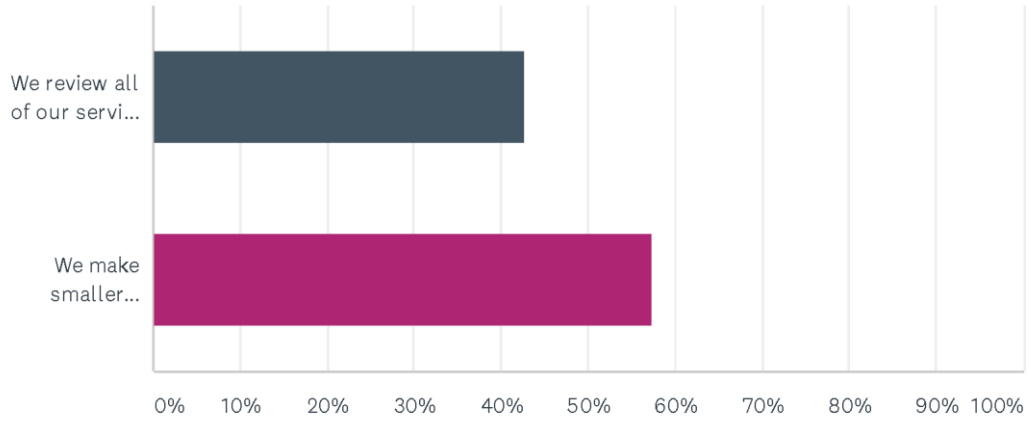
Fig 2. Question one graph exported from SurveyMonkey

The majority of people said they would be prepared to travel further for a specialist appointment, if they could be seen quicker. However, this was of course dependent on a number of factors – such as the severity of the condition and distance they would have to travel. Some people found this a difficult question to answer as different factors could impact on the response. People wanted to see a specialist for their care, and many would be prepared to travel for that service if they had access to transport. People felt this could be difficult for older people or people who rely on public transport. Public transport and non-emergency patient transport was raised as a particular issue in our area. Public transport in our rural areas is a problem for people due to the infrequency of services.

Annex 1

Q2 Thinking about all of the services that we fund and the savings we need to make, would you rather…

Answered: 5,529 Skipped: 203



ANSWER CHOICES	RESPONSES	
We review all of our services and only keep the ones that have the greatest positive impact on the health of our community, while stopping others	42.65%	2,358
We make smaller reductions to most of our services	57.35%	3,171
TOTAL		5,529

Fig 3. Question two graph exported from SurveyMonkey

This question was not a popular question, people did not feel that we should be reviewing or reducing any services. This question was skipped by the highest number of people responding to the survey. People felt that we should just carry on overspending – the Government should solve the issues by giving more money to the NHS in this area. People felt that services were spread thin enough as it is, and that the Government should fund the NHS properly to provide good levels of service to everyone. Some people felt that a rise in taxes or national insurance should be considered to pay for more NHS care. People felt that our local MPs should be supporting and lobbying the government to fund the NHS better in our area. People also told us that this question really made them think and realise the tough decision that the CCG were facing.

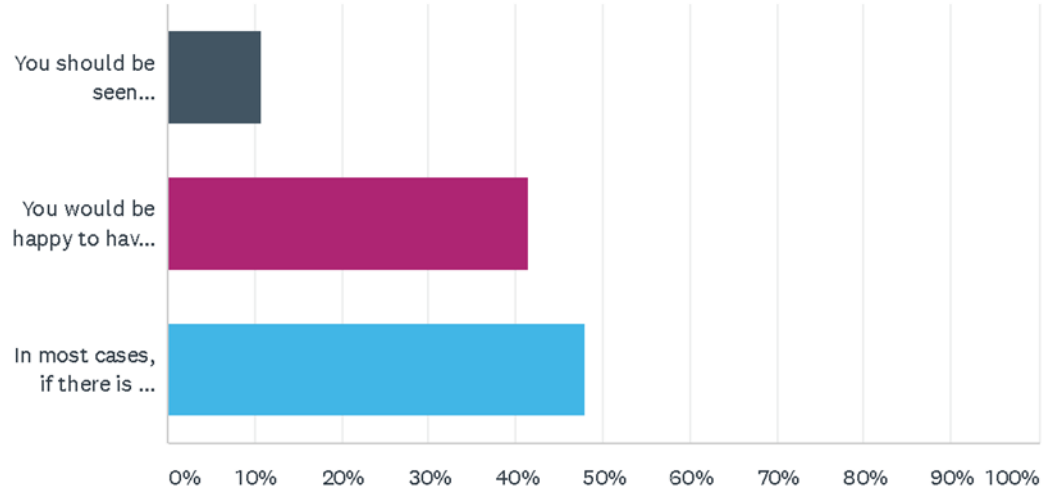
There was also feedback about which people should be entitled to free NHS care. There was a feeling that people who visit the UK for a short period of time should be charged to receive health services provided by the NHS including emergency care. People should have to prove their residency through ID and health insurance documents before they receive care.

We also received feedback that all NHS services should be delivered the same across the whole country. There shouldn't be regional differences. "Postcode lottery" of services was seen to be unfair and wrong. People mentioned this most when talking to us about IVF services. Roughly 30-40 people urged the CCG to reinstate IVF treatment for at least one cycle.

We were also told the NHS shouldn't fund any treatments or services that don't directly improve people's health or save lives – included in this were cosmetic surgery, vasectomies, gluten-free food prescribing, and IVF.

Q3 We spend millions of pounds on routine follow up appointments after a treatment or a procedure. If everything has gone well, do you think...

Answered: 5,657 Skipped: 75



ANSWER CHOICES	RESPONSES	
You should be seen face-to-face to be reassured that everything has gone well	10.62%	601
You would be happy to have a telephone call or video call (such as Skype) with a health professional to follow-up how you are doing and go in to see the Doctor if there is any concern	41.49%	2,347
In most cases, if there is no need for a follow up appointment, then you would be happy to be given a number to call if you had any concerns	47.89%	2,709
TOTAL		5,657

Fig 4. Question three graph exported from SurveyMonkey

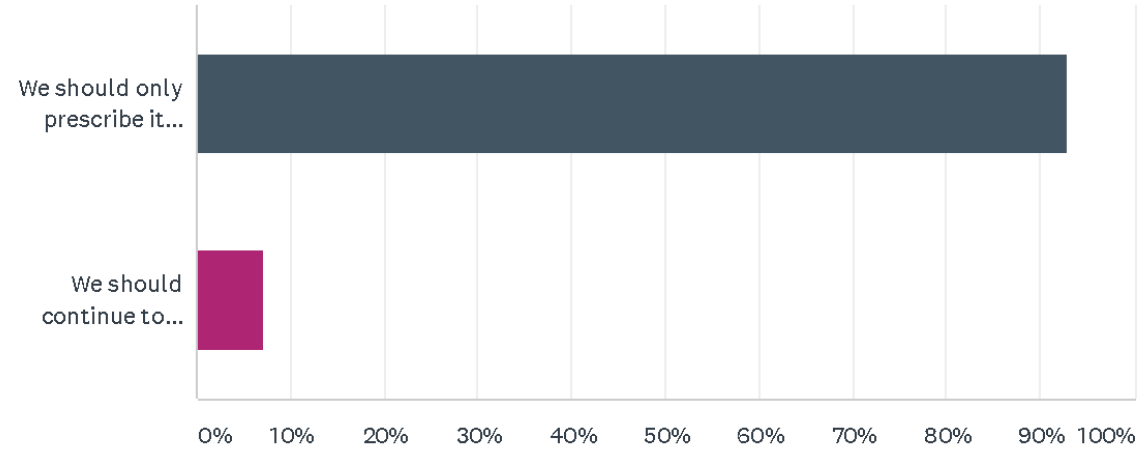
People felt that if a follow-up appointment could be easily done by phone or using technology then they would prefer not to travel to those appointments. People often felt that a follow-up appointment just to be told everything had gone well were a waste of time and expense to both themselves and our NHS staff.

People told us that travelling to our hospitals and parking there could be a real hassle and take a lot of time out of their day. They were happy to see technology used more effectively

in this area. However they did want us to be mindful that some people are excluded from use of technology whether that is computers, tablets or telephones due to age, lack of understanding on the equipment, not able to access the equipment, or due to communication issues.

Q4 We spend £5.3 million on medications each year that could be bought over the counter rather than via a prescription. Often these medicines are cheaper to buy over the counter than it is to pay for a prescription. Given the constraints on NHS finances, do you think that…

Answered: 5,639 Skipped: 93



ANSWER CHOICES	RESPONSES	
We should only prescribe items that cannot be readily purchased over the counter to enable the money to be spent on other healthcare services	92.84%	5,235
We should continue to prescribe anything people need and reduce other healthcare services	7.16%	404
TOTAL		5,639

Fig 5. Question four graph exported from SurveyMonkey

People were mostly supportive of GPs not prescribing medicines that could easily and cheaply bought over the counter in most pharmacies. However, people felt that there should be still be exceptions to this at the GP's discretion. If the GP felt that the patient would not buy the medicine and the condition or illness would deteriorate then they should still prescribe that medicine. People also told us that people on low incomes may struggle to buy those medicines so should still be able to get them on prescription if deemed necessary by their GP or prescribing clinician.

People also told us that schools and some care agencies would not administer medicines that were not prescribed, so they needed to get those medicines prescribed to ask the school or care givers to administer them.

People told us that they felt the people who receive free prescriptions should be reviewed. Some people receive free prescriptions due to having a specific long-term condition as that condition requires them to take regular medicines. The free prescriptions then apply to everything that is prescribed to treat that person, whether related to their long-term condition or not. People felt that the free entitlement should only apply to drugs related to the existing condition, not everything else. People also questioned which conditions made people eligible for free conditions. Asthma was raised as a condition which didn't make people eligible for free prescriptions but people with asthma need a lot of ongoing medical prescriptions to keep well. People asked us to review eligibility for free prescriptions, especially age. Free prescriptions from the age of 60 years was considered too young, especially now that retirement ages were higher than this.

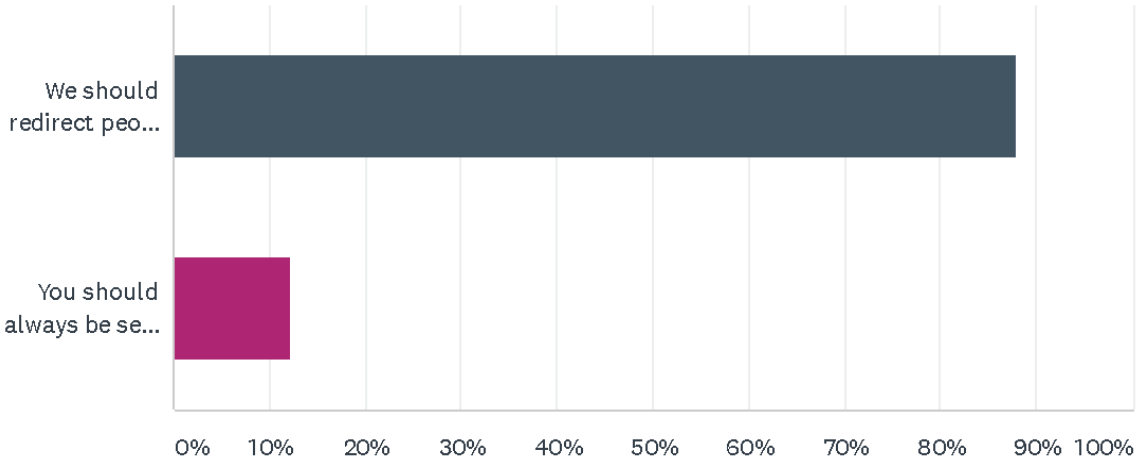
Another suggestion was that the NHS should print the costs of the drugs on the packets so people could see how much their medication was costing the NHS even if they were entitled to get it for free. People might then be more careful about what they ordered and in what quantities.

Some people felt that drugs should be prescribed in larger amounts to reduce necessity for constant re-ordering and administration cost, other felt that when medications were being changed that smaller amounts should be prescribed. Then if the patient had a bad reaction there would be much less waste.

People also thought that the NHS centrally should negotiate harder for better deals on drug prices.

Q5 Like many other areas we have busy A&E departments and sometimes we struggle to see the most urgent cases quickly. Do you think…

Answered: 5,659 Skipped: 73



ANSWER CHOICES	RESPONSES	
We should redirect people to other NHS services if you go to A&E and do not have a serious injury or illness that needs to be dealt with as an emergency	87.88%	4,973
You should always be seen at A&E if you go there and you shouldn't be turned away	12.12%	686
TOTAL		5,659

Fig 6. Question five graph exported from SurveyMonkey

There was generally consensus on this issue in the comments we received and at the public meetings. People told us that we should turn people away from A&E if they shouldn't be there. A&E should only see those that are urgent.

Although some people felt that could be a risk as some people presenting with what might appear to be minor ailments could actually be more urgent.

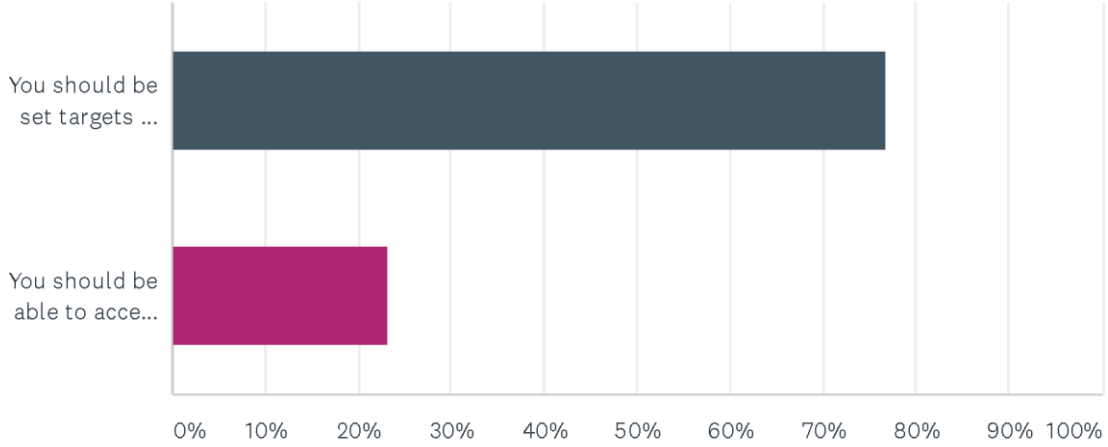
This question also raised the issue that people don't know where to go, or what needs urgent care. Some people felt you shouldn't be able to walk into A&E. You should only be able to go there if you have been directed there from a different service or delivered by ambulance. However, some people told us that it is known that if you go to hospital in an ambulance, you are given priority which doesn't encourage people to drive themselves there and could account for unnecessary ambulance call outs.

People felt that we should have a triage service that sees everyone first unless they are in an ambulance or referred there by being seen by a clinician elsewhere first.

A few responses said that people who abuse alcohol and illegal drugs should not be treated by the NHS in A&E. Or if they need to be treated, they should be billed for their treatment.

Q6 Research shows that by living a healthy lifestyle – for example not smoking, maintaining an active lifestyle and healthy weight, and not drinking too much alcohol – you can reduce your chances of suffering from a number of illnesses and diseases, such as cancer, diabetes and heart disease. Given these facts, do you believe…

Answered: 5,641 Skipped: 91



ANSWER CHOICES	RESPONSES	
You should be set targets to improve your own health, such as stopping smoking, reducing your weight or alcohol consumption, before having planned operations	76.74%	4,329
You should be able to access whatever services you need, even if you do not make lifestyle changes that would help to manage your condition better	23.26%	1,312
TOTAL		5,641

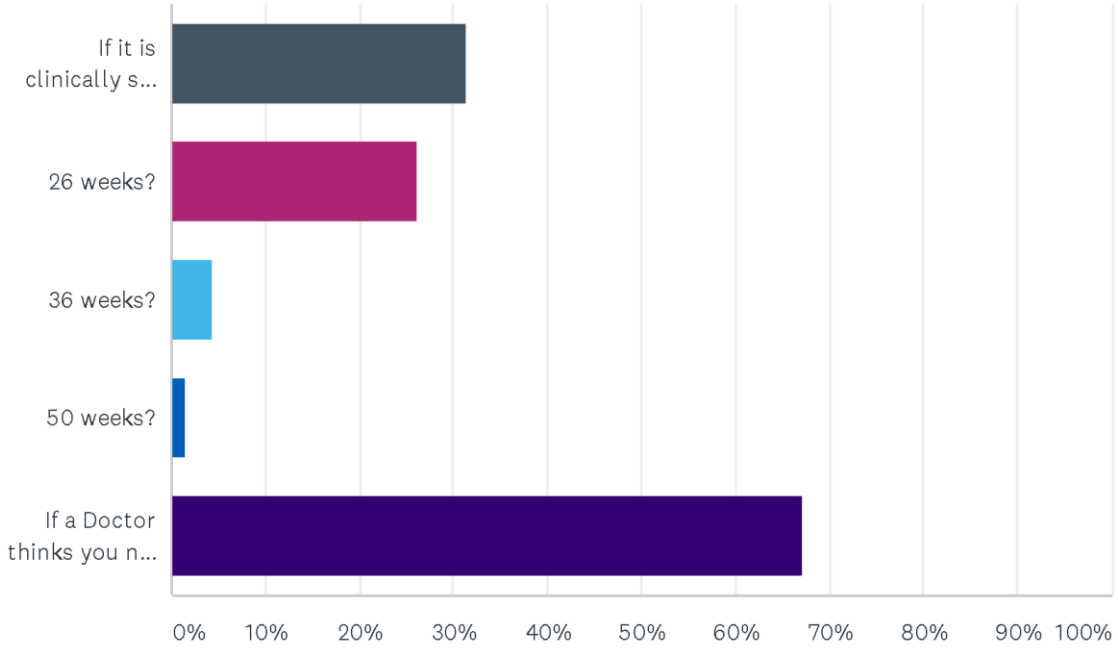
Fig 7. Question six graph exported from SurveyMonkey

The feedback we received on this issue was that people should be empowered to look after themselves, but not in a patronising way. Setting realistic goals and targets in order to improve their health is much better than imposing restrictions on services for people based on their weight or whether they smoke or not. Some people may not have access to information on healthy lifestyles so more needs to be done to educate people, especially children and young people. Changing old habits to a healthy lifestyle can be difficult so people need support.

Some people told us that the NHS should look at alternative therapies and holistic treatments, especially around healthy lifestyles and wellbeing.

Q7 Due to medical advances and people living longer and with more complex diseases we are seeing a big increase in the numbers of hospital referrals and planned operations. There are a number of reviews into how waiting lists are managed. Do you think . . .

Answered: 5,643 Skipped: 89



ANSWER CHOICES	RESPONSES	
If it is clinically safe to do so, you would be happy to wait longer than 18 weeks for a procedure or appointment so that more urgent patients can be seen first? If so, how long would you be prepared to wait...	31.28%	1,765
26 weeks?	26.10%	1,473
36 weeks?	4.39%	248
50 weeks?	1.54%	87
If a doctor thinks you need to be seen, then you should be seen as soon as possible	67.22%	3,793
TOTAL RESPONDENTS		5,643

Fig 8. Question seven graph exported from SurveyMonkey

People told us that they felt that waiting times were long enough. People have accepted that you have to wait for NHS treatment but felt that 50 weeks, or nearly a year was too long, especially if you were experiencing pain or discomfort.

People understood that priority was given to some conditions but felt that more could be done to reduce waiting times.

People felt that if all of their tests and consultations could be done on the same day in the same place then they wouldn't mind waiting a bit longer. People got frustrated with multiple visits to the same hospital for tests on one day, results on another, visit with a consultant on a different day again. People want a one stop shop for diagnosis – all tests on the same day, in the same place, followed by an appointment with someone who can understand the results. Lots of people told us about inefficiencies around repeated tests, where a GP would request a test only for this to be repeated if the patient saw a different medical professional. Test results not being shared before appointments meaning that tests needed to be repeated.

Lots of people told us that the NHS should be training many more GPs, consultants, nurses, midwives and other health professionals. People thought that If we had more clinical staff trained in the UK then we wouldn't have such long waiting times. A number of people felt that nursing training should not be through a degree. People should not have to pay university fees to training to be a nurse. This should be vocational training through apprenticeship-type training. This type of training does exist but is not widely known about. People felt there should be bursaries and training grants for people who want to work in medical professions that are bound into working in the NHS for a number of years after the training is complete. Introduce more degree-level apprenticeships for medical training so people can earn while they train.

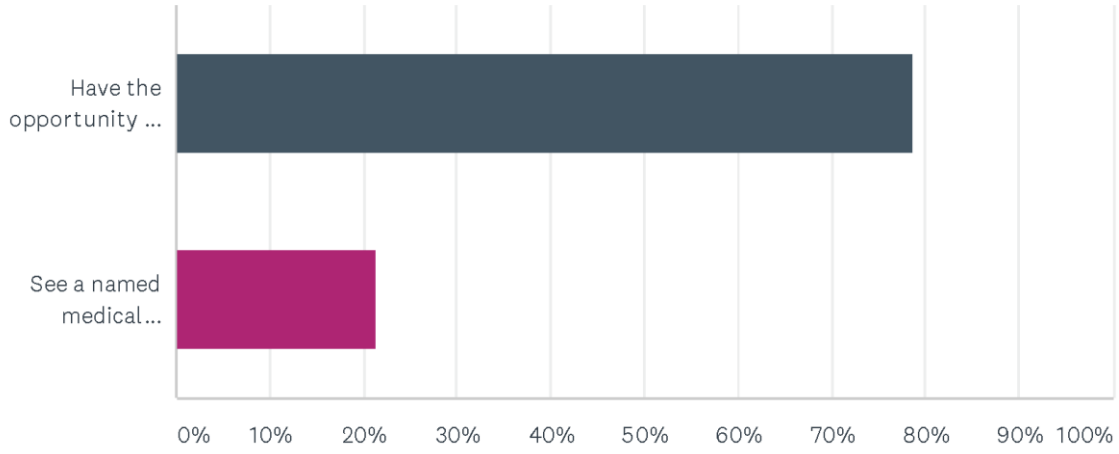
Others felt that there should be more NHS staff generally – in all areas. This would help with admin such as booking appointments and managing waiting lists etc. Others felt that all NHS managers should have to have medical training so they can fill in when needed. For example, we shouldn't have professional managers in the NHS, everyone should work on the front-line treating patients.

As well as training more staff people felt that more staff were needed in frontline service, especially nurses and healthcare assistants in hospitals. They felt that staff didn't have the proper time needed to care for people fully and that people in hospital were left on their own a lot, or if they had family, that the relatives were doing some of the care.

People also felt that there should be reduced managers and admin staff to allow for more clinical staff. Although others felt that each service should have dedicated admin and appointment team to book and manage appointments. Other felt that the NHS should be run by professional managers from business who could negotiate better deals for NHS resources.

Q8 Looking at how we use technology, would you prefer to…

Answered: 5,578 Skipped: 154



ANSWER CHOICES	RESPONSES	
Have the opportunity to access healthcare services faster via technology, for example telephone appointments with your GP or live chat with a trained healthcare professional	78.70%	4,390
See a named medical professional face to face, but have to wait longer for that appointment	21.30%	1,188
TOTAL		5,578

Fig 9. Question eight graph exported from SurveyMonkey

Lots of people agreed with increasing the use of technology in the NHS, for booking appointments, cancelling appointments, and for GP appointments. Increased use of Skype for GP appointments and follow-up appointments with consultants was also mentioned.

Also, people thought we should be exploring the use of Telemedicine for certain long-term conditions. Diabetes monitoring and blood pressure monitoring were mentioned in relation to remote monitoring.

People told us that they wanted to be sent reminders by text of hospital appointments, like some GP practices do. That text and email reminders would avoid people missing appointments.

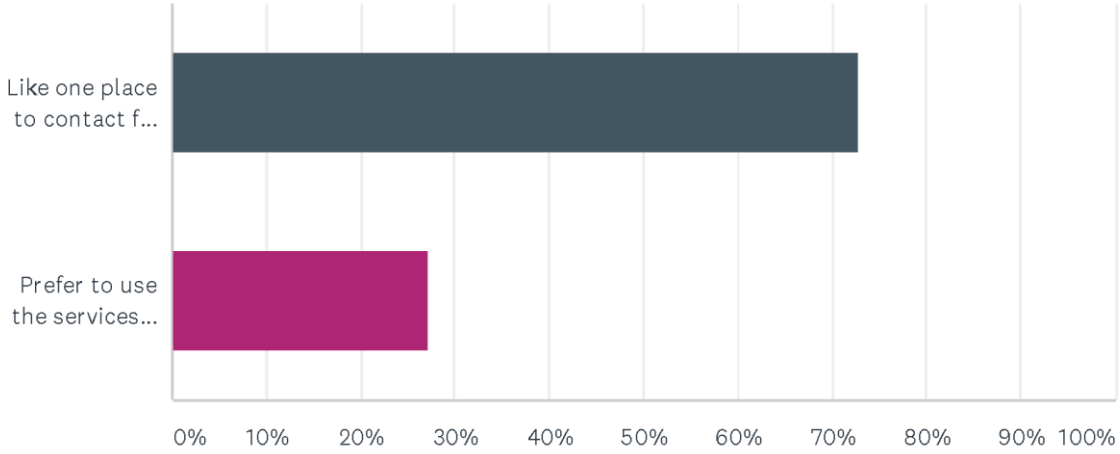
Some people did ask us to consider older people and people who found technology difficult to use in considering how to use technology more in the NHS. People shouldn't be excluded because they are not able to use technology. Some existing systems would need to remain.

When considering technology people told us they didn't understand why the NHS didn't have a single medical record system that could be accessed by health professionals from any health or care venue. People assume in our technologically advanced age that this would be something the NHS could achieve.

Some people told us that GP and NHS websites are too technical or full of jargon that makes them difficult for most people to use.

Q9 When you feel unwell, but it is not an emergency, and you need to see someone to talk about it, would you:

Answered: 5,646 Skipped: 86



ANSWER CHOICES	RESPONSES	
Like one place to contact for advice and treatment which can book you an urgent appointment with the right service, within two days or sooner if need be	72.85%	4,113
Prefer to use the services you know are available and see how quickly you can be seen, such as A&E, Minor Injury Units, Urgent Care Centres, GP out of hours or GP urgent appointments	27.15%	1,533
TOTAL		5,646

Fig 10. Question nine graph exported from SurveyMonkey

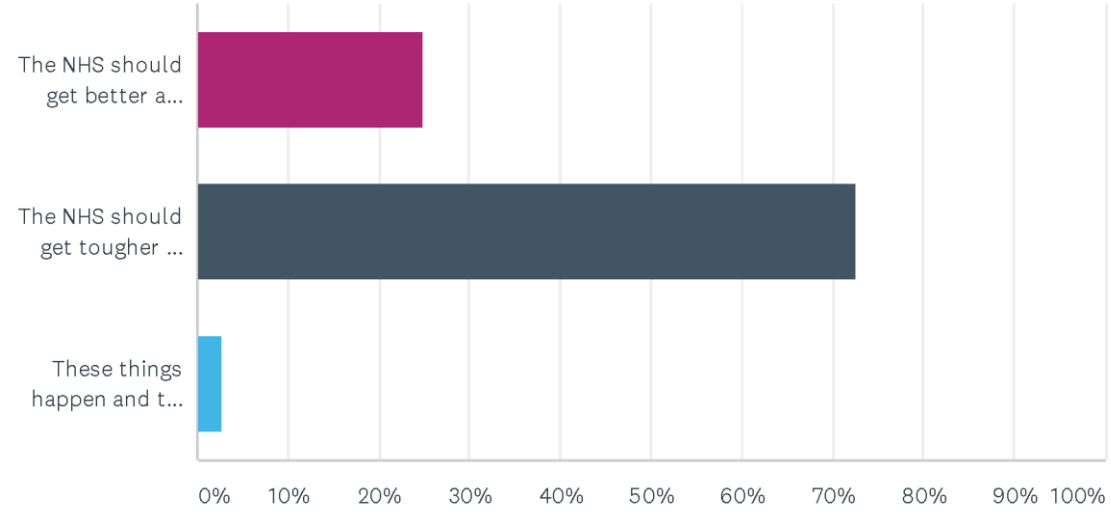
People wanted to remind us that the NHS 111 telephone service is difficult for people who have hearing disabilities or who have learning disabilities. This needs to be considered when developing this service further. Especially as more and more interface with the NHS is done over the telephone.

People told us that they are often confused by the range of services. They sometimes aren't in a position to decide what is and isn't an emergency. When a person you care about needs help or is in pain then it can feel like an emergency, and you take them to where you know they will get help.

Some people gave us good feedback about how the NHS 111 service had directed them to the right service or booked them an appointment. Others were less trusting of the service. Some told us that the questions took too long and were not personal enough.

Q10 Nearly eight million hospital appointments were missed across the country in 2017/18. Each hospital outpatient appointment costs around £120, which means almost £1 billion worth of appointments were missed - the equivalent of 257,000 hip replacements or 990,000 cataract operations. Almost 1.2 million GP hours were wasted because people did not turn up to their appointment - that's the equivalent of 600 GPs working full time for a year. Do you think...

Answered: 5,568 Skipped: 164



ANSWER CHOICES	RESPONSES	
The NHS should get better at reminding people to attend, using automatic reminder systems wherever possible	24.82%	1,382
The NHS should get tougher on people who frequently miss appointments, unless they are vulnerable or have exceptional reasons for doing so	72.52%	4,038
These things happen and the NHS should be flexible enough to manage this	2.66%	148
TOTAL		5,568

Fig 11. Question ten graph exported from SurveyMonkey

People felt strongly that the NHS should be getting tougher on people who miss their appointments without a valid reason.

This question raised lots of issues around **charging people for missed appointments.** Some people suggested that the NHS should charge a small standard fee for every appointment – suggestions between £10 - £30. This money is then refunded if you attend the appointment. People also felt there should be standard charges across the

whole system for any missed appointment that cannot be proven to have valid reason for being missed. Other suggested a three strikes system, on the third missed appointment you are charged for all previous appointments. Lots of people wanted a system introduced where you had to log a bank card or credit card with the NHS in order to receive services. Then it would be easy to charge people for missed appointments or misuse of the service.

Other people suggested the NHS develop a billing type system that lets a patient know how much their treatment would have cost if they had to pay for it. People would then start to value the service they receive from the NHS instead of taking it for granted.

People were keen to point out that there should always be exemptions for people on low incomes.

Another suggestion was that the NHS should charge people who attend A&E after taking alcohol or illegal drugs. There should also be charges for misuse of the service, or abuse of staff. If people attend A&E inappropriately, they should be told that they can be treated at A&E but they will be charged, if they want a free service then they need to go somewhere else.

Several people also thought that people should be charged for meals in hospital, this would help to improve the standard of food and be less of a drain on NHS resources.

Some people felt that if people could afford medical insurance then they should be encouraged to buy it, leaving the NHS for those who can't afford it.

Linked into this several people told us that we should introduce a deposit system for NHS equipment, so less of it went missing. For equipment such as mobility aids you should have a deposit to make it worthwhile retuning it when it is no longer needed. That equipment should always be returned so it can be used by other people. Too much disposable equipment used

The other issues that this question raised was parking at our acute sites. Parking issues should be properly planned before any new health facilities are built, or services are moved. There are not enough spaces, charges are too high. Often this can result in missing appointments as there is nowhere to park, or it takes so long to park that the appointment is missed. Another issue for parking is that there are never enough spaces for people with mobility issues near to the entrance or exit. This concern was raised as an issue at both of our large acutes, but with particular issues at Peterborough City Hospital. With only one exit and entrance to the site there can often be huge issues for people trying to leave, or ambulances gaining access at busy times.

Some people felt that staff should be given free parking at their places of work, other felt that staff should not be able to park in hospital car parks and other arrangements should be made for staff freeing up parking for patients and those attending with them. This was a particular issue for some staff as well as patients and visitors. People also felt that parking charges should go directly to the hospital trust not to private companies who manage the carparks. Public transport and cycling access were also raised as issues. Although there is public transport to our acute sites it was felt that not enough was done to promote and encourage use of sustainable transport.

Other issues raised

GP services. People had a lot to tell us about GP services. People were aware of the shortages faced by GP practices and felt that not enough was being done to train new GPs and encourage them to remain GPs. We should focus on recruitment and retention of GPs and associated practice staff. People told us of the difficulties they had making appointments at various GP practices, that they had to call at specific times of day then couldn't get through on the phone, or had to make multiple calls or stay of hold for long lengths of time. Often then to be told that all the appointments had gone, and they needed to call back at another time. People told us that they often had to wait a long time for a planned GP appointment and that getting through on the day was difficult.

Some people who had experience of the Doctor First system of call backs really liked this service as it meant that they spoke to someone on the day every time. Other people did not like this service as they felt they were being denied a face-to-face appointment.

Many people told us that there simply weren't enough GP appointments and they felt they had to struggle to be seen. Also, that GP appointments were too short, that they wanted to discuss a range of issues with the GP not just one thing in a short 10-minute appointment. Some people asked us why there couldn't be group appointments for people with the same condition such as diabetes, they could talk to each other as well as trained medical staff.

Some people told us that would prefer there to be a range of staff available at the GP practice, nurses and pharmacists so the GPs time could be used for those that need it most. Some people felt they wanted more stability and consistency in Primary Care, that they were always seen by different people which meant they were going over things from a previous appointment. People also told us that they wanted GP appointments to be available at weekends and later into the evenings. People felt that this would prevent people from turning up at A&E unnecessarily.

Sustainability and environmental issues. People told us that we were not doing enough to ensure that our sites and services were environmentally sustainable – in terms of transport facilities, waste management, and reduction of carbon footprint. They asked questions about resource use for managing our buildings as well as how we are working to reduce the carbon footprint of the NHS locally.

Mental health services. Mental health services were seen a key issue that needed addressing. People told us that we needed to increase spending in this area and give more support at an earlier stage to those who need mental health support. People found it difficult to access services and apart from calling 999 didn't know how to get help for someone in a crisis situation.

There was an emphasis from people on improved services for children and young people. People felt that not enough support was given to children and young people early enough. That people did not know where to go to find help for children and young people and more should be done in collaboration with education services. It was felt that finding the right support early enough was difficult, often leading to a mental health crisis that could have been avoided.

People felt that waiting lists – and the length of time between referral and treatment was often far too long in this area of service. People also wanted us to be aware that other services were difficult to access for people with mental health needs. More training for all staff in recognising those with mental health needs was needed.

Dementia support was a specific area that was raised, people found it difficult to access support, and assessments and more services were needed to help those with dementia and Alzheimer's, which could in part reflect our attendance at two dementia support group meetings. Older people had specific mental health needs and need different types of support.

Other specific services that were mentioned were eating disorder services. People told us that access to these services were difficult, as often the person needing help does not recognise it, or accept they need it. It is often family or friends who need help to support he person with the eating disorder, and there is a lack of provision around these types of conditions. People also mentioned the charity Petals in their responses. This was in the news as the BIG conversation started. People found this a very valuable service and wanted us to be support the service to continue.

Royston - We had a large number of responses from people in the Royston postcode area people from Royston told us that it was important to them to have a health and care hub in **Royston** using the old hospital site. The 'friends of Royston hospital' group circulated a lot of leaflets in Royston with support of the local MP Oliver Heald. Lots of response wanted us to look at using the old hospital site as a community health resource, or an intermediate care facility for older people between hospital and home.

Health and social care should work more closely together – particularly for children and older people. It was felt that services were too disjointed, and it was difficult to know where to go to get help when it was needed. People felt there was a waste of money and resources by health and social care not working closely together. There need to be more community funded roles which help people in the community. People also told us there were shortages of care assistants working to help people with their social care needs.

St George's hydrotherapy pool in Peterborough was mentioned by just a few respondents as an important facility. People it should be supported by the local NHS even if they can't fund the service. Many people benefit from this facility and pay for the service themselves.

NHS dentistry - needs improvement. People told us there are not enough dentists who take NHS patients in some areas.

Hinchingbrooke Hospital – keep service there for people of Huntingdon.

Carers – people talked to us about the difficulties faced by carers. There are thousands of carers out there who are in effect part of an unpaid workforce, it is hard for them to attend meetings, and they have little support.

Demographic information

We collected a small amount of demographic information in order to be able to ensure that we were reaching a broad range of people from across our area demographics.

In relation to age, those who chose to answer this question gave the following responses:

ANSWER CHOICES	RESPONSES	
16-29	9.19%	523
30-44	25.01%	1423
45-59	29.43%	1674
60-74	28.53%	1623
75+	7.84%	446
TOTAL		5689

The number of people between the ages of 16-24 went up after we had emailed the BIG conversation documents to all school sixth form departments in our area.

In relation to ethnic background this was a free text question in order not to be too prescriptive in how people wanted to respond.

The majority of people who answered this question gave their ethnic background as white British. Roughly 100 people described their ethnicity as European. There were some responses from people describing their ethnic background as Asian, Mixed, Black, Pakistani, African, and Indian, roughly 20 people from each group.

We also asked people for the first part of their postcode. The mix of postcodes showed that we had responses from a wide geographical area covering our whole area. Half-way through the engagement we looked at the data for where people lived to make sure we were reaching people across the area. In the postcode areas where we had the least responses, we did some targeted work on Facebook groups to encourage more people to take part, and this saw an increase in the numbers for these postcode areas.

Next steps

1. Share the feedback and responses to the BIG conversation with all of our stakeholders and the public via the CCG website.
2. Share the feedback and responses to the BIG conversation with NHS England, all other NHS providers in and around Cambridgeshire and Peterborough.
3. To ensure that the feedback from the BIG conversation is considered as part of the commissioning process for the future.
4. The BIG conversation with Primary Care – we have just stared another BIG conversation with our primary care staff and teams to ask them what they think is going well and not so well. To ask them how we can improve primary care and ensure it is sustainable for the future.

APPENDICES

Appendix 1 – Healthwatch Community Values Panel Report 1
Appendix 2 – Healthwatch Community Values Panel Report 2
Appendix 3 – Healthwatch response to BIG conversation

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The first

Community Values Panel

Talking about the availability of over the counter medicines on prescription.

Can our NHS afford this?

An independent panel for Cambridgeshire and Peterborough

Contents

Key Findings

30 local people from across Cambridgeshire and Peterborough joined a Community Values Panel to have a say on funding local health services.

The panel was set up by the people who plan and buy health services in our region – Cambridgeshire and Peterborough Clinical Commissioning Group (CCG). It was supported by our Healthwatch.

The panel met twice in the autumn of 2019 to help the CCG work out what's important to local people. This report includes the outputs of the first panel meeting on 24 October in St Ives.

Panel one

Twenty-six panellists on the day helped the CCG think about whether people should still be able to get over the counter medications on prescription. They heard from experts at the CCG who told them about:

+ The tough decisions the CCG has to make to reduce their £75 million debt. And how they are having a 'Big Conversation' with local people to help them think about this.
+ How the CCG spent £117 million on prescriptions in 2018. This includes £5.3 million on medicines that people could have bought without a prescription.
+ How £4.7million worth of unused medicines were returned last year. Once returned, they must be destroyed and cannot be used for other patients.

What the panellists thought

Panellists were asked to vote on how much they agreed or disagreed with the following statements at the start and then again at the end of the day. We wanted to see how their views changed after finding out more about the issue.

1. **We should only be prescribed items that cannot be purchased over the counter to enable the money to be spent on other health services.**

   At the start of the day, over half of the panellists thought GPs should only prescribe medication that cannot be bought over the counter. A further quarter thought they should still be able to prescribe over the counter medicines in exceptional circumstances.

   At the end of the day, people's votes remained similar.

2. **We should continue to prescribe anything that people need and reduce other healthcare services.**

   At the start of the day, seven out of ten panellists thought the CCG should not reduce other healthcare services so they could continue to prescribe anything that people need. At the end of the day this increased to eight out of ten people.

Shared values

Through a series of activities, the panellists thought about what values were most important to them around access to over the counter medicines on prescription. They also talked about what was least important for the CCG to consider.

Most important

+ People taking personal responsibility – with better education and information.
+ Reducing waste.
+ There was a 'safety net' for vulnerable people.
+ Financial prudence.

Least important

+ Entitlement to 'free' medication.
+ Personal choice.

About the panel

Why the panel was formed

More people are using NHS services. But money is limited. The CCG's £1.3 billion pays for things such as doctors, hospitals, community services, some pharmacy services and mental health services.

But the CCG is operating with £75m debt and needs to make some tough decisions about what health services to buy for the region's 980,000 people.

They must save money this year and spend less in the future.

The Community Values Panel is part of the CCG's Big Conversation asking people:

+ What they value most, and
+ What changes could be made to the way people access and use health services.

Our Healthwatch suggested a Community Values Panel as a new way to help the CCG understand in some depth what's important to a representative sample of our local population. And to find out which values the panel prioritises when considering a particular part of our local health service in challenging times.

Big Conversation

Between October and December 2019, the CCG launched their 'Big Conversation' to help them understand what is most important to people in the local community.

They asked people ten questions about the choices they say need to be made about affording future services. This was done via an online survey as well as a series of public meetings and visits to local community groups.

As part of finding out what's important to people, the CCG asked Healthwatch to run a series of Community Values Panels to look independently at several topics within the Big Conversation.

The Community Values Panels are funded by Cambridgeshire and Peterborough Clinical Commissioning group.

Who the panellists are

The 30 members of the Community Values Panel are a representative sample of the population of Cambridgeshire and Peterborough.

People were recruited through a publicity campaign promoted by Healthwatch, partner organisations and the local media, as well as through Healthwatch social media and local events.

Panellists were selected to reflect the diverse demographic characteristics of the population. This was based on age, gender, and district of residence. The selection also aimed to reflect the area's disability, ethnicity, sexuality, long-term conditions and caring profile appropriately.

Not everybody was able to come to both panels. This representative selection was also used when a small number of panellists dropped out and were replaced.

Healthwatch took people's names off the application form when choosing panellists to make sure the selection was fair.

All panellists were paid £50 for each four-hour workshop and reasonable travel costs. The funding included covering the cost of taxis for panellists with sensory impairments and learning disabilities.

Details of how we reflected the CCG population in the membership of the Community Values Panel is shown in Appendix 1.

How the Community Values Panel works

The model is based on the National Institute for Health and Clinical Excellence (NICE) Citizens' Council model which was identified as best practice.

https://www.nice.org.uk/Get-Involved/Citizens-Council.

Healthwatch also learnt from work done to set up Citizens' Councils / Panels in other parts of the country for varying purposes.

Panel meetings were convened by an independent facilitator, Phil Hadridge, with extensive experience in running workshops, and our Chair Val Moore who had direct experience with NICE Citizens' Council.

Healthwatch staff facilitated the table conversations and captured the panellists' contributions throughout the day using a variety of means.

An induction for the panellists included an overview of the NHS (the King's Fund 2018 video), a basic introduction into the CCG's role in buying health services for the local population and the pressures it currently faces.

How the topics were chosen

The CCG and Healthwatch identified topics from the Big Conversation for each panel meeting to consider. Panellists didn't know what the topic was before the day, so had no opportunity to prepare.

This approach provided an opportunity to look at initial reactions and probe more deeply into how people felt and thought about the questions.

The topics for the first two panels were:

+ Prescribing and over the counter medicines
+ Urgent and emergency care.

The CCG provided background information and expert input on each of the topics to help the panellists understand the context and challenges. The panellists were encouraged to ask questions of the experts.

Meeting each other and setting the ground rules

Time was taken at the first meeting to introduce each other and develop ground rules. The panellists decided that they needed to be:

+ Open.
+ Respectful.
+ All comments valid.
+ No question is 'silly'.
+ Not sharing content of day on social media.
+ Confidential, anonymous and not attributable.
+ Photos not to be used until after session.

How the panel was structured

Each Panel meeting followed the same format with some variations in methods:

+ Topical questions described.
+ Vote on questions to test panellist divergence on the topic.
+ Experts, specialists in the topic, explaining context.
+ Structured discussion in small groups.
+ Further scenarios explored.
+ Facilitator exercise to identify community values – what matters, and how people prioritise them.
+ Repeat vote on the topic to explore changes in the Panel view and for individuals.
+ Summary, evaluation and closing business.

Feedback from the CCG representative/s and the local experts was welcomed.

The evaluation forms and the facilitator-led team debrief informed the design and practicalities for the second workshop. A summary was shared with the panellists.

Prescribing and over the counter medicines

The purpose of the first panel was to discover the values people have in mind when considering whether the NHS should prescribe free over the counter medications to people, or not.

Meeting everybody

The session started with an explanation what the Community Values Panel is.

And how the Panel members would explore and develop their thoughts by using a variety of tools and techniques to aid thinking, talking and listening

Panellists introduced themselves, explaining why they had applied to join the panel.

+ Interested, care about the NHS ('The NHS is close to my heart', 'I feel passionately about the NHS')
+ Importance of diversity – 'having all our voices heard'.
+ Equity of access – 'we should all be able to use the same range of services'.
+ Recognising difficult decisions are necessary - financial challenges in the NHS locally.
+ Concerns about the closure (and threat of closure) of local health facilities particularly in rural areas (additional rural challenges) 'things are working well in my GP surgery – I don't want it to change'.
+ Need to reduce demand on services – greater emphasis on prevention.
+ Mental health/holistic wellbeing.
+ Personal interests in local services and hospitals.

The next conversation established ground rules for the way the panellists, facilitators and experts would work together. Panellists were given the opportunity to try out their voting devices with a brief health related quiz.

Where did the panel stand on the topic of the day?

The panellists were asked to vote on two statements at the start of the day.

Statement 1: We should only be prescribed items that cannot be purchased over the counter to enable money to be spent on other health services

12 of the 23 panellists who voted agreed with the statement, and a further six said only in exceptional circumstances. Four panellists disagreed and one was unsure.

Statement 2: We should continue to prescribe anything people need and reduce other healthcare services

19 of the 25 panellists who voted disagreed with this statement, four agreed and two were unsure.

What the experts said

The panellists heard about the financial challenges the CCG are currently facing from Jane Coulson, one of their officers.

The topic of prescribing over the counter medication was introduced by Chief Pharmacist from CCG, Sati Ubi, and Dr Cathy Bennet, a GP and primary care lead for the CCG on prescribing.

Their presentation covered the size and cost of local primary care prescribing, the issue of significant waste, and explained the CCG's prioritisation of the local medicine spend of £117m (see Appendix 2).

In 2018/9

+ £4.7m spent on drugs which were prescribed but not taken.
+ £1m spent on 'low value' drugs (e.g. glucosamine).
+ £5.3m spent on over the counter medication (e.g. paracetamol, head lice treatments, emollients, gluten free products and baby milk).

Questions from the panellists

The panel was surprised to hear that more prescriptions were written for over the counter medicines in areas where people had a higher disposable income.

There was significant interest from the panellists. They asked many questions both during the presentation and in the wide-ranging conversations at their tables.

The questions they asked

+ What happens to the money when there is a difference between the actual cost of the medication and the prescription charge?
+ Can I choose which items on my script I will pay for? I'm concerned that changes will lead to further rise in prescription charges.
+ Could all GPs be encouraged to sign up to a set of principles which would encourage common practice across the area? What can be done to help GPs push back?
+ What more can be done to discourage people from stockpiling their drugs?
+ Is there any alternative to the destruction of unopened drugs? Has this always been the practise?
+ Is there any more information available about drugs destroyed that would help target campaigns?
+ How do I buy medication over the counter if I don't know what I need? I will still need to see a GP?
+ Why is medication not used?
+ Why do GPs and practices vary in terms of their repeat prescribing methods? Seems to be one month sometimes two months. Do 28 day only scripts make more work for the practice?
+ How should reviews happen? Is it appropriate for a dispenser to question the need for medications in front of people?
+ I can only buy two boxes of 16 paracetamol tablets at any one time, but I can get more if I need more on a prescription. How will I avoid lots of return trips to the supermarket?
+ Why am I having problems getting the medication I need?

What the experts told us

The experts from the CCG explained that it is was not possible to re-use medicines, even when unopened, as pharmacies had no knowledge about how medicines had been stored by patients.

They told the panellists that medicines were incinerated for many reasons. This could include clinical reasons, for example when a patient had adverse reaction to prescribed medication. Although there hadn't been any local large-scale audits, they suspected that routinely available common drugs account for a large proportion of incinerated medicines.

They explained that it was only possible to account for medicines returned to pharmacies for incineration. In many instances, patients destroy unwanted or unused medicines themselves.

Discussing changing prescribing practices, the experts explained that GPs are independent contractors and that there are limits to the pressure that can be put on them to change practise.

There is a degree of nervousness from GPs who have concerns about:

+ The amount of time they would need to spend explaining why they couldn't prescribe over the counter medicines.
+ Getting complaints from patients who felt entitled to the medicines.

Different practices can have different approaches to prescribing. This can include things like the number of weeks for a prescription, e.g. 14 or 28 days or longer in some circumstances. But all professionals supported a greater use of practices' online systems to order medication and Apps such as the NHS App.

In response to what they had heard

The panellists as a whole were shocked by what they heard about the amount of wasted medicines. This is what individuals said:

"The public needs to be better educated about this."

"If they saved money from not prescribing so many over the counter drugs – then we could have more money to spend on other things, like a health advice centre."

"If this change is made and you cannot get over the counter medicines on prescription, then I think there will be conflicting views. There will be some angry people – but they will probably be the ones who could afford to pay. And then some others will be fine."

"It is unfair that only people in Cambridgeshire and Peterborough would not be able to get over the counter medicines on prescription, but people elsewhere could. It would be fairer if it was everywhere in the UK."

"I have more disposable income now than I ever had, but because I am over 60 I can get my prescriptions free, whereas my neighbours who are both working and struggling to make ends meet, have to pay. That doesn't seem right,"

"Those of us who can pay, should pay."

"Some supermarkets charge more than others for even generic paracetamol. How can we influence market forces?"

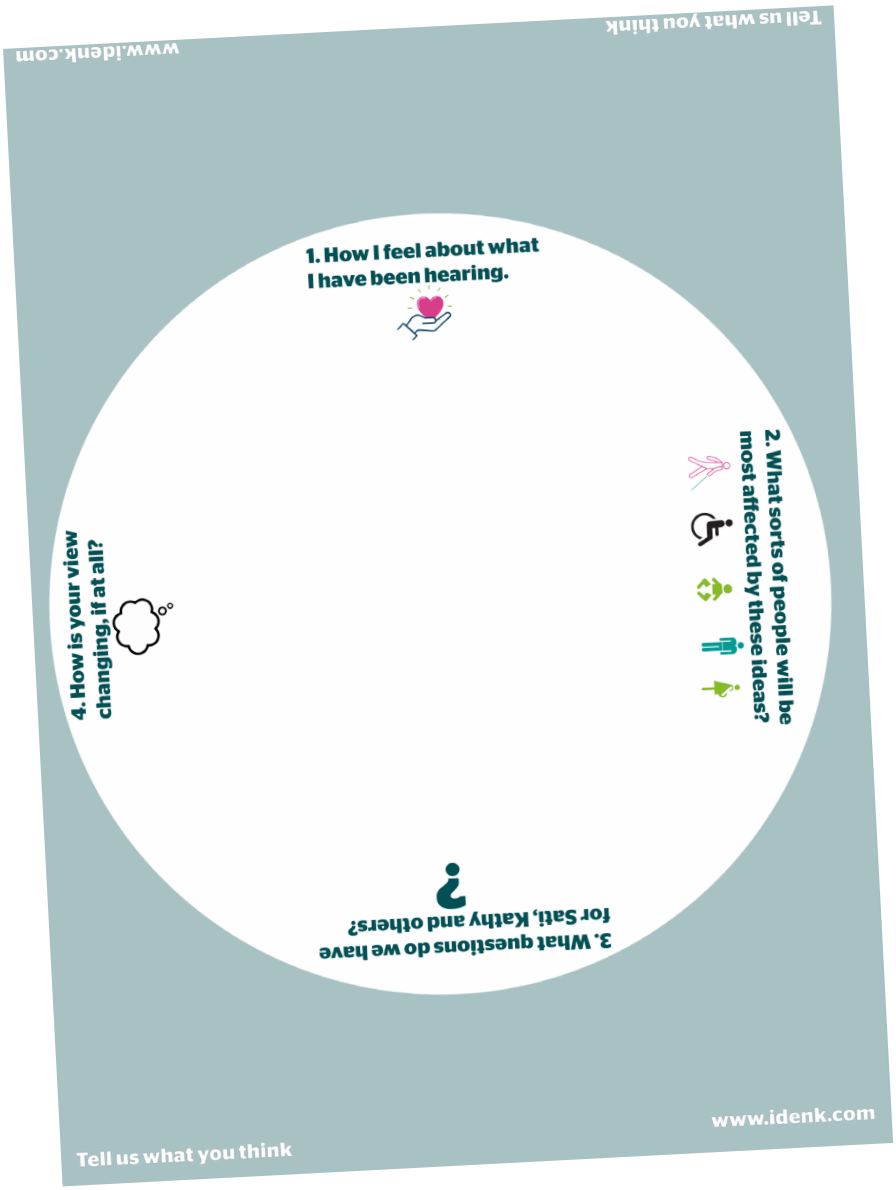
Exploring the issue in more detail

The panellists took part in five facilitated table conversations to explore the issue in more detail. The five groups each also reflected aspects of the demographic mix of the local population.

They talked about:

+ How they felt about what they'd been hearing.
+ What sorts of people would be most affected by changes in prescription practice.
+ If they had any questions for the experts.
+ If their views were changing at all.

Panellists were encouraged to record their feelings, views and questions on posters and post it notes on each of the tables.



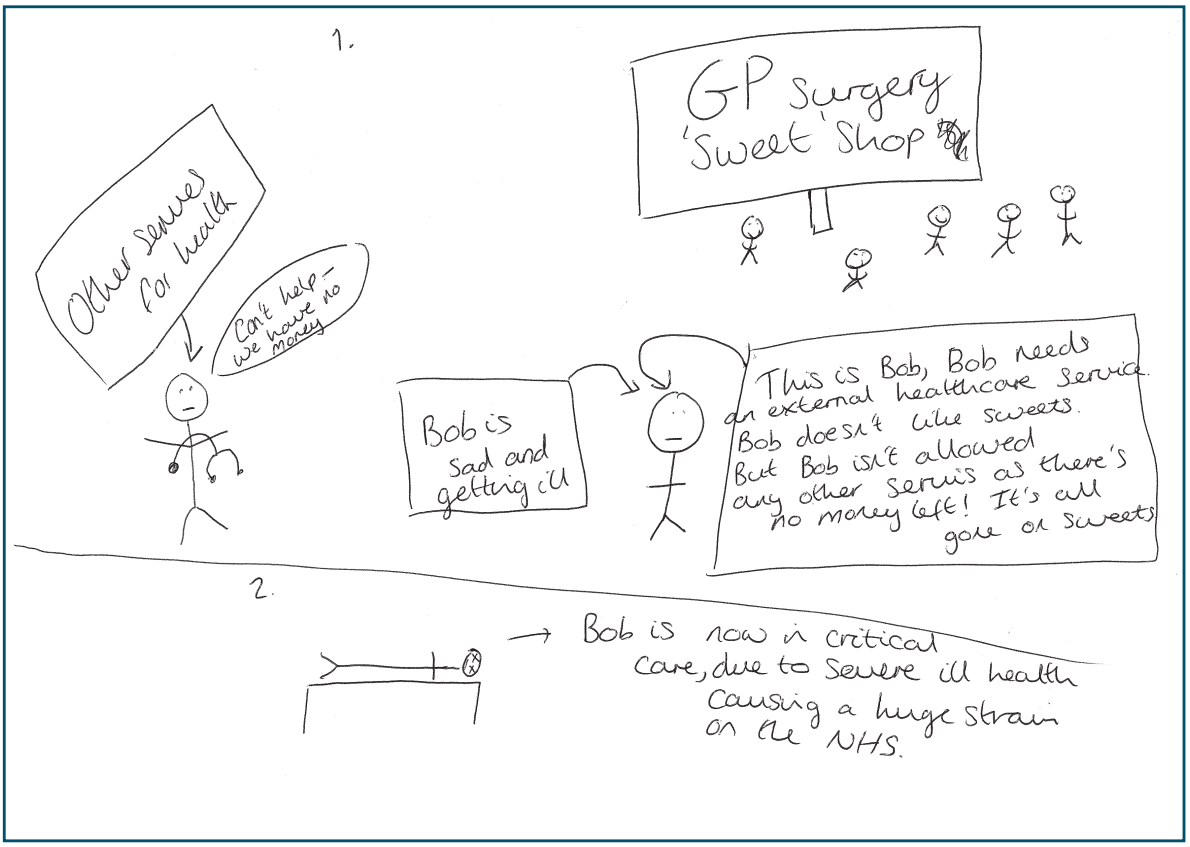
Several themes were identified from the table conversations

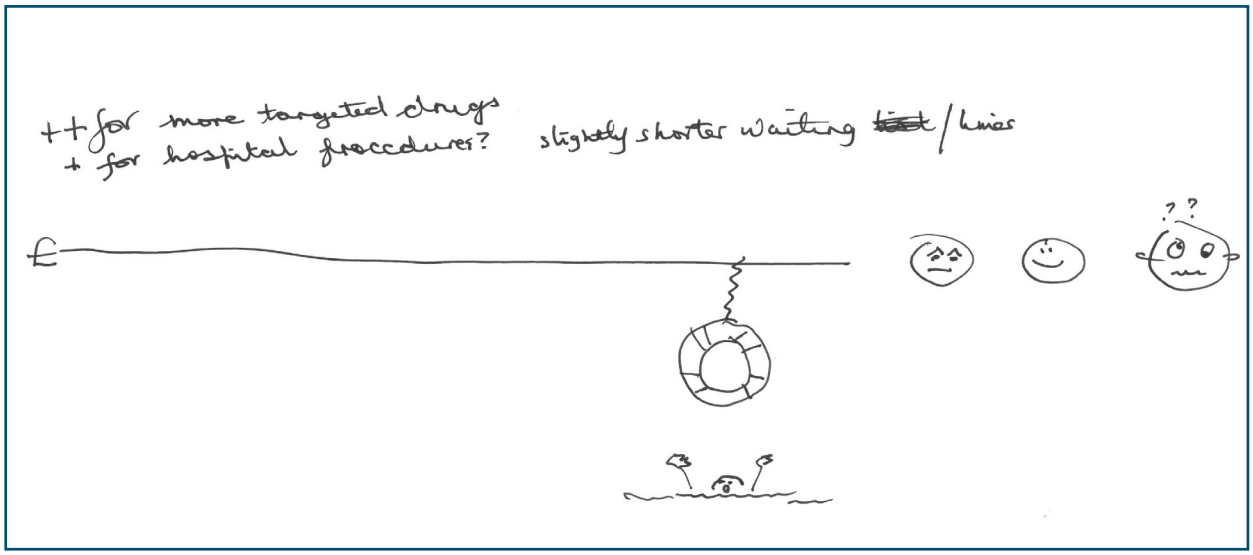
+ Support and pride in the NHS.
+ A desire to see the issue of waste tackled.
+ More, and simpler information to get key messages about waste and cost out to the local population.
+ Degree of lack of understanding that drugs will still be available to them.
+ A 'safety net' for vulnerable groups was imperative.
+ Consistency about what constitutes 'vulnerable'.
+ Support for personal responsibility.
+ Little evidence of shifting views, but people feel better informed.
+ A wish to place the issue in its wider public health context – keep people well and active 'prevention is better than cure'.
+ Implications for people who rely on other people to pick up drugs and prescriptions.
+ Support for making more and wider use of local pharmacists.
+ Wish to see all GP surgeries work to the same set of principles – at very least across the Cambridgeshire and Peterborough, but ideally nationally.

The table posters are summarised in Appendix 3.

And it felt a bit like this!

We asked our panellists to describe with drawing or words, how they felt having heard from the experts and taken part in the discussion of the topic.

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+ for hospital procedures?
slightly shorter waiting ~~test~~ / lists
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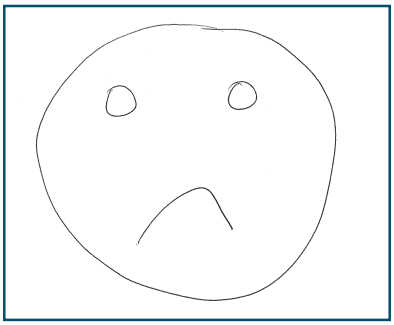
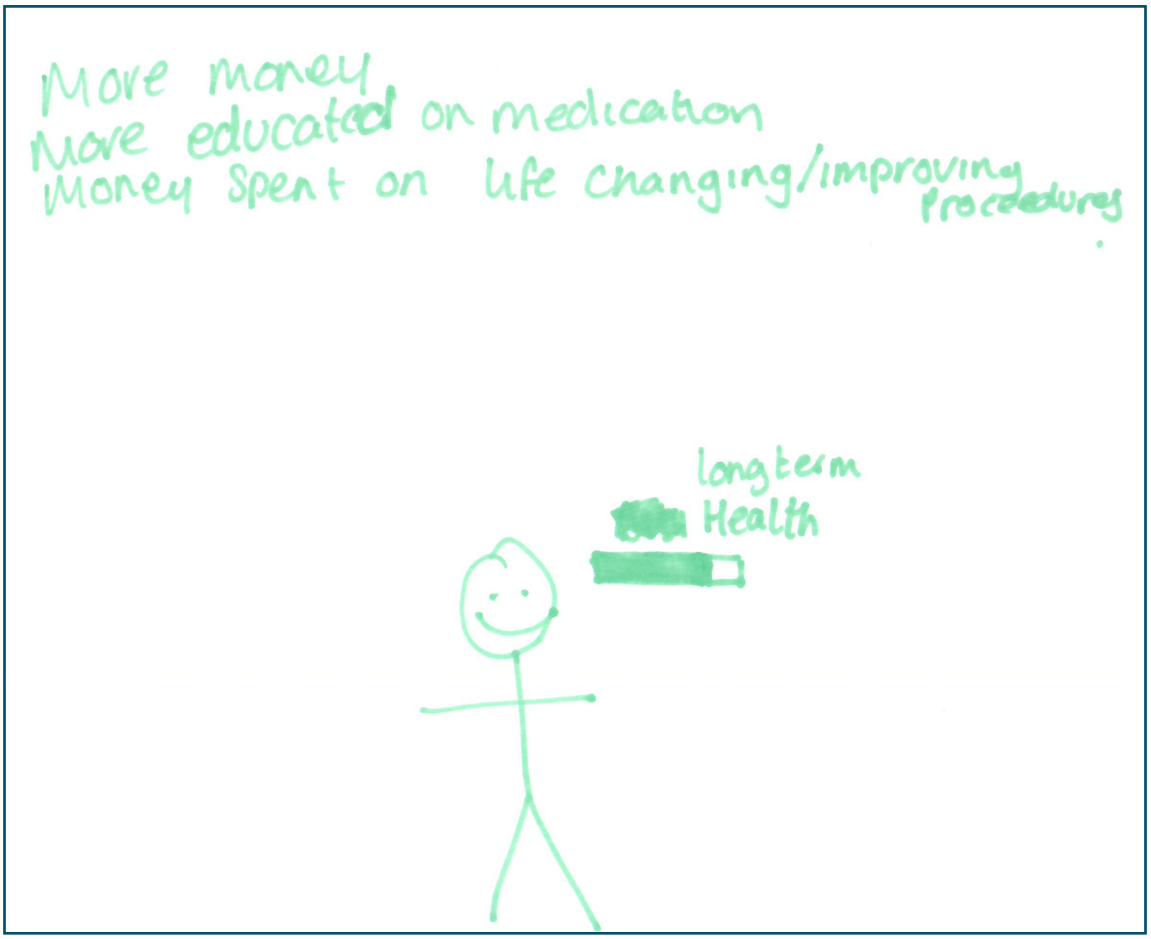
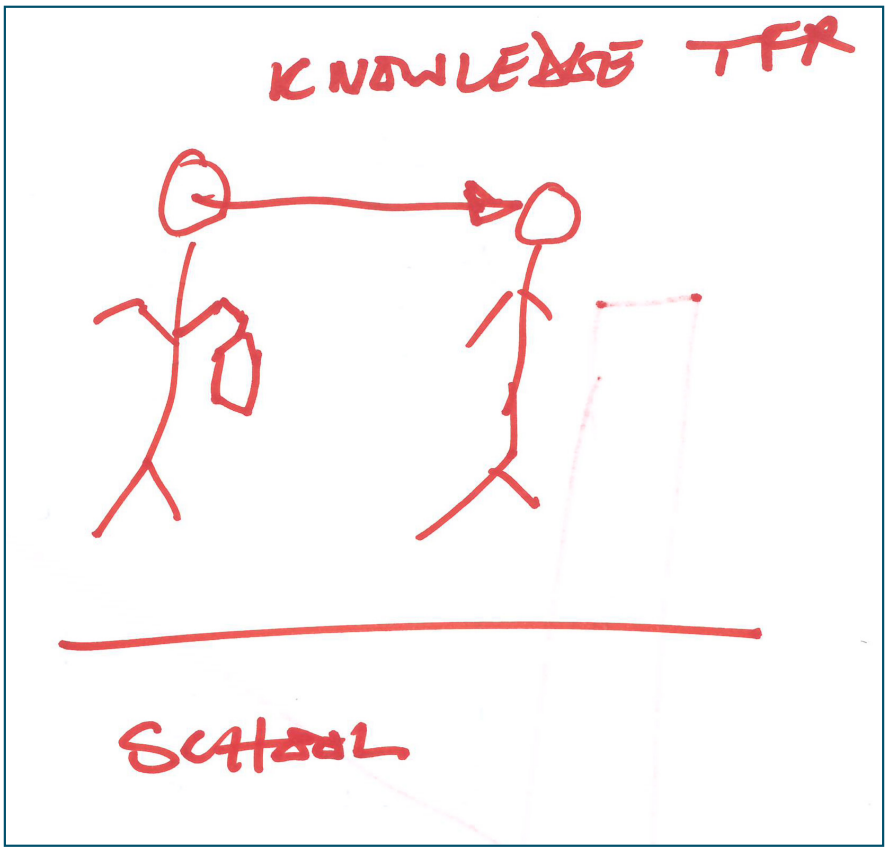
for NHS




More money
More educated on medication
Money Spent on life changing/improving procedures
long term
Health


KNOWLEDGE TFR
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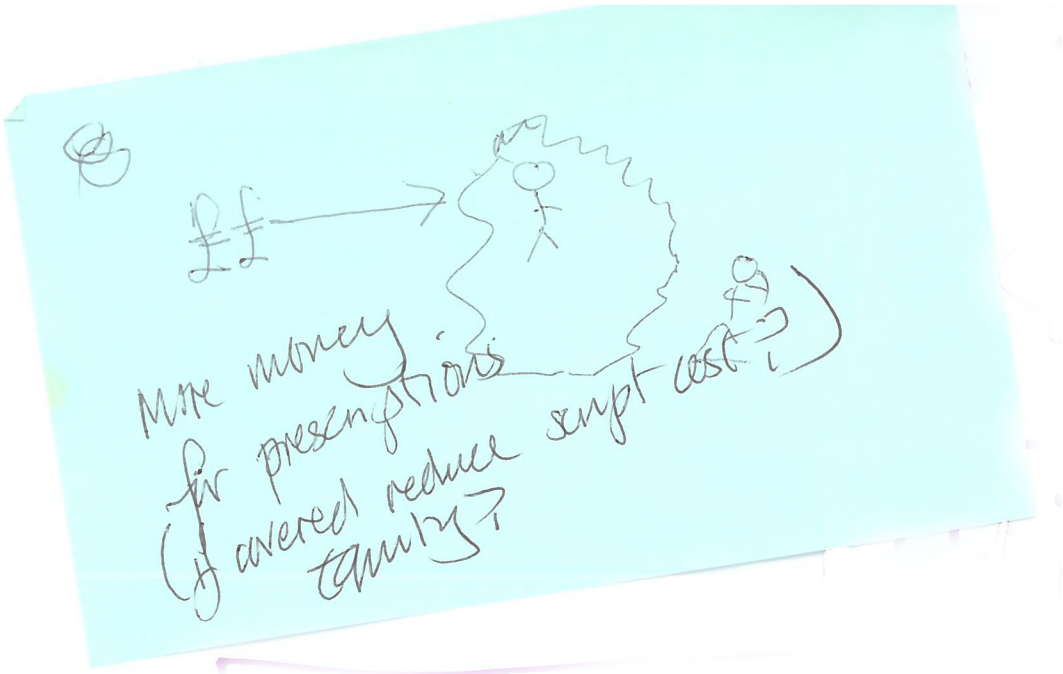
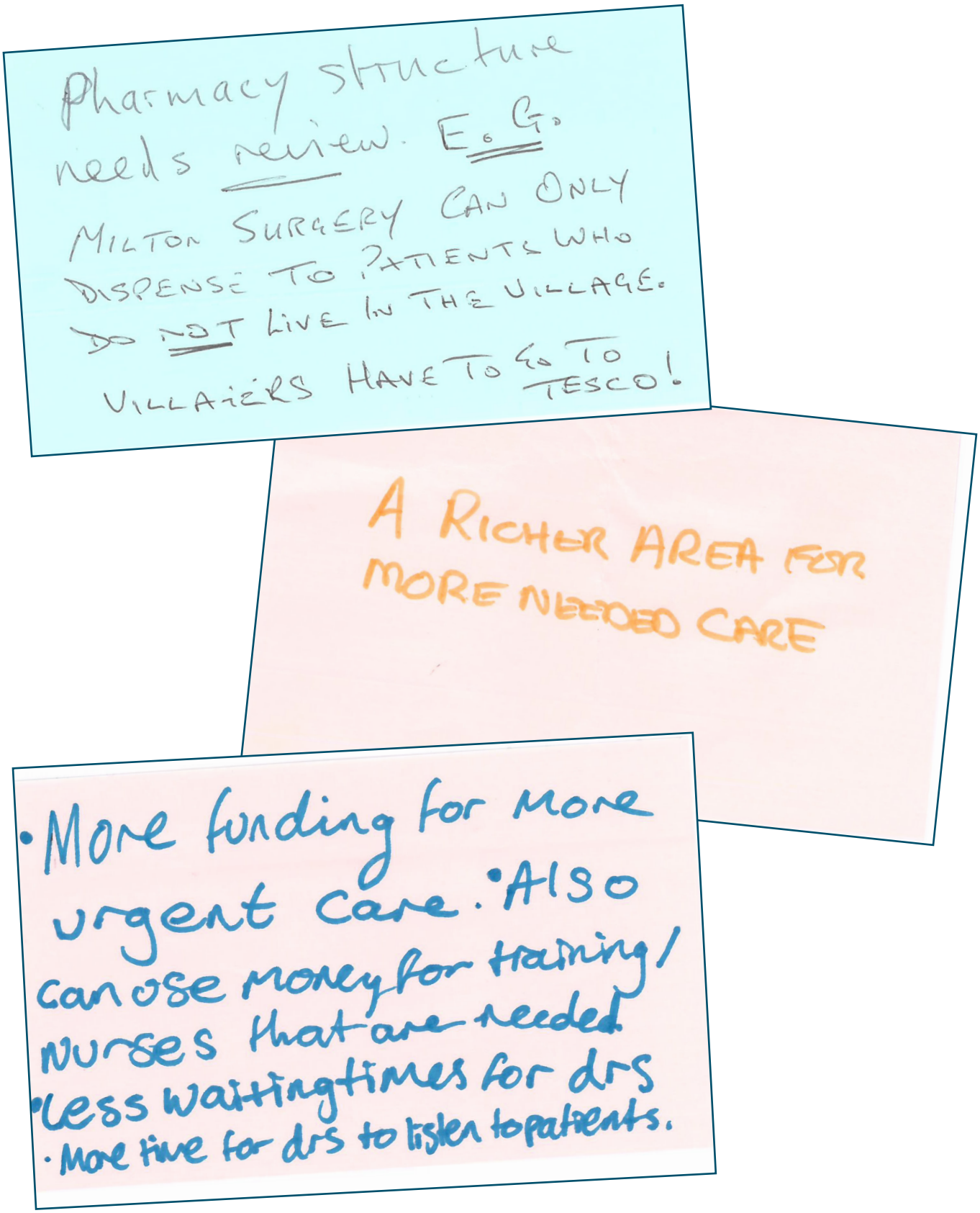
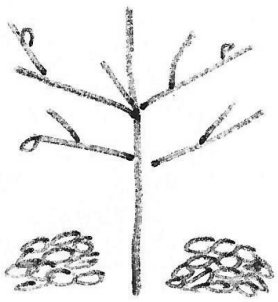
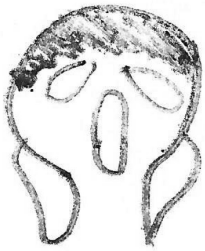

£ £
More money
for prescriptions
(if covered reduce
family?
sept cost?)



See page 37 for the words.





Death

Poor quality of elderly

Lower care for young

Less doctors + nurses

Hospital closures + Poor Aftercare

Insecure health future.

? ? ? ? ?

£ £ £ £ £

DRAIN

The panellists each explained their picture (or words) to the others at their table. Again, several themes were illustrated, for example:

+ Concerns for future funding.
+ Possible threats to services.
+ Confusion about which medications may not be available.
+ Annoyed about the amount of waste.
+ Queries about how potential savings would be spent.

This conversation led on to the panellists then discussing what were the two or three things which they feel the most important.

Values and what matters most

Each group was asked to reach a consensus about the values that were most and least important to them when considering the availability of over the counter medicines on prescription. And which they felt should underpin any future decisions about changes in prescribing.

This was a demanding exercise; however, the panellists were able to agree about what was most important to them.

Which values were most important

The panel as a whole wanted people to take more personal responsibility for their health and wellbeing. And more responsibility for making choices about medicines that were thoughtful of the cost to the NHS. They believed that better education as well as easily available and understandable information was key to this.

The panellists all agreed that there had to be an adequate safety net to make sure vulnerable people were able to get all the medication they needed.

The panellists had been shocked by the amount and value of medication that was routinely destroyed and wanted this addressed.

Messages about financial prudence underlay all the conversations.

Which values were least important

Panellists found it particularly difficult to identify and agree, either individually or collectively, which values they regarded as least important. One group was unable to complete this exercise.

The panellists told us that individual personal choice should be less important. Individuals expressed concerns about people feeling that they were entitled to 'free' medication.

There was a general agreement that doctors should be less concerned or embarrassed about saying 'no' to patients. They also told us that pharmaceutical company profits should be less important but recognised that this was an issue beyond the influence of CCG.

People wanted to see the expert's voice balanced with the patient's voice so that less emphaisis is put on what the expert says and wants.

Appendix 4 shows the full details of the panellists' lists.

Repeating the Panel votes

At the end of the day, the panellists voted again on the two statements related to the day's topic.

The first vote took place before the experts introduced the topic and the second vote at the close of the session.

Statement 1: We should only be prescribed items that cannot be purchased over the counter to enable money to be spent on other health services.

12 of the 23 panellists who voted agreed with the statement, and a further six said only in exceptional circumstances. Four panellists disagreed and one was unsure.

	First vote	Second vote
Yes	12	14
Only in exceptional cases	6	6
No	4	4
I'm not sure	1	1
Total	**23**	**25**

Statement 2: We should continue to prescribe anything people need and reduce other healthcare services.

At the end of the workshop the second votes showed a small change in response to statement two.

Only one panellist answered yes – 'We should continue to prescribe anything that people need and reduce other healthcare services.

Two more people replied 'no', increasing this vote from 19 to 21, and 'I'm not sure' by one.

More people chose to vote on the second occasion. Unfortunately, there was insufficient time to explore the vote more fully to unpick whether there had been any real shift in panellists' opinions about what they described themselves as a very complex issue.

	First vote	Second vote
Yes	4	1
No	19	21
I'm not sure	2	3
Total	**25**	**25**

Rounding off the day

At the close of the meeting, panellists told us how much they had enjoyed the session. They said they welcomed the opportunity to have their voices heard. And that they had learned a lot about the topic and the challenges faced by the CCG from the opportunity to hear and ask questions of the experts.

The evaluation forms confirmed what we had been told. They also said they had valued the opportunity to meet other people and hear their opinions. They liked the tools and techniques used, for example the voting and the table facilitation.

The evaluation forms also told us about the administrative arrangements which we could improve upon, for example the length of time spent on introductions, microphone arrangements and the quality of the coffee.

Reporting on the work of the Community Values Panel

Four panellists volunteered as report checkers to help Healthwatch make sure the reports produced from each meeting accurately reflected the tone and content of the event.

The report produced from each event, along with a shared introduction, sets out:

+ The question being considered.
+ A narrative of the Panel activities.
+ The voting results/ranking at each stage.
+ The factors that influenced people's views and any conclusions.
+ Social values and deliberations about their priority relating to the topic. This is for the CCG to use as community values guidance for taking forward future policy.

Appendices

Appendix 1

Reflecting the population in the CCG area – the percentages and panel makeup.

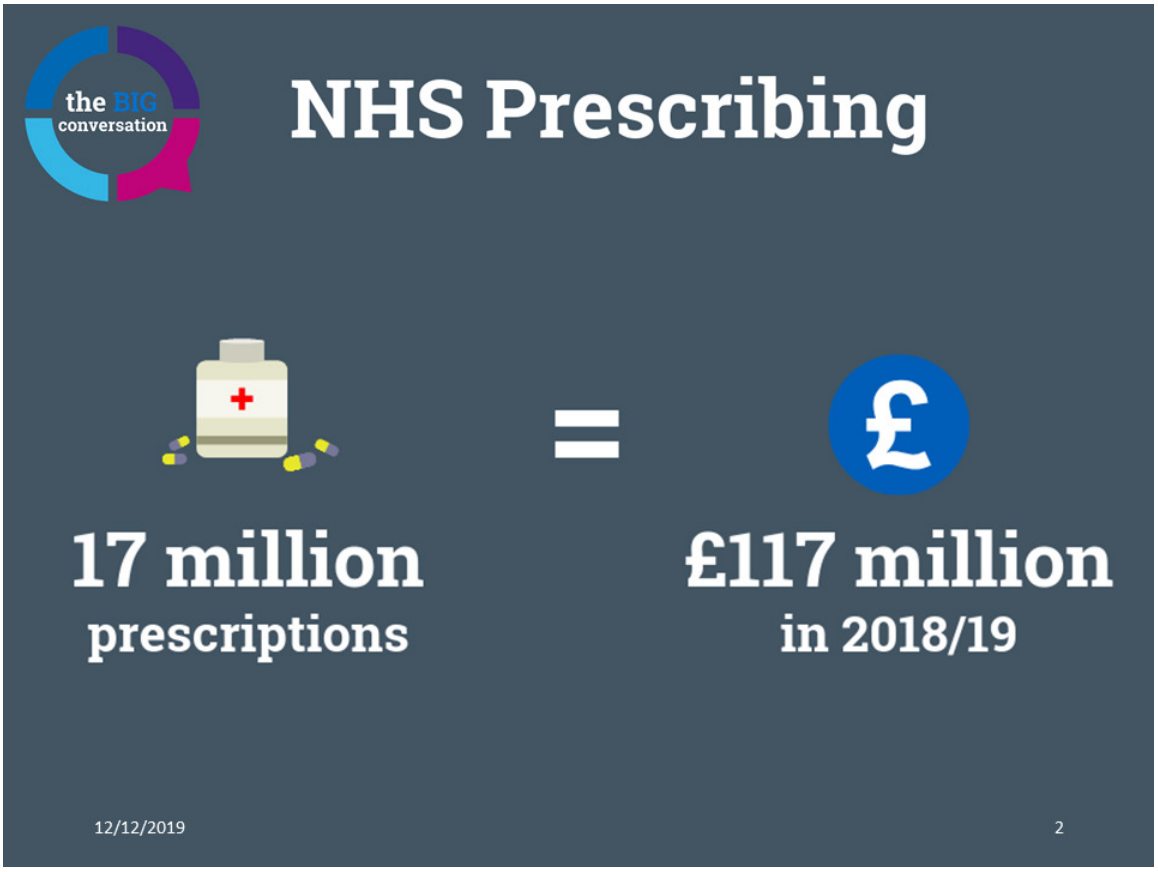
Gender	Female	Male
Percentage in local population	50%	50%
Number of panellists	15	15

Which district or city people lived in	Cambridge	East Cambs	Fenland	Hunts	South Cambs	Peterborough
Percentage in local population	15%	10%	12%	20%	19%	24%
Number of panellists	4	3	4	6	6	7

Age	15 to 24	25 to 44	45 to 64	65+
Percentage in local population	15%	33%	31%	21%
Number of panellists	5	10	9	6

Sub-categories in population	Carers	Disability or long-term condition	LGBTQ+	Minority ethnic community
Percentage in local population	12%	20%	10%	10%
Number of panellists	4	6	3	3

Appendix 2 - CCG Presentation slides



Over the Counter Medication

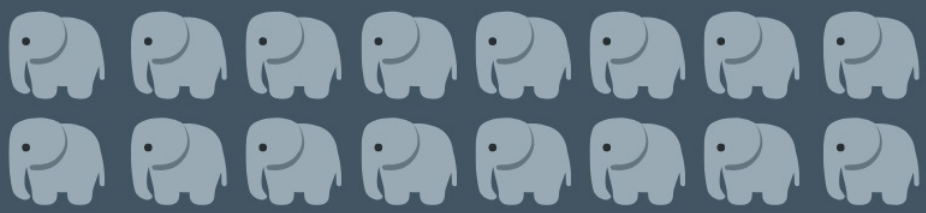
Last year we spent £5.3 million on medicines that our patients could easily have purchased without a prescription at a pharmacy or supermarket.

These include common medicines like paracetamol, emollients (skin creams/lotions), vitamins and indigestion and heartburn remedies, which are more expensive to the NHS when prescribed, compared to how much they cost to buy.

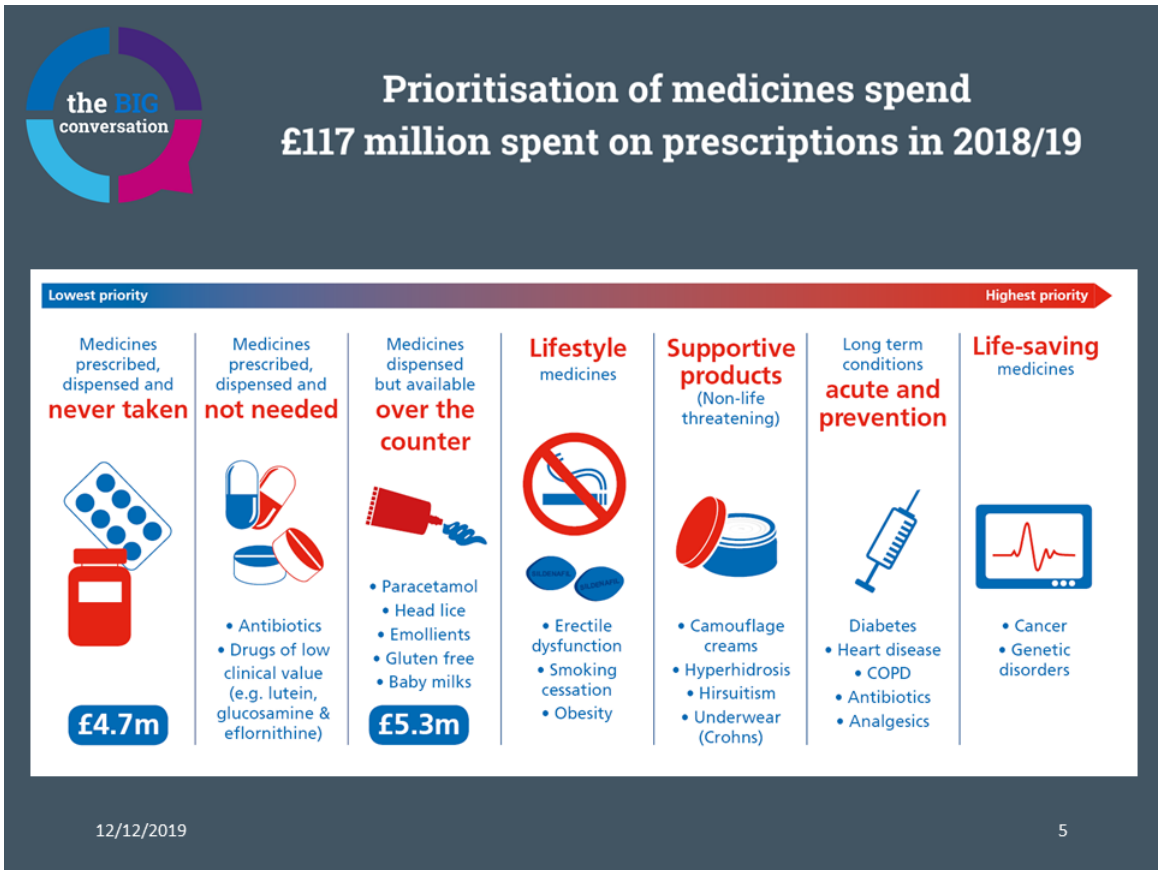
12/12/2019 3

Medicines Waste

£4.7 million of unused medicines wasted
(101 tonnes)



That's equivalent to 16 elephants


the BIG conversation
Prioritisation of medicines spend
£117 million spent on prescriptions in 2018/19
Lowest priority
Highest priority
Medicines prescribed, dispensed and never taken
£4.7m
Medicines prescribed, dispensed and not needed
• Antibiotics
• Drugs of low clinical value (e.g. lutein, glucosamine & eflornithine)
Medicines dispensed but available over the counter
• Paracetamol
• Head lice
• Emollients
• Gluten free
• Baby milks
£5.3m
Lifestyle medicines
• Erectile dysfunction
• Smoking cessation
• Obesity
Supportive products (Non-life threatening)
• Camouflage creams
• Hyperhidrosis
• Hirsuitism
• Underwear (Crohns)
Long term conditions acute and prevention
Diabetes
• Heart disease
• COPD
• Antibiotics
• Analgesics
Life-saving medicines
• Cancer
• Genetic disorders
12/12/2019
5

Appendix 3 - Summary of table posters

Question	What people said
How do I feel about what I have been learning?	Prevention better than cure. Very complicated. I feel peeved that sealed drugs are destroyed. I think the public needs to be better informed and educated about OTC drugs. People don't need medication if we do more to keep them healthy and young. We should try to reduce demand – concerned about safe disposal – people still put drugs down the loo. Time frames for support and care needs to be invested in to deliver best support to the public – saves lives and health.
What sort of people will be most affected by these ideas?	Needs to be exemptions – GP decision? Safety net essential. I suspect the elderly and disabled will be most disadvantaged so there must be a safety net regarding OTC drugs. Vulnerable groups. People who are in poverty – unaware of this, who don't have a voice/ financial/disabilities/minorities. This affects everybody. Helping people out in their local community.
What questions do we have for our experts?	Greater use of generic drugs? Should government take the lead on awareness raising – rather than local?
How is your view changing, if at all?	My views have not changed re over the counter drugs Becoming more aware of the issues. Environmental impact of medicine wastage. We need to be more aware and not in denial. Increasing population – increasing pressure. Income disparity – unfair on those who cannot afford care and medicine, need support.

Question	What people said
How do I feel about what I have been learning?	Frustrated. Are points made being listened to? See French model for basic care for everyone. NHS provides too much (e.g. cosmetic procedures), look at original purpose, NI contributions do not reflect service provision. Free prescriptions at 60 – a political issue. Need better negotiations with drug companies. Personal responsibilities?
What sort of people will be most affected by these ideas?	Rural areas/older, less mobile people who live alone/people on low incomes, especially working people with low income. Wealthy pensioners? Are they 'entitled' or should be linked to retirement age? Cost of living.
What questions do we have for our experts?	How much do drugs cost? More or less than £9? Why doesn't the NHS have their own factories to produce generic drugs cheaply (Indian model)? But concerned about conditions for workers – costs v ethics. Need more advice and recommendations from GPs. What drugs are going into 'waste'? Are they prescribed or also OTC medicine?
How is your view changing, if at all?	Offer a simple YES/NO to those people who want to or are wealthy enough to give up their right to a free prescription. Why just keep paying it to everyone regardless.
Issues/comments unable to allocate	Patients should check their drug bag before leaving the pharmacy. NHS 'Dignitas'. GP conferences funded by pharmaceutical companies.

Question	What people said
How do I feel about what I have been learning?	Good idea to have notices at pharmacies – inform £9 prescription v .45p paracetamol. Reasonable to buy privately when cheaper. People stockpiling drugs now – waste. Need local supplies. £16 taxi, return to nearest ? Confused. Difficult to get what you need. Worried about supplies. Concerned about wrong prescriptions, contra-indications with existing conditions. Need advice.
What sort of people will be most affected by these ideas?	Learning disabilities/lack of understanding. Disabled. Everyone. People with autism. Long term conditions. Low income. Financial difficulties.
What questions do we have for our experts?	How do we educate everybody? Can suppliers do 'sample packs' to see if suitable – could reduce waste? What can you do to prevent stockpiling medicine? Media doesn't help/social concerns.
How is your view changing, if at all?	Not a straightforward 'yes' or 'no'. Feel more informed. Needs simplifying. View hasn't changed due to knowledge and experience.
Issues/comments unable to allocate	

Question	What people said
How do I feel about what I have been learning?	Alarmed to hear how much is wasted. Waste – given a month's supply of tablets but only needed to take them for 10 days. GPs need to be able to say 'no'. Training – cost v benefits.
What sort of people will be most affected by these ideas?	People: With long term conditions. On benefits – already get free? On low incomes. House bound. Disabled. Volunteer shopping services – could they check for medicine cabinet drugs? Could they buy them? Risks?
What questions do we have for our experts?	Private prescriptions: are they always converted into NHS prescriptions? Personal experience. People who pay for private care. Patients recognise professional standards of pharmacist and their potential. Can pharmacists tell patients if OTC is cheaper? Delivery systems – could that be better utilised? Could the voluntary sector do more ??shopping (probably too much risk). GP - set of principles? Yes, but CCG can't insist so need to encourage a conversation.
How is your view changing, if at all?	No – but the problem is much bigger, more complex and expensive . Additional information won't make a difference.
Issues/comments unable to allocate	People being refused expensive treatments that are actually part of their necessary care. Asked GP for prescription for foot issues. Told to buy it as would be cheaper. It wasn't, foot care important for people with diabetes. NHS is free at point of use: + Health tourism (different issue) + Means testing + Private health insurance

Question	What people said
How do I feel about what I have been learning?	Need education – take ownership of own health. The NHS makes me feel alive. I pay for my prescriptions by pre-payments. Most of my medicines keep me alive, but some things I get on my prescriptions help keep me comfortable. If I don't have these things I would not feel so well and might need antibiotics. But this is on the list as something that might be taken away.
What sort of people will be most affected by these ideas?	
What questions do we have for our experts?	
How is your view changing, if at all?	
Issues/comments unable to allocate	

Appendix 4

Summarised from each table's conversations.

What is most important to you?	What is less important to you?
Education: + General public + Start young + GPs re clinical staff/trainers (Access to education and information) Reduce waste. Good availability of medicines (waste). Prudence – make best use of the money available.	
Achieving best value for the NHS and patients – over the counter, common drugs available at capped price. Informed but hard decisions need to be made due to the size of the deficit – redefine NHS. Personal responsibility to self-care first – education and information.	Except exceptional circumstances – people's right to 'free medication'. If you can, do, Just focusing on one thing in isolation – waste elsewhere, e.g. + More appointments – less frequent prescribing. + No blood test available (purchase Saturday private nurse).
Education and access to information for people. Keep it fair – need to reduce inequalities. People taking responsibility for selves with support for those who can't – a safety net.	Doctors should be less afraid of upsetting people, not embarrassed to say 'no'. Pharmaceutical company/shareholder profit. Money (but we know it really is important).
Those most able to look after themselves to be educated and encouraged to do so. Using resources wisely. Good information (self-care) on over the counter medication.	Choice.

Safeguarding our NHS. Safeguarding the most vulnerable people in our society. Personal responsibility and greater self reliance including preventing ill health.	The expert's voice, balance it with the patient's voice (I think the group were trying to say that less emphasis should be put on what the expert says and wants – it led on to the conversation about use of cutting edge IT and AI). Everything doesn't have to be 'cutting edge', 'flashy' .

Post it notes - see page 20.

1. Pharmacy structure needs reviewing, e.g. Milton surgery can only dispense to patients who do not live in the village. Villagers have to go to Tesco.
2. A richer area for more needed care
3. *More funding for more urgent care. *Also can use money for training/nurses that are needed. * Less waiting times for doctors. *More time for doctors to listen to patients

Contact us

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Healthwatch is your independent champion for health and care. Our job is to make sure that those who run local health and care services understand and act on what really matters to people.

healthwatch Cambridgeshire

healthwatch Peterborough

The second

Community Values Panel

Talking about urgent and emergency care

An independent panel for Cambridgeshire and Peterborough

Contents

Key Findings

30 local people from across Cambridgeshire and Peterborough joined a Community Values Panel to have a say on funding local health services.

The panel was set up by the people who plan and buy health services in our region – Cambridgeshire and Peterborough Clinical Commissioning Group (CCG). It was supported by our Healthwatch.

The panel met twice in the autumn of 2019 to help the CCG work out what's important to local people. This report includes the outputs of the second panel meeting on 19 November in St Ives.

Panel two

On the day, 29 panellists helped the CCG think about care in our Accident and Emergency Departments. They wanted to know if people should be redirected to other NHS services if they arrive at A&E but do not need emergency treatment.

They heard from experts at the CCG who told them about:

+ The range of NHS services that provide urgent and emergency medical treatment. And how NHS 111 helps guide people to the right service.
+ How much it costs the NHS to provide these services.
+ The increasing number of people using urgent and emergency services.

What the panellists thought

Panellists were asked to vote on how much they agreed or disagreed with the following statements at the start and then again at the end of the day. We wanted to see how their views changed after finding out more about the issue.

Statement 1: We should redirect people to other NHS services if you go to A&E and do not have a serious injury or illness that needs to be dealt with as an emergency.

At the start of the day, most of the panellists agreed with the statement. Only four panellists told us that they were either unsure or disagreed. At the end of the day all the panellists who voted agreed with this statement.

Statement 2: You should always be seen at A&E if you go there and you should not be turned away.

The vote on the second statement suggested less certainty. At the start of the day, only half of the panellists agreed that people should always be seen if they went to A&E.

There was a small change in the vote at the end of the day when fewer panellists were 'unsure'. Slightly more panellists agreed with the statement and slightly more panellists disagreed. The conversation about the outcome of the vote on the second statement was particularly interesting.

Panellists talked about the significance of the different terminology used in each statement. And how they felt about people being 'turned away' - which they didn't like - as opposed to 'redirected'. This highlighted important issues about how people would be redirected, by whom, and in what circumstances.

Shared values

During the day the panellists got involved in a variety of discussions and activities. These encouraged them to consider what was important to them in relation to using emergency and urgent care services.

At the end of the event, the panellists decided their values, in order of priority, were:

+ Most in need first.
+ Access to information.
+ Access to the expert.
+ Access to a range of services.

About the panel

About the Community Panel

The Community Values Panel was set up and run by our local Healthwatch, and independently facilitated by Phil Hadridge of idenk. It is funded by Cambridgeshire and Peterborough Clinical Commissioning group. The Panel is a part of the CCG's Big Conversation asking people:

+ What they value most, and
+ What changes could be made to the way people access and use health services.

The panel workshops aim to find out which values the panel prioritises when considering a particular part of our local health service in challenging financial times.

30 panellists were selected to reflect the diverse demographic characteristics of the population in Cambridgeshire and Peterborough. This was based on age, gender, and district of residence. The selection also aimed to reflect the area's disability, ethnicity, sexuality, long-term conditions and caring profile.

More information about the role of the panel, the selection of panel members and how each panel works is included in the report of the first panel workshop - 'The first Community Values Panel - Talking about the availability of over the counter medicines on prescription', also published in January 2020.

Picture shows one of our panellists.

How the panel meeting was structured

Each panel meeting followed the same format with some variations in the methods used to capture panellists' discussions.

This was:

+ Topical questions described.
+ A vote on questions to test panellists' divergence on the topic.
+ Experts, specialists in the topic, explaining context.
+ Structured discussion in small groups.
+ Further scenarios explored.
+ Facilitator exercise to identify community values – what matters, and how people prioritise them.
+ Repeat vote on the topic to explore changes in the panellists' views.
+ Summary, evaluation and closing business.

All panellists were paid £50 for each four-hour workshop and reasonable travel costs. The funding included covering the cost of taxis for panellists with sensory impairments and learning disabilities.

Details of how we reflected the CCG population in the membership of the Community Values Panel is shown in Appendix 1.

Facilitator exercise to identify community values – what matters, and how people prioritise them.

+ Repeat vote on the topic to explore changes in the Panel view and for individuals.
+ Summary, evaluation and closing business.

Feedback from the CCG representative/s and the local experts was welcomed.

The evaluation forms and the facilitator-led team debrief informed the design and practicalities for the second workshop. A summary was shared with the panellists.

About the second panel workshop

29 panellists attended the second Community Values Panel. Most had also attended the first one. The few who couldn't come to this session were substituted with people who similarly reflected the demographic profile of the Cambridgeshire and Peterborough area.

We improved the format of the second panel based on feedback from the panellists after the first event.

They liked:

+ The input from experts.
+ Using voting buttons.
+ And the way the table discussions had been run.

We made it better by:

+ Spending less time introducing people.
+ More time in discussions.
+ And by using a smaller room so we didn't need a sound system.

Picture shows one of our panellists.

Urgent and emergency care

A&E departments in all our hospitals are very busy. A&E staff often struggle to see people with urgent needs as quickly as they would like.

The purpose of the second panel was to discover the values the panel members have in mind when they consider which urgent and emergency care service people should use.

The day started with everyone meeting the other panellists again and new panellists introduced themselves. Panellists told us they had enjoyed working with the people on their table at the first workshop and welcomed the opportunity to meet them again. And work mostly in the same groups.

The next conversation reminded everyone of the ground rules agreed at the first panel, for the way the panellists, facilitators and experts would work together.

Panellists were given the opportunity to try out their voting devices again with a brief quiz related to the day's topic.

They were asked:

+ What number would you ring if someone in your family has chest pains and breathing problems?
+ Where would you go if someone in your family has sprained or broken their ankle?
+ What number would you ring if you are feeling unwell but are not sure if it's an emergency?
+ Are you confident that you know the difference between an urgent health need and an emergency?
+ Do you know where to go for more information?

The responses to these questions immediately stimulated conversations.

Panellists were confident in their responses to the first three questions. Although a significant number of people were unsure about the most appropriate route to treatment for chest pain or a broken ankle.

Interestingly, 26 of the 28 people responding to the third question knew that they should ring 111 if feeling unwell and unsure if it is an emergency, showing that people had absorbed the messages about using NHS 111.

When asked did you know the difference between emergency and urgent care, panellists were nearly evenly split between 'yes' and 'I'm not sure'. Two people said 'no' they were not confident they knew the difference .

In response to the last question about seeking information, more than half the panellists who responded - 16 out of 27 - said they were unsure or didn't know where to go for information.

Where did the panel stand on the topic of the day?

Panellists were asked to vote on two statements at the start of the day.

Statement 1: We should redirect people to other NHS services if you go to A&E and do not have a serious injury or illness that needs to be dealt with as an emergency.

A	Strongly agree	15	56%
B	Agree	8	30%
C	I'm not sure	1	4%
D	Disagree	3	11%
E	Strongly disagree	0	0%
	Total	**27**	**100%**

Most of the panellists agreed with the statement. Only four panellists told us that they were either unsure or disagreed with this statement.

Statement 2: You should always be seen at A&E if you go there and you should not be turned away.

The vote on the second statement was more ambiguous. This time only half of the panellists agreed that people should always be seen if they went to A&E. Panellists talked about how they felt about the term 'turned away' and were concerned about how this would happen in practice.

What the experts said

Jessica Bawden, from the Clinical Commissioning Group, explained the role of the CCG in contracting health services for local people. And told them about the 'Big Conversation' initiative to hear what people have to say about affording health services in difficult financial times.

She outlined in principle the different urgent and emergency services and which service people should most appropriately use when they feel unwell. She acknowledged that the range of services varied across the area and that choice of service could be complicated.

Experts Dr Andrew Anderson a local GP and the clinical lead for urgent and emergency care, and Mr Vaz Ahmed, A&E Consultant, Addenbrooke's Hospital, gave more details about the pressure on services. See Appendix 2 for the slide set used.

We heard that

+ Calls to NHS 111 have been increasing year on year.
+ Since July 2018, patients have been able to use 111 online.
+ More people are using urgent and emergency care services every year. The biggest increase is in A&E, where there's an average extra 44 people a day.
+ Roughly 15% of people attending A&E departments locally on weekdays could be treated appropriately elsewhere. This was higher at weekends.

Picture shows one of our panellists.

What we heard from our panellists

Panellists had differing levels of awareness of the range of emergency and urgent care services available.

Everyone was familiar with A&E departments. And many panellists had had direct or indirect experience of using A&E departments at the hospitals across the area and beyond.

Fewer people were aware of Minor Injury Units (MIU), Walk in Centres, and Urgent Treatment Centres (UTC).

We heard a range of comments based on panellists' direct experience of these services.

"Better than nothing" - Wisbech MIU

"Speedy", "Excellent, can't praise it enough", "It's comforting to know that it is near by" - Ely MU

"Very fast", "Excellent" - Doddington MIU

"Quite good", "Only open limited hours" - St Neots walk in centre

A lot of panellists commented on the confusion caused by:

+ Services with different names operating across the area.
+ Different opening hours.
+ And differing in what treatments are provided.

Most panellists were unaware how GP extended hours worked in their local area.

Many panellists didn't know the difference between the functions of an MIU and an UTC.

Panellists were unaware that NHS 111 was also available to the public as an online app and a web page. They were interested to know more about how these worked.

Questions from the panellists

Panellists had lots of questions for the experts.

"When there is so much pressure on A&E why was the out of hours service in Chesterton closed?"

"Why is there no other service other than what is offered on the Addenbrooke's site?"

"Does the MIU/UTCs being open affect the workload at the A&E departments?

"Why are some people sent to A&E post discharge when the minor issue could probably be dealt with by community health services?"

"How do the emergency and urgent care out of hours services handle the additional needs of people with learning disabilities?"

"Is there really not enough staff to meet the demand? There needs to be greater flexibility to attract people to stay in NHS employment, or to return "

"Addenbrooke's works like a magnet sucking people into A&E first. Couldn't there be a wider range of services spread across the city and surrounding areas?"

"A&E departments are not the best place for treating emotional and mental health problems. We need different services"

"Services need more funding. How can we lobby for a fairer funding settlement for this area?"

"What happened to GPs 24 hour duty of care?"

"What are people told now at the point of triage if staff feel they are using the service inappropriately"

"Would a more even spread of MIUs across the area help manage demand?"

What the experts said

All the experts acknowledged that there was need for greater consistency around services. This included:

+ Where they were based.
+ The opening times.
+ And the range of treatments.

They also said:

+ Locating different services together, like the out of hours' service on the Addenbrooke's Hospital site, helps make best use of limited resources. Especially staff.
+ More work was needed to make sure that some procedures could be provided in the local community.
+ There was now a wider range out of hours' support for people in mental health crisis.
+ Adjustments to funding services to reflect population growth were slow and small. And do not reflect real population growth.
+ Redirecting people to alternate services 'at the front door' of A&E departments was difficult.
+ But encouraging people to phone first, e.g. to NHS 111, would provide an opportunity to redirect people to the best service to meet their needs.
+ Providing urgent care within GP extended hours' services would reduce pressure on A&E departments.
+ However, many patients still don't know about alternatives to using A&E departments.

In response to what they heard

There was a wide range of responses from panellists to what they heard from the experts. This is what some of the panellists told us.

"Services need to be more 'hard nosed', some people are just time wasters"

"People need better information and signposting"

"People living and working in a 24-hour culture want to be seen NOW"

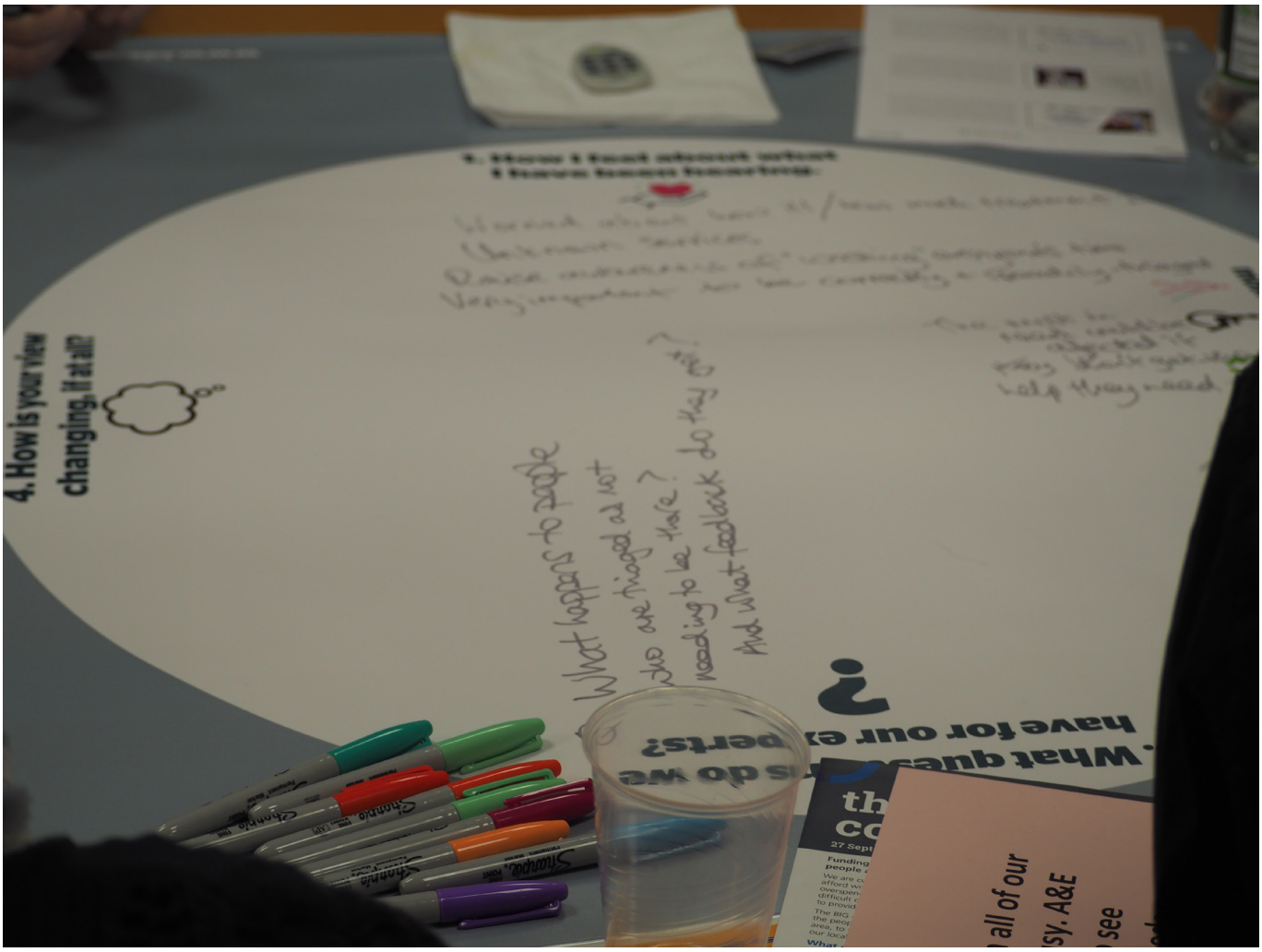
Exploring the issue in more detail

The panellists took part in facilitated conversations at four tables to explore the topic in more detail.

What they talked about:

+ How they felt about what they'd been hearing.
+ What sorts of people would be most affected by possible changes in practice.
+ If they had any questions for the experts.
+ If their views were changing at all.

Panellists were encouraged to record their feelings, views and questions on posters and sticky notes on each of the tables. Appendix 3 records these.



Picture shows notes from the panellists as they took part in this section of the day.

What they said:

+ Those that have access to wider range of services appreciate them.
+ But there were concerns about how people may be redirected, where to, and by whom. People didn't want to be 'turned away', but maybe redirected.
+ There was a lack of knowledge about what services are available and where they are.
+ Inconsistencies between different services gets in the way of people using them.
+ Limited and varying opening hours restricts how much people can use services.
+ Concerns about a growing emphasis on encouraging people to use phone and online-based services.
+ There's a need for more and better advertising to inform people of the best service for their treatment.

The panellists' experiences of using services

In our next conversation, we encouraged our panellists to think about their own decision to seek emergency and urgent care services. Drawing on their own experience, what had helped them get that service, and what was difficult.

Did they notice any information gaps? Could they suggest any improvements which may have helped? Each table talked about one of each of the services and panellists were able to move to a table they felt best suited their experience or interest if they wished.

The topic tables were:

+ A&E.
+ NHS 111.
+ MIU/Urgent care services / Walk in centres.
+ GP out of hours' services.

We reminded panellists that they should only share experiences that they felt comfortable talking about.

Themes identified and how panellists felt

Panellists liked:

+ How easily they could use NHS 111 via the phone or an app. However, some people weren't sure when they should call 999 or 111, and wondered if there were too many emergency numbers.
+ That it was easy and reassuring to use local urgent and out of hours' services, such as the MIUs.
+ Local services could help them avoid long waits at A&E.

Panellists didn't like

+ That they sometimes had a long wait for a call back from NHS 111.
+ That it was hard to decide which service they should use.

Picture shows notes from the panellists as they took part in this section of the day.

Panellists felt:

+ There should be more awareness campaigns about the range of services available to meet people's differing health needs, including out of hours' concerns and emergencies.
+ Patients should be asked routinely if they had used NHS 111 when they go directly to a service.
+ Concerned about homeless people and people from Gypsy, Roma and Traveller communities who may not be able to telephone services first.
+ There needed to be a wider skill set in the staff working in alternative urgent care services.

Appendix 4 gives more information about these conversations.

Which values are most important?

The panellists' next activity was to try to think about what was important to them when using emergency and urgent care services. Each table had a set of nine cards representing values relevant to the day's topic.

Panellists talked together to try to find agreement about how important each value was. They represented this by ordering the cards into a diamond shape. with the most important values at the top and the least important at the bottom.

The values they talked about were:

+ Access to range of facilities.
+ Prevent further harm.
+ Access to the expert.
+ Most in need first.
+ A safe place to go .
+ Convenient – good use of my time.
+ Efficient services.
+ Access to information and advice.
+ Equal opportunities.

Some panellists thought that some of the values were intrinsic in how the services should be provided. For example, all the services should be assumed to be a safe place to go. And equal opportunities was the natural outcome of most in need first.

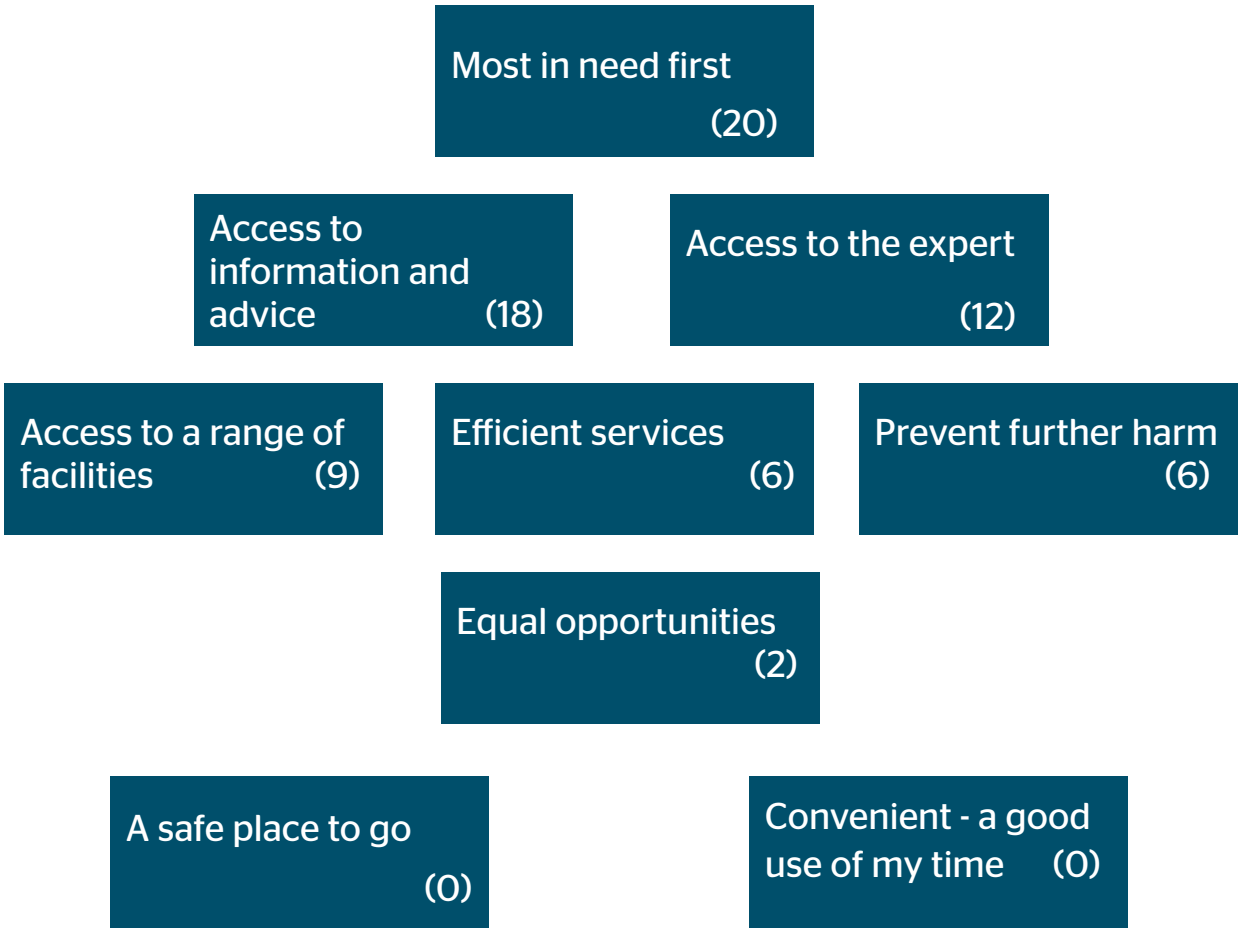
Some panellists wanted to make additions to the list. An additional two values were added by panellists:

+ Meet my health needs.
+ Quality of assessment.

The exercise generated a lot of conversation. Finding consensus was difficult. Each table shared its experience of trying to order the cards. We heard that panellists had found it easier to agree on what was less important, and to some extent on the values they would place in the 'middle' of the diamond.

In the final step in this activity, all the panellists were given three stickers to put on the final set of values, to rank their importance overall. The number on each of the boxes indicates how many stickers were put on the respective card. Two of the cards ('convenience, a good use of my time' and 'a safe place to go') had no stickers added to them.

This is how the panellists ranked the cards



Repeating the panel votes

At the end of the day, the panellists voted again on the two statements related to the day's topic.

The first vote took place before the experts introduced the topic and the second vote at the close of the session.

Statement 1: We should redirect people to other NHS services if you go to A&E and do not have a serious injury or illness that needs to be dealt with as an emergency.

		First Vote	Second vote
A	Strongly agree	15	21
B	Agree	8	6
C	I'm not sure	1	0
D	Disagree	3	0
E	Strongly disagree	0	0
	Total	**27**	**27**

The second vote showed panellists more firmly supporting the statement. Following the presentations and conversations, everyone who voted now agreed with the statement.

Statement 2: You should always be seen at A&E if you go there and you should not be turned away:

		First vote	Second vote
A	Strongly agree	10	9
B	Agree	4	6
C	I'm not sure	5	2
D	Disagree	3	5
E	Strongly disagree	6	5
	Total	**28**	**27**

The vote on the second statement showed less change. Fewer panellists were 'unsure'. Slightly more panellists agreed with the statement and slightly more panellists disagreed. The conversation again indicated the significance of the different terminology used in each statement with 'redirected' as opposed to 'turned away'.

Rounding off the day

We wanted to know how the panellists felt about the topic and conversations which they had taken part in. They were asked to pick out a photograph from a selection which they felt resonated with how they felt. Some of the panellists shared their choices with us.

They expressed the energy and enthusiasm they had felt, although one panellist said she felt 'quite disturbed' as she felt the experts 'had a different view of the world'.

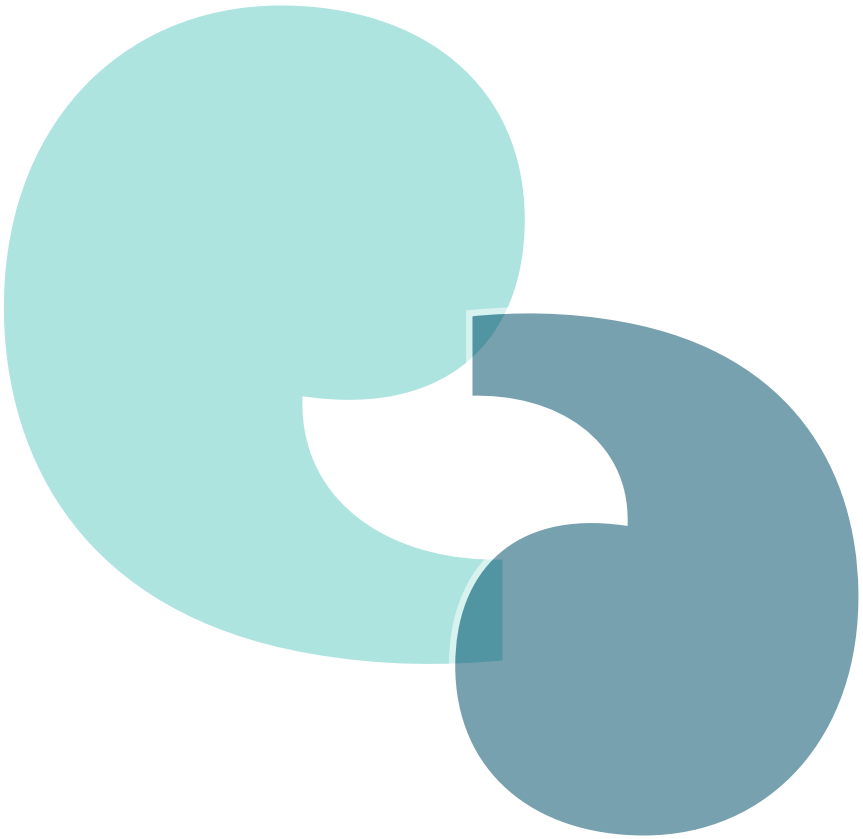
Panellists felt they had learnt a lot. They expressed how much they had enjoyed the session again and told us that they would look forward to potentially more panel meetings in 2020.

The panellists told us in their evaluation forms that they had valued the opportunity to talk with the experts who they felt were interested to hear what they had to say.

Four panellists volunteered to read the reports to check that they reflected their experience of the day.

Picture shows one of our panellists.

Appendices



Appendix 1

Reflecting the population in the CCG area – the percentages and panel makeup.

Gender	Female	Male
Percentage in local population	50%	50%
Number of panellists	15	15

Which district or city people lived in	Cambridge	East Cambs	Fenland	Hunts	South Cambs	Peterborough
Percentage in local population	15%	10%	12%	20%	19%	24%
Number of panellists	4	3	4	6	6	7

Age	15 to 24	25 to 44	45 to 64	65+
Percentage in local population	15%	33%	31%	21%
Number of panellists	5	10	9	6

Sub-categories in population	Carers	Disability or long-term condition	LGBTQ+	Minority ethnic community
Percentage in local population	12%	20%	10%	10%
Number of panellists	4	6	3	3

Appendix 2 - CCG presentation slides


the BIG conversation
NHS Urgent and emergency care
In Cambridgeshire and Peterborough we have:
Urgent treatment and Minor Injury Units
• Peterborough Urgent Treatment Centre at The City Care Centre
• Wisbech Minor Injury Unit at North Cambs Hospital
• Ely Minor Injury Unit at Princess of Wales Hospital
• Doddington Minor Injury Unit at Doddington Community Hospital
• St Neots Walk-In Centre
Accident and Emergency Departments:
• Addenbrooke's Hospital
• Hinchingbrooke Hospital
• Peterborough City Hospital


the BIG conversation
NHS Urgent and emergency care
AND we have:
• NHS 111, including GPs and clinical advisors
• GP Out of Hours services
• GPs supporting the front door of A&E
• GPs supporting our Minor Injury Units
• Extended Access to GP appointments
It's sometimes hard to know where to go.
NHS 111 is here to help.
17/01/2020
4

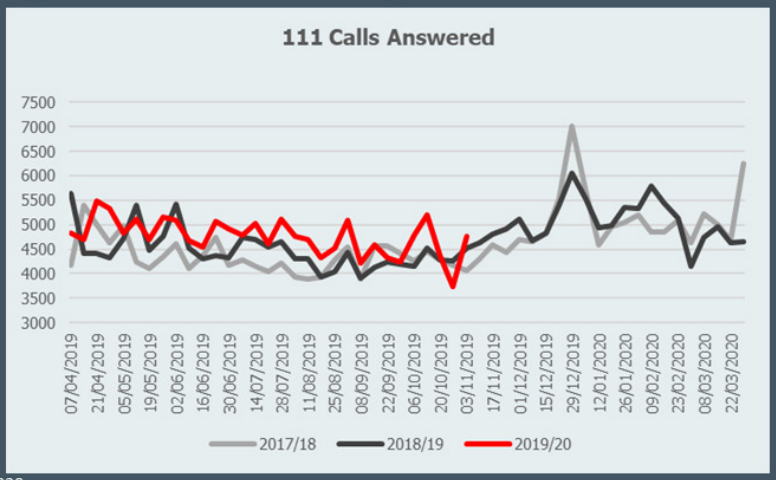
How much do urgent care services cost the NHS?

A trip to A&E	Calling out an ambulance	A visit to your local GP	A night's stay in hospital
£73	£180	£46	£1,722

17/01/2020 5

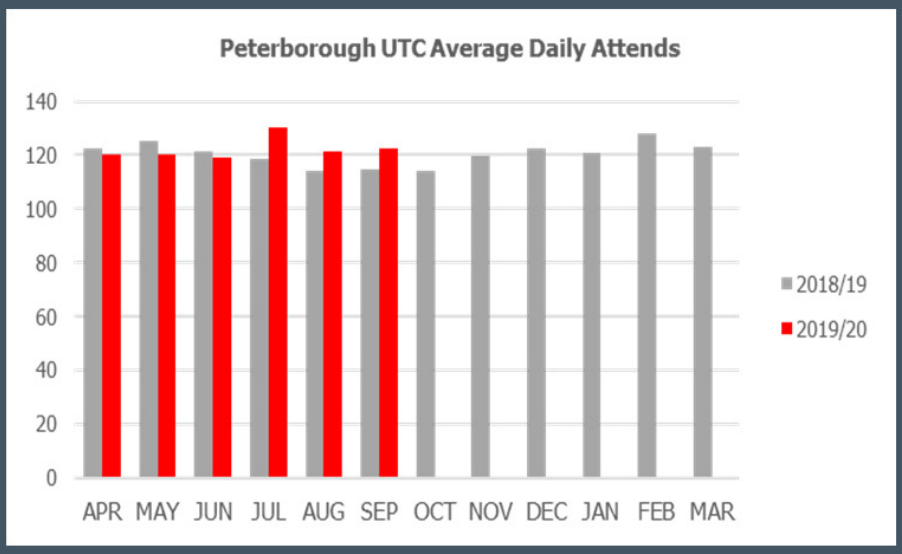
People are using these services more

Calls to NHS 111 are increasing year on year. Since July 2018 patients have also begun to use NHS online.



17/01/2020 6

People are using these services more



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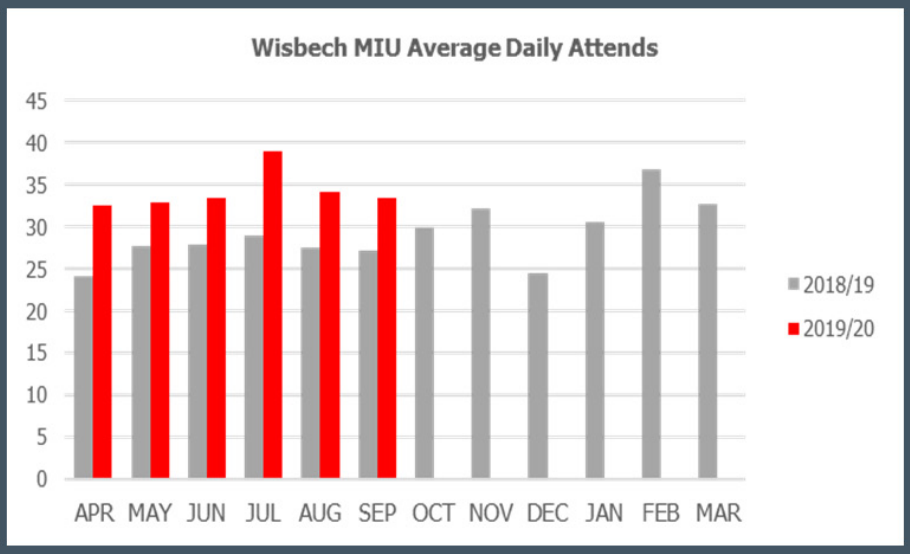
People are using these services more



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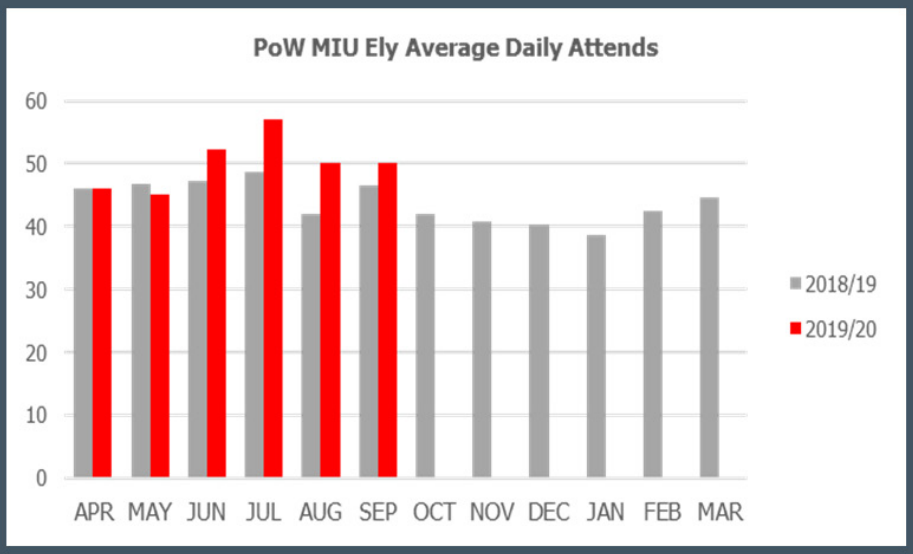
People are using these services more



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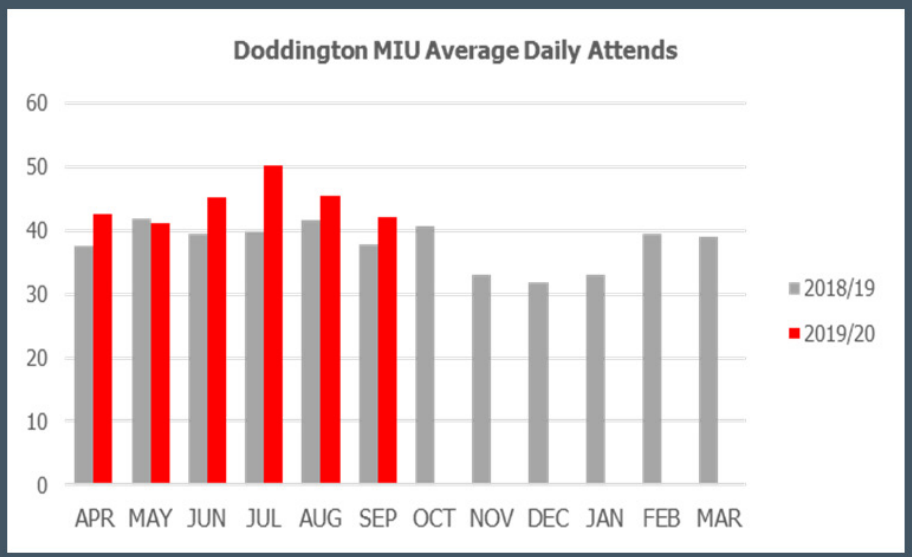
People are using these services more



17/01/2020 10

Use of Accident and Emergency Departments

A&E attendances
have increased by **4%** annually for the last five years

This means an extra **44** patients a day go to A&E

* Compared to 2014/15

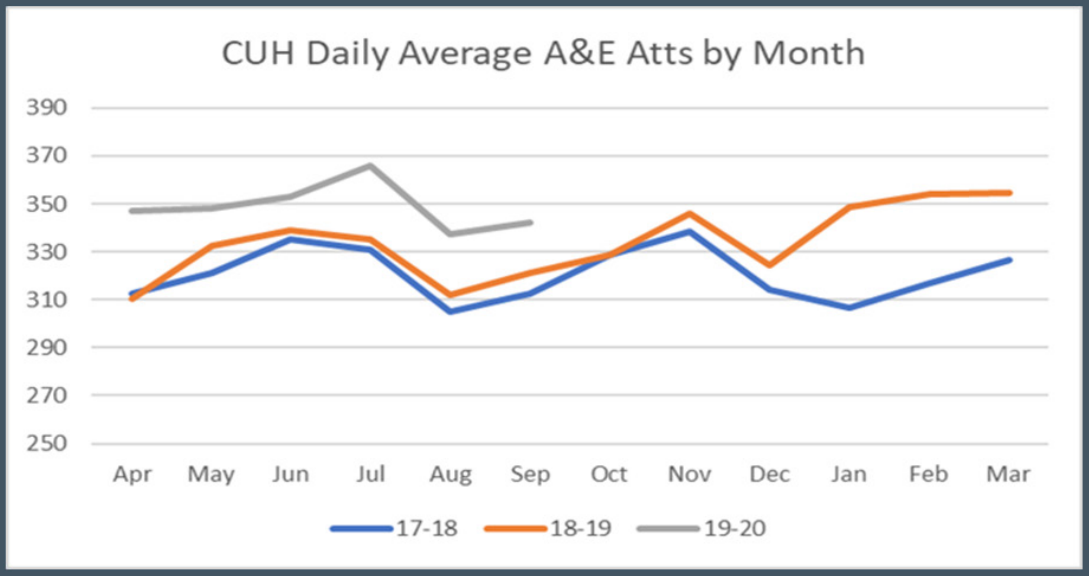
Elective care**
has increased by **2.6%**

This means an extra **42** patients are treated in hospital dailiy*

** Elective care means inpatient and day patients at hospital

17/01/2020 11

Use of Accident and Emergency Departments



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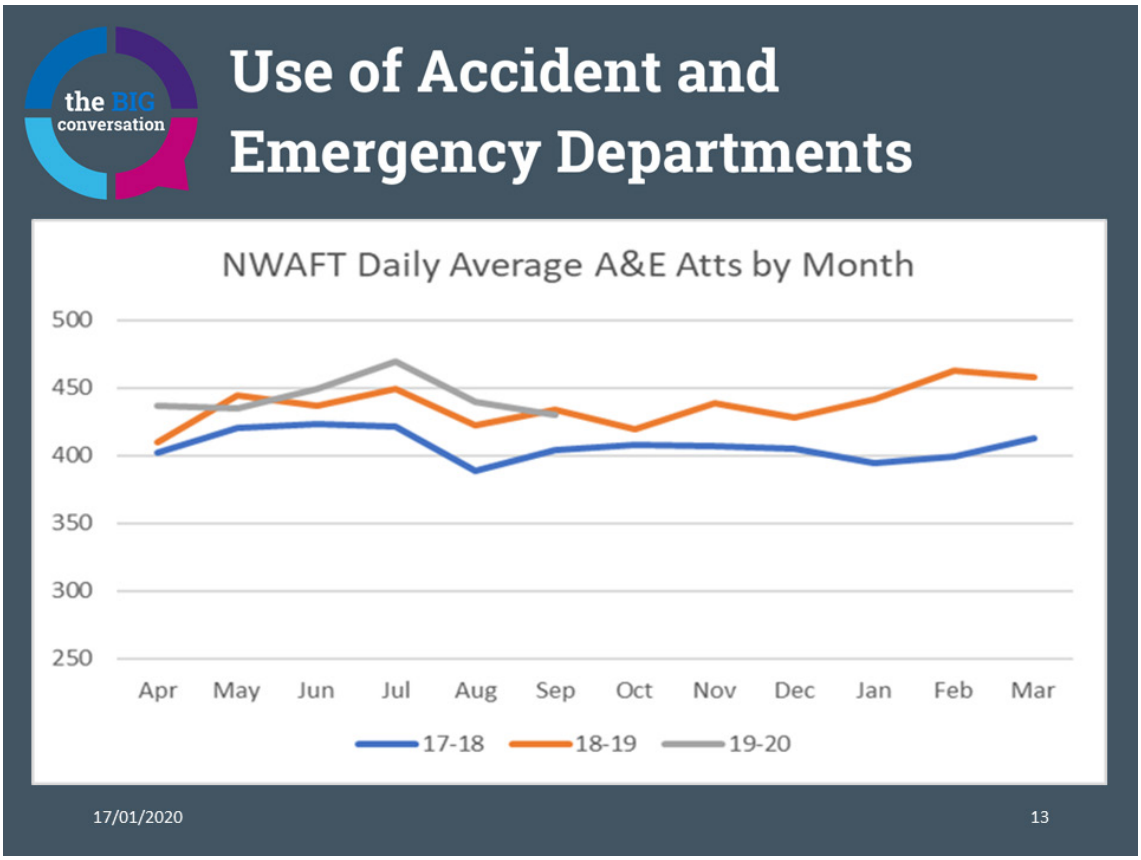

NWAFT - North West Anglia Foundation Trust. This trust runs Hinchingbrooke Hospital and Peterborough City Hospital.

CUH - Cambridge University Hospital Foundation Trust. This trust runs Addenbrooke's Hospital and the Rosie Hospital.

Appendix 3 - Summary of table posters

Question	What people said
How do I feel about what I have been learning?	+ Worried about how ill I am / how much treatment I need. + Unknown services. + Raise awareness of 'wasting everyone's time'. + Very important to be correctly and speedily triaged . + Public health info for people who have unhealthy lifestyles.
What sort of people will be most affected by these ideas?	+ The most in need could be affected if they don't get the help they need. + People who don't use IT/mobile phones might be disadvantaged. + Cambridgeshire lacks mobile signal in many places. + Worries about long ambulance waits – people abusing ambulance service (i.e. calling an ambulance when they could have called a taxi or a driver).
What questions do we have for our experts?	+ What happens to people who are triaged as not needing to be there and what feedback would they get? + Would more MIUs help? Take pressure off? Already? Is there a way they could?
How is your view changing, if at all?	+ Advertise NHS app. – could counteract 'Google effect'. + Something like the advert with the chaps in moustaches (directory services).

Question	What people said
How do I feel about what I have been learning?	+ Surgical procedure in Addenbrooke's – then other services send you back to A&E. + It's very complex. + At weekends, feel there are no options but A&E. + Worried about A&E wait. + Worried about turning away – always see at triage. Education and information needed. + Worried about ambulance estimate (cancer centre, collapse, short transfer, 8 hour).
What sort of people will be most affected by these ideas?	+ Elderly. + Low IT skills. + Vulnerable groups.
What questions do we have for our experts?	+ Support for people with learning disabilities in A&E. + Paramedics don't want to call an ambulance.
How is your view changing, if at all?	+ Good recent use of 111/A&E. improved view. + Interesting to hear about booking systems. + Better view of 111 – much improved, would use.

Question	What people said
How do I feel about what I have been learning?	+ Pleased to be living in Peterborough – localisation of services is a great idea for Cambs, don't take the services away from P'Boro'. + Education. More GP hours, NHS is a 24/7 service not just for weekdays. + I'm happy I live in Peterborough. + If they don't need to be in A&E, the correct thing is to turn them away.
What sort of people will be most affected by these ideas?	+ 111 – is ?? to the questions they ask and patients can ??? things. 999 – A&E. + People who struggle for transport -if they get a lift to A&E but then turned away, they may have to wait too long there to go to other facilities. + Elderly, don't want to call 999 so call 111 when they are actually ill. Youngsters call 999 when they don't need to – educate. + Some elderly people don't know they are acutely ill.
What questions do we have for our experts?	+ How can you and us lobby for fairer funding for this area? + Why don't GPs open 24/7? + What plan do you have to open an MIU in Cambridge?
How is your view changing, if at all?	+ Redirect, not turn away. + Where can I go? How do I find out? + People do not know about services outside of A&E. + Confused about where to go – told off for going to the wrong place.
Other comments	+ NHS 111 option 2 for mental health is failing + Broken bones – a long wait to look at x-ray by a doctor. Why not have a rapid access doctor who can discharge etc?

Question	What people said
How do I feel about what I have been learning?	+ Addenbrooke's growth + Addenbrooke's takes everyone - site is horrendous, overcrowded and poor access. Use out of centre area. + Addenbrooke's – overloaded/access/parking + Correlation between opening hours of walk in services and A&E- impact on demand. + Cost of real estate v cost of skills. + Thread of today's discussion – GP GP GP, not enough about extending NHS 111 service. Young/in work etc most use mobile apps all the time. Educate them to use 111 instead of GP.
What sort of people will be most affected by these ideas?	+ People not registered with GPs – how many? + Ability to travel/accessibility /parking. + Many people are not registered with GPs – Addenbrooke's A&E is only service for them.
What questions do we have for our experts?	+ Why have GPs at A&E when there are highly qualified nurses around?
How is your view changing, if at all?	+ More dynamic and informative advertising of the 111 service. Currently just not at a sufficient level of public comprehension. Get Saachi & Saachi type approach to up its awareness. + Flexibility for workforce – older staff returning to work/ bank staff. + Could have mobile units like breast screening units for walk in? Put a Walk in in Cambridge, for out of hours, e.g. at Trumpington P&R. + Green cross code – knew all about it as adults and children – excellent advert. Something similar to inform and educate. Was memorable and interesting.
Other comments	+ Manage the sense of expectations 'I've paid my NI'/Need to revise old cottage hospital concept based at GP. – become MIU, -empty bed blocking at Addenbrooke's, - place for low hours contract staff to return to work. + GP services, some can offer same day, - 5 min,- regular appointments still 4-6 weeks. Not available out of hours, not where I live, - referral to 111 or Addenbrooke's.

Appendix 4 - summary from table discussion

NHS 111

What helped	What was difficult
+ Ease of use – phoning. + NHS online web access. + Easy to remember phone number.	+ Lack of information. + Wait for call back was too long. + People don't know which is the right number. 999 or 111. + Some people call 111 when they need 999 and vice versa.
Any Information gaps	**Improvements?**
+ Big gaps in information. + Info for 111 app, education/info. + More advertisement on services, e.g. TV ads and leaflets. + Neighbours talking, 'Oh I used the 111 service and it was rubbish,' to someone who hasn't used it, automatically thinks it'll be bad and not call. + Too many numbers for emergency / health.	+ Gypsy communities who travel and homeless communities have no GPs or cannot always access it so use A&E. + Inaccurate / not up to date information online. + Encourage surgeries to be active on local chat mail and social media to advertise preferred contacts e.g. 111 and online. + Educate! + 111 at the door – 'Have you called 111?' + Education – advertising in roadshows in shopping centres, GPs.

Out of hours' care

What helped	What was difficult
+ Time of day/Bank Holiday. + Not sure if emergency or urgent. + Advice from out of hours' services avoided long trip to A&E – able to treat as guided over the phone. + Reassurance.	+ Questionnaire (algorithm) to access OOH very long. + Wrong prescription – too much pressure / training skills?
Any Information gaps	**Improvements?**
+ Couldn't use it if don't know it exists – thought Cambridge shut. + Access to OOH advice on phone.	+ Awareness campaign + Extend hours. + Skill set of OOH staff.

A&E

What helped	What was difficult
+ I knew I was really ill. GP no help, operation next day. + Caring attitude. + Paramedics inspired confidence.	+ If surgical procedures – 'told must go to A&E'. Knowing if it is A&E you should visit, especially out of GP hours. + No empathy shown for people with learning disabilities - lack of understanding. + Ambulance patients in same queue as walking. + Told need to go to A&E – no ambulance available –'find a lift'.
Any Information gaps	**Improvements?**
+ 111 can direct you to the more appropriate service. + Telephone number for A&E – encourage you to ring. + Lack of knowledge of local options.	+ Investment in staffing – getting staff in the right place. + Phone triage in A&E – awareness. Clear phone number. + Clear guidance – how to get communication. + Re-look at shift patterns – all emergency staff.

MIU / Walk in

What helped	What was difficult
+ Local – reassurance + Quick	+ Not one near me. + Not knowing opening hours. + Weekend closed. + Glass wall between CCG areas and hospital catchment areas on boundaries.
Any Information gaps	**Improvements?**
+ Didn't know about them and opening hours. + Awareness of who (age) and what conditions can be treated.	+ Sales pitch for MIUs. + Distribution of staff? + Get skilled people in – workforce initiative + Pop up clinics for long term conditions (like breast screening units in car parks)

Picture shows panellists talking about their experience of using services - this was the table that talked about NHS 111.

Picture shows panellists voting on what values were most important to them.

Contact us

Call: 0330 355 1285 (local call rate number)

Email: enquiries@healthwatchcambspboro.co.uk

Website: www.healthwatchcambridgeshire.co.uk

Website: www.healthwatchpeterborough.co.uk

Healthwatch is your independent champion for health and care. Our job is to make sure that those who run local health and care services understand and act on what really matters to people.

healthwatch Cambridgeshire

healthwatch Peterborough

Healthwatch Cambridgeshire and Peterborough

The BIG Conversation: Our response

Context

Healthwatch Cambridgeshire and Peterborough recognise the financial pressure and growing demand being placed upon our local health and care services. We therefore welcome this public conversation and were happy to support the initial promotion. However, once the election was called, our Healthwatch took a decision to refrain from promoting and commenting on any consultations. This decision was based on advice from Healthwatch England.

We are aware that the local implementation plan for the NHS Long Term Plan will be published early in 2020. Healthwatch Cambridgeshire and Peterborough believe that this conversation being held in, what appears to be, isolation of this plan is a missed opportunity. The local Sustainability and Transformation Partnership is required by this plan to evolve into an Integrated Care System, this conversation does not refer to this shift in its text nor its questions.

This consultation response is based upon feedback received from local people and other organisations and our existing intelligence. In July 2019 we published the 'What Would You Do?'[1] (WWYD) report which compiled the views of local people on the NHS Long Term Plan. We have used its findings to assist in this response.

The Big Conversation consultation process

Regarding the process we make the following observations:

- We are pleased that the CCG has received a large number of responses to their survey. This demonstrates the very high level of interest that people have in their local health and care services.
- We are disappointed with aspects of the format of the 'Share your views' section. Questions were in 'either /or' format or gave options but included differing concepts, and sometimes covered multiple issues. In seeking to be simple the options come across as loaded and when broken down could be confusing. In Q 1 for example both options might be appropriate depending on the issue (impeding mobility) or severity (urgency). Yes or No options were implied but not used, e.g. Q7.

[1] http://www.healthwatchcambridgeshire.co.uk/news/what-would-you-do

- There were a good number of public meetings held but we are aware that there were very few members of the public at some of these.

- Alternative formats of the consultation documents were not ready until some time later in the process.

Our feedback on the Big Conversation 'Share your views' topics
Regarding the topics covered by the 10 questions we make the following comments:

- The referral of patients to secondary care is over-complicated. We hear from many people about problems they experience with this process, particularly with those specialisms in high demand. There is massive opportunity to use digital solutions to improve these processes and decrease their poor experience of longer waiting times.

- People would welcome more follow up appointments by email and telephone. Quite frankly people are bewildered why this is even a question. It is not good use of anyone's time.

- Our WWYD report clearly tells the story of transport difficulties in most areas of Cambridgeshire and Peterborough. More use of digital solutions can help with this. People also want to see more basic services in their communities and are then prepared to travel further for more specialist help. The shift of resources and expertise from hospital to community is essential in making this happen.

- Digital solutions will not be appropriate for everyone however. There needs to be an understanding that not everyone is able to engage digitally and that there are severe connectivity problems in many areas of Cambridgeshire particularly.

- We receive large numbers of stories regarding fragmented care. The system needs to find new models to overcome barriers caused by commissioning and contracts that can result in service duplication or gaps.

- It appears that are huge amounts of money to be saved through better prescribing systems. People tell us they are being given medications they do not want nor request.

- Care needs to be taken to ensure a balance between cost of branded versus generic medicines and effectiveness for individual patients. We are aware that changes of medication can result in side effects that then need further review or medication.

- We welcome action being taken by the CCG and providers of NHS services to relieve the pressures on A&E and would urge more robustness in triaging and getting people to the right place for their health need.

- People want to look after themselves better. Our WWYD report showed that people want more information about this. Information on self-care, self-management and healthy lifestyles is fragmented and often unknown.

- People want to be more involved in decisions about their care. There needs to be a shift to a culture that places the patient voice at the centre of their own care and recognises that the patient is the expert in how their condition affects them.

The findings from the first two Community Values Panels (commissioned by the CCG and delivered by Healthwatch Cambridgeshire and Peterborough) are reported directly to the CCG prior to publishing in early 2020. The topics we were asked to explore in some depth with the selected panel of 30 local individuals, who together represent the population characteristics of Cambridgeshire and Peterborough, were about prescribing and over the counter medicines, and about accessing urgent and emergency care.

The missing question?
We believe that this is a lost opportunity to seek ideas about meaningful patient and public engagement, particularly in light of the emerging Integrated Care System. We note that this conversation did not ask the public about broader engagement with health and care service changes and how to improve potential for co-production.

Healthwatch Cambridgeshire and Peterborough is keen to help shape the conversation about how complaints and compliments information can be better shared and used in the future, and how NHS and other care organisations can learn from feedback about integrated care and how to involve people in the design of new services.

Summary
Healthwatch Cambridgeshire and Peterborough understand the need for savings to be made but believe that an integrated health and care system would be cheaper and more effective for patients and provide a better experience for all.

The intentions to build on primary care, use technology better and improve opportunities for shared decision-making and self-care are supported by the feedback we get from local people.

Val Moore (Chair) Sandie Smith (CEO)
Healthwatch Cambridgeshire and Peterborough
18th December 2019

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HEALTH AND WELLBEING BOARD	AGENDA ITEM No. 7
25 FEBRUARY 2020	PUBLIC REPORT

Report of:	Wendi Ogle-Welbourn, Executive Director, People & Communities	
Cabinet Member(s) responsible:	Cllr Lynne Ayres, Cabinet Member for Education, Skills, University and Childrens Services	
Contact Officer(s):	Toni Bailey, Assistant Director: SEND / Inclusion Sheelagh Sullivan – Head of SEN and Inclusion Services	Tel. 07592612380

LOCAL AREA SEND (LASEND) INSPECTION UPDATE REPORT

R E C O M M E N D A T I O N S	
FROM: Wendi Ogle-Welbourn, Executive Director	**Deadline date:** *N/A*

It is recommended that the Health and Wellbeing Board:

1. Review the latest position regarding the findings of the SEND Local Area Inspection and the associated Written Statement of Action as attached in Appendix 1

1. ORIGIN OF REPORT

1.1 This report originated at the request of the HWB Agenda Setting Group.

2. PURPOSE AND REASON FOR REPORT

2.1 This report is being presented to:

- Feedback on findings of the SEND local Area Inspection and progress on the associated Written Statement of Action

2.2 This report is for the Health and Wellbeing Board to consider under its Terms of Reference No. 2.8.3.4

To keep under review the delivery of the designated public health functions and their contribution to improving health and wellbeing and tackling health inequalities.

2.3 This report links to the Children in Care pledge: Support Children in Care to have a good education.

3. TIMESCALES

Is this a Major Policy Item/Statutory Plan?	**NO**

4. BACKGROUND AND KEY ISSUES

4.1 Statutory duties

The Council and its partners has a number of statutory duties that are outlined in the SEND Code of Practice 2014 which includes the duty to produce Education Health and Care Plans (EHCP's).

4.2 LASEND Inspection Context

Between 10 June 2019 and 14 June 2019 Ofsted and the Care Quality Commission (CQC), conducted a SEND inspection of Peterborough local area to judge the effectiveness of the implementation of the Special Educational Needs and Disability (SEND) reforms in the Children and Families Act 2014 and to review the area's provision for children and young people with SEND.

Three inspectors were involved: Heather Yaxley HMI, Deborah Mason, Ofsted and Paula Morgan, CQC.

As part of their work the inspectors reviewed documentary and published evidence, the Local Offer website and information from a 'webinar' with parents/carers which took place in the week before the inspection.

The inspectors carried out the on-site inspection over 5 days with formal verbal feedback provided on the fifth day.

Inspectors spoke with children and young people with disabilities and/or special educational needs (SEND), parents and carers, local authority and NHS officers. They visited a range of providers and spoke to leaders, staff and governors about how they were implementing the special educational needs reforms.

Inspectors looked at a range of information about the performance of the local area, including the local area's self-evaluation. Inspectors met with leaders from the local area for health, social care and education. They reviewed performance data and evidence about the local offer and joint commissioning.

4.3 SEND Local Area Inspection – Findings: Areas of Strength

The strengths identified were:

- Co-production of plans and services is well established. Children, young people, parents, carers and professionals work well together to improve services.
- Leaders use a variety of methods and opportunities to engage with families.
- SEN coordinators and SEND Hubs were praised for their proactive approach in responding to feedback and meeting the training needs of staff in settings across the city and therefore staff are becoming better informed and confident to pick up early identifications of SEND.
- The new Joint SEND strategy and provision for short breaks are good examples of meaningful and thorough co-production between professionals and parents and carers.
- Supported internships offer an increasing number of young people with SEND paid employment.
- Children and young people with complex health conditions get good support from the well-established children's community nursing service.

4.4 SEND Local Area Inspection – Findings: Areas for development

Ofsted and the CQC published the final report on 13 August 2019. The report indicates that the inspectors agreed that their findings chimed with Peterborough's own self evaluations and many areas of strength were identified. However, they had significant concerns about the need for improvement in the 5 areas set out below:

- Joint planning, including commissioning, and intervention are not sufficiently well

established to make sure that all agencies and services play an active role in meeting the requirements of 2014 disability and special educational needs reforms.

- There is no quality assurance framework for the local area's work for children and young people with SEND. Intended outcomes for children and young people are not targeted, measured or evaluated well enough to inform leaders about the impact of the work to implement the reforms effectively.
- The current arrangements for the DCO in relation to the implementation of the reforms do not allow the post holder to fulfil the obligations of the role sufficiently.
- Early support is well embedded for children in early years but does not follow through in all areas of the lives of children and young people as they get older. It takes too long for children, young people and families to get the support they need.
- The provision for young people aged 18 to 25 is not sufficiently developed to make sure that young adults have the full range of opportunities and support that they need as they move through into adulthood

4.5 **Written Statement of Action (WSOA)**

The local area were required to produce a Written Statement of Action (WSoA) to address the areas of development outlined in the report. The WSoA was co-produced by a working group that consisted of partners from education, health, social care and our parent / carer forum, who received advice and guidance directly from the DfE to support completion. The WSoA was submitted to Ofsted within the required deadline of 15 November 2019.

On 4 December 2019, PCC received a letter informing that Ofsted and the CQC accepted the WSoA as 'fit for purpose', save some additional recommendations. These included:

- Ensuring that social care leaders have a sufficient impact on actions;
- That the statement make adequate references to specific measures that include reviewing changes made and addressing outcomes for all aged 0-25
- To make outcomes for those aged 18-25 more specific.

The WSoA has been uploaded on the Peterborough website to enable parents, carers and young people to see how we are planning to address the challenges outlined by the inspection findings.

The WSoA highlights the following workstreams led by a senior accountable sponsor:

Workstream 1: Joint Planning and Commissioning Including Interventions
Senior accountable sponsor: Wendi Ogle-Welbourn, Executive Director, People & Communities, PCC/CCC

Workstream 2: SEND Quality Assurance
Senior accountable sponsor: Jonathan Lewis, Service Director Education PCC/CCC and Alison Bennett, Assistant Director Safeguarding and Quality Assurance, PCC/CCC

Workstream 3: Role and Arrangements for the DCO
Senior accountable sponsor: Marek Zamborski, Senior Responsible Officer, CCG

Workstream 4: Getting Support Early
Senior accountable sponsor: Raj Lakshman Consultant in Public Health Medicine PCC/CCC and Karen Moody, Head of Prevention and Early Help Services, PCC/CCC

Workstream 5: Provision and Opportunities for Young Adults aged 18-25
Senior accountable sponsor: Debbie McQuade, Assistant Director Adults Social Care, PCC

Each of the workstreams have a range of actions and have dedicated delivery partners to ensure that the actions are competed and implemented to achieve the intentions and impact necessary to improve joint working across Peterborough.

Ofsted and CQC are anticipated to return to re-inspect within 18 months (from May 2021).

4.6 **Monitoring Visits**

The Department for Education and NHS England conduct a number of monitoring visits during the 18 month period – between acceptance of the WSoA and the reinspection.

The first monitoring visit is scheduled for 25 February 2020.

As part of the process for the monitoring visit, the local area are required to submit a proforma outlining key activities since the WSoA was accepted. Headline activity is listed below:

- All workstreams have active working groups addressing key issues. These groups have met on a regular basis and are developing action plans which are linked to the Joint SEND strategy and the actions from the WSoA
- There is a steering group which is linking the key workstreams together and ensuring they are on track with the wider activity from the WSOA
- From this there has been a young person's event linking the key workstreams and identifying priorities from young people themselves around key areas.
- Adult ICES re-tender commenced January 2020 (new tender from April 2021) and the public engagement process commenced January 2020 (includes children and young people).
- Publication of the revised 'provision of continence products' pathway on the Local Offer website
- Interim arrangements (to relieve immediate pressure on DCO) for a 6-month secondment arrangement for a full time Children's Complex Cases (LD/MH/ASD) keyworker has been in place since January 2020
- Children's Complex Cases Commissioning Team restructure has been agreed at COT meeting in January 2020. HR Consultation process will be undertaken during February 2020
- Monthly highlight report for the Joint Child Health & Wellbeing Commissioning Board now includes SEND DCO reporting. The CCG will negotiate the WSoA and SEND Strategic Action plan into provider contracts for 2020/21
- SEND Health operational working group has been established, with health providers, PCF and Statutory Assessment Team engagement and participation. Terms of Reference for this group have been reviewed and updated to identify key priorities for 2020. Areas of focus – improve health advice and information on EHCP's, improve health information available on Local Offer web pages, training and development
- Initial practice development workshop session completed to enhance the facilitation skills of the SEND Health Champions in January 2020
- The Preparing for Adulthood (PfA) Health group held an Annual Health Check (AHC) focused workshop, with action plan developed. A questionnaire was completed by young people at a recent PfA event to ask about whether they know about AHC's and whether they had had one. The action plan will be reviewed at next meeting in March 2020
- SEND in Reception event held in October 2019, with further termly events
- Children on the Early Support Pathway who entered reception in September 2019 have been given the opportunity to be retained on the Early Support Pathway
- Lead officers for the 'Every Contact Counts' workstream of the Best Start in Life programme held a focus group in December 2019, the outcome of which will be taken back to the next meeting of the wider implementation group
- Clear reference to SEND is now within the Healthy Child Programme specification
- A task and finish group has been identified to look at specific outcome measures for children with SEND. The first meeting was held in January 2020. It was agreed to look at the EYFS profile outcomes for children with SEND

- Questions in relation to whether or not children / young adults have SEN needs have now been made mandatory on the Early Help Module case management system at point of completing the Early Help Assessment
- A KPI Task & Finish Group has been set up, with the first meeting in February, to identify initial KPIs
- Two weekly remedial action plan meetings to monitor progress of reduction in waiting times have been established
- Joint work is taking place between the neurodevelopmental service and Area Senco to provide briefing sessions to SENCO's
- The Local Transformation Plan has been updated
- A mental health needs assessment has been completed
- The SEND Health Group will review transition pathways on the local offer at the next meeting in February
- Strategic transitions protocol to be commenced in April
- Updated service specifications will include transitions / PFA arrangements for CYP with SEND through 2020/21
- The Curriculum Group are reviewing and reflecting on increased offer for activities for young adults post 16 with an EHCP

5. CONSULTATION

5.1 There is on-going consultation, as part of a co-production routine throughout the workstreams for the Written Statement of Action. In addition:

- The Peterborough SEND Partnership Group met in December and January to review action taken on the Joint SEND Strategy and the Peterborough Written Statement of Action
- A range of Preparing for Adulthood meetings have been held to discuss key areas of the WSoA
- The Joint SEND Executive Board met in October to review and comment on the WSoA before submission and will monitor progress at the next meeting in February

6. ANTICIPATED OUTCOMES OR IMPACT

6.1 The intended outcomes covered by this report are focussed on improving the provision for SEND by maintaining standards that are recognised as good, or better by Ofsted and CQC and by delivering a joint strategy for SEND across both Peterborough and Cambridgeshire which enables our pledge to 'Make SEND everybody's business' to widen awareness and knowledge of how support services can improve outcomes for all across the community.

It is anticipated that this will have a neutral impact on the councils carbon emissions as the way services are delivered will not directly change as a result of this report.

7. REASON FOR THE RECOMMENDATION

7.1 HWB members to be sighted and feel assured that appropriate action is being met to meet the recommendations of the Written Statement of Action.

8. ALTERNATIVE OPTIONS CONSIDERED

8.1 Do nothing – this would likely result in the DfE reporting lack of progress to the Minister.

9. IMPLICATIONS

Financial Implications

9.1 None.

Legal Implications

9.2 None.

Equalities Implications

9.3 None.

10. BACKGROUND DOCUMENTS

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

10.1 None

11. APPENDICES

11.1 Appendix 1: Written Statement of Action

Peterborough Local Area Written Statement of Action

(Special Educational Needs and Disabilities)

November 2019

Contents

Foreword

Senior leaders across the Council, the Clinical Commissioning Group, Public Health and their partners welcome the inspection report which tested the progress of the local area in meeting the requirements of the 2014 SEND reforms, finding areas of both strength and weakness.

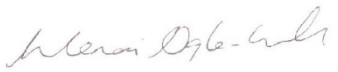
Areas of strength included the growing impact of the SENCo network, the strength of coproduction with parents and young adults and the increasing influence of young adults in strategy through initiatives like the 'Big Youth Shout Out'. Inspectors also identified areas of weakness and leaders are determined to address these within the resources available so that we do all that is possible to improve outcomes for children and young adults with special educational needs and disabilities (SEND). We are committed to working more effectively together to ensure that children, young adults and their families lead happy, healthy and fulfilled lives.

Our pledge to improve the life outcomes for children and young adults with SEND is expressed in our joint SEND strategy with Cambridgeshire - 'Special Educational Needs and Disabilities (SEND) is Everybody's Business'. We developed this strategy by listening carefully to what children and young adults with SEND and their families and carers told us about their experiences and views. We worked closely with families, children and young adults to produce this strategy and commit to the same level of participation and engagement to ensure the delivery of the delivery of the written statement of action below.

We have high aspirations for all our children and young adults and want to ensure they have the right support that is provided in the right place and at the right time so that they can thrive and be the best they can be. We will ensure that the written statement of action drives robust, sustainable and high-quality improvements in their lives and the lives of their families.

Councillor Lynne Ayres, Cabinet Member for Children's Services, Education, Skills and the University, Peterborough City Council

Wendi Ogle-Welbourn, Executive Director People and Communities for Cambridgeshire & Peterborough councils



Jan Thomas Accountable Officer for the Cambridgeshire and Peterborough Clinical Commissioning Group

Introduction

Between 10th June 2019 and 14th June 2019 Ofsted and the Care Quality Commission (CQC), conducted a SEND inspection of Peterborough local area to judge the effectiveness of the implementation of the Special Educational Needs and Disability (SEND) reforms in the Children and Families Act 2014 and to review the area's provision for children and young adults with SEND.

Three inspectors were involved: Heather Yaxley HMI, Deborah Mason, Ofsted and Paula Morgan, CQC. As part of their work the inspectors reviewed documentary and published evidence, the Local Offer website and information from a 'webinar' with parents/carers which took place in the week before the inspection. The inspectors carried out the on-site inspection over 5 days with formal verbal feedback provided on the fifth day. Inspectors spoke with children and young adults with disabilities and/or special educational needs (SEND), parents and carers, local authority and NHS officers. They visited a range of providers and spoke to leaders, staff and governors about how they were implementing the special educational needs reforms. Inspectors looked at a range of information about the performance of the local area, including the local area's self-evaluation. Inspectors met with leaders from the local area for health, social care and education. They reviewed performance data and evidence about the local offer and joint commissioning.

Findings

Ofsted and the CQC published the final report on 13th August 2019. The report indicates that the inspectors agreed that their findings chimed with Peterborough's own self evaluations and many areas of strength were identified. However, they identified significant weaknesses in the 5 areas set out below:

1. Joint planning, including commissioning, and intervention are not sufficiently well established to make sure that all agencies and services play an active role in meeting the requirements of 2014 disability and special educational needs reforms.
2. There is no quality assurance framework for the local area's work for children and young adults with SEND. Intended outcomes for children and young adults are not targeted, measured or evaluated well enough to inform leaders about the impact of the work to implement the reforms effectively.
3. The current arrangements for the DCO in relation to the implementation of the reforms do not allow the postholder to fulfil the obligations of the role sufficiently.

4. Early support is well embedded for children in early years, but does not follow through in all areas of the lives of children and young adults as they get older. It takes too long for children, young adults and families to get the support they need.
5. The provision for young adults aged 18 to 25 is not sufficiently developed to make sure that young adults have the full range of opportunities and support that they need as they move through into adulthood

As a result, the local area is required to produce a written statement of action (WSOA) by 15th November 2019. OFSTED will respond to the WSOA within 10 working days of receipt with an evaluation on whether the WSOA is fit for purpose. If required, a further 20 days is provided for resubmission of an amended version.

Response

The significant areas of weakness identified in the inspection report are addressed in this written statement of action (WSOA).

The written statement of action has been coproduced by the SEND partnership Group and refined by a smaller 'drafting' sub group of the partnership group and signed off by the SEND Executive Board.

The written statement of action will be shared widely through the Local Offer, networks, newsletters, conferences, partners and stakeholders including Peterborough Family Voice (our local Parent Carer Forum), and our SEND Independent Advice and Support Service.

The area is committed to involving children and young adults with SEND and their families in decisions about services for them. Coproduction is well embedded in local practices. Parents/carers have participated at all stages in the development of this written statement of action. Parents/carers will be involved in all working groups and we will also take every opportunity for children and young adults to be included in the improvement work.

The WSOA has five workstreams which mirror the five areas of weakness identified by the inspection. Each workstream is sponsored by a senior officer (AD equivalent level or above) from the LA or CCG. These senior officers are accountable for the delivery of actions within their workstream. The senior accountable officer (SAO) has an identified multi – agency delivery team of officers at manager level or above with whom they will ensure the delivery of the actions set out.

The WSOA is separate from other existing action planning although there will inevitably be areas of overlap, particularly with the joint SEND action plan associated with the joint SEND strategy. The WSOA addresses areas specific to the weaknesses raised by the inspection and is intended to cover a period of approximately 18 months. The joint SEND strategy expresses the long-term ambitions of the joint area but it is anticipated that the areas of work covered by the WSOA will enhance work to implementation of the strategy.

Governance and accountability

The Cambridgeshire and Peterborough Child Health and Well-Being Commissioning Board has responsibility for the commissioning of integrated services to support children and young adults, including those with SEND. The Commissioning Board is supported by the Child Health Executive Board, which comprises of commissioners and providers. These Boards report to the Health and Well-Being Board. Membership of the Executive includes Chief Officers from the Local Authority, Cambridgeshire and Peterborough Clinical Commissioning Group, Cambridgeshire Community Services, Cambridgeshire and Peterborough Foundation Trust, Health Watch, Local Hospitals, Public Health, Family Voice, Pin Point (parent/carer forums).

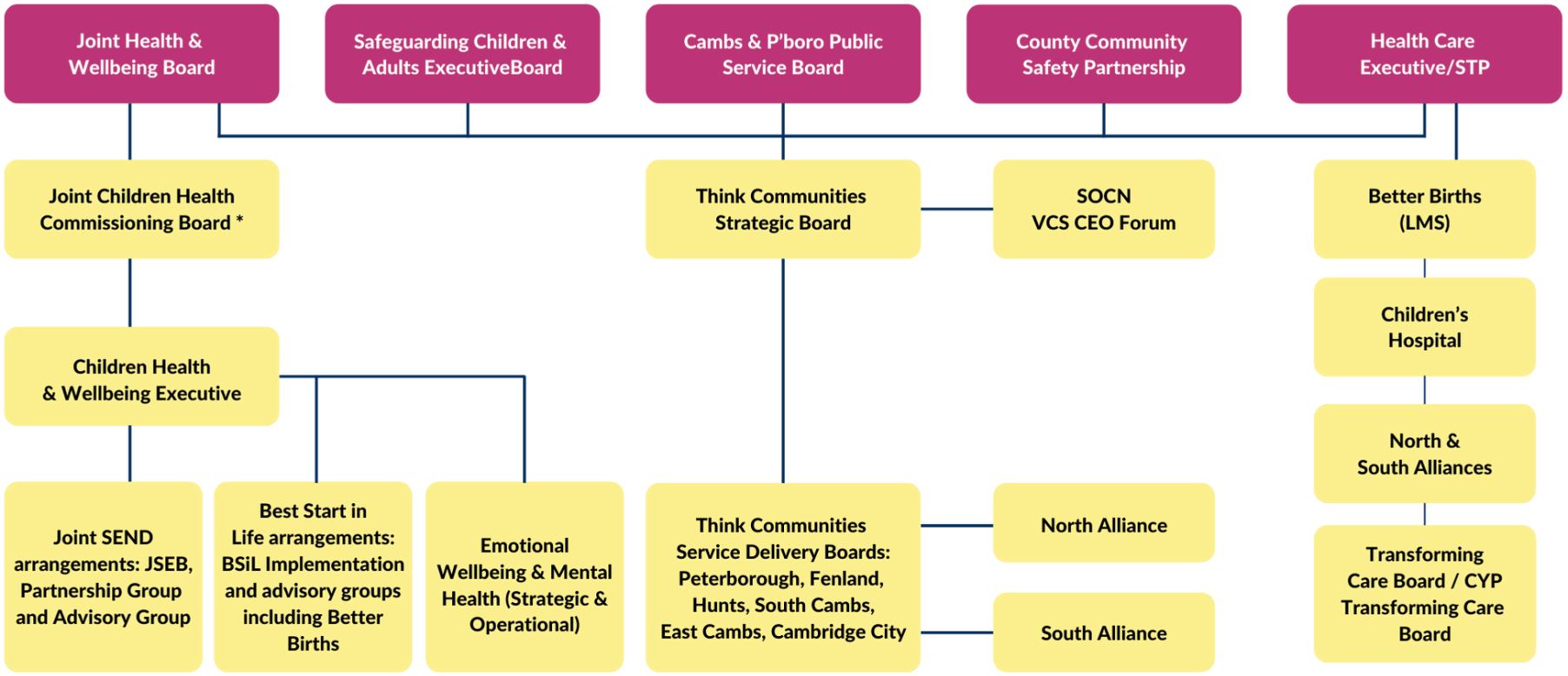
The SEND Executive Board reports into the Commissioning and Executive Boards. It is responsible for the development and delivery of the SEND Strategy and Plan. It will have oversight of the delivery of the written statement of action in Peterborough, escalating any areas of concern to the Commissioning or Executive Board, depending on the nature of the concern. The SEND Executive Board is supported by Peterborough and Cambridgeshire Partnership Groups who are responsible for driving delivery of the Strategy and Action Plan.

This governance structure is illustrated in the following diagram.

***The Joint Children Health Commissioning Board feeds into the CCG Boards, LA Committees and Health Executive/STP where appropriate.**

NB: a children 0-25 with complex needs (including tier 4)' group has recently been established to discuss the Tier 4 list and ensure plans are in place for discharge and agree funding, address and resolve areas of contention between the LA and health, update on the work developing provision for children with disabilities, consider any Ministry of Justice (MOJ) young people who will need provision. This group will feed into the Children Health & Wellbeing Executive.

Cambridgeshire and Peterborough Governance Structure



Full and thorough consideration has been given to the way in which each of the workstreams will be managed. Having considered carefully all of the options a deliberate decision has been made to give responsibility to senior accountable officers for ensuring that work progresses. Each senior accountable officer has a multi-agency team with whom they will deliver the workstream. The emphasis has been deliberately placed upon impacts and outcomes and the need to work together in partnership to get the job done. The senior accountable officer will be responsible for ensuring the collation of progress reports to the SEND Executive Board. This approach is designed to promote the importance of the SEND agenda across all partners and provide strong leadership to ensure responsibility across all partners for delivery – everyone is actively 'at the table'. The senior responsible officer will oversee the allocation of tasks within each workstream and it is anticipated that these responsibilities may sometimes be joint across agencies and/or will alter as work progresses.

The use of a BRAG rating has been agreed to provide an at a glance summary of progress. Some of the actions set out have already been completed since the inspection.

The ratings are as follows:

Blue – complete

Green – on track

Amber – behind schedule

Red – not started/risk

A column has been added to identify the resource implications of actions as follows:

AR – Additional resource is or may be required

ER – Actions covered by existing resource

Written Statement of Action

Workstream 1: Joint planning and commissioning including intervention
Senior Accountable sponsor: Wendi Ogle-Welbourn DCS & Chair of the Child Health & Wellbeing Commissioning and Executive Boards
Delivery partners: Child Health Commissioning & Executive Board Members**,** Family Voice (parent-carer forum) representative, Sheelagh Sullivan (Head of SEN and Inclusion Services) , Graham Puckering (Head of 0 – 25 Service), Jackie Cozens (Local Offer Lead), Jo Dickson (Communications), Toni Bailey (Assistant Director SEND), Tom Barden (Business Intelligence), Siobhan Weaver (Designated Clinical Officer)
Significant area of weakness that needs to be addressed: Ofsted and CQC said: "Joint planning, including commissioning, and intervention are not sufficiently well established to make sure that all agencies and services play an active role in meeting the requirements of 2014 disability and special educational needs reforms."

Outcomes (what we intend to achieve and their impact)	Ref	Implementation (Actions - what are we going to do)	Resource Required	Key milestones (Action tracker)	Deadline	BRAG + date
1.1 There is a clear and ambitious joint commissioning strategy, including effective service delivery arrangements, for children and young adults (0 – 25) with SEND that ensures: • all services play an active role in meeting the requirements of the SEND reforms • issues raised at inspection are prioritised **Impact**	1.1a	Coproduce a joint SEND commissioning strategy that will : • be based on identified needs • build on a gap analysis • monitor delivery of commissioned services • sets priorities for improvement and puts in place an action plan to rectify any deficit in provision	ER	Needs assessment initiated and agreed by the Joint Child Health Commissioning Board (JCHCB)	Nov 2019	Nov 2019
				Baseline of needs identified by families is recorded	Jan 2020	
				Mapping existing resources against needs and identify gaps in meeting needs	April 2020	
				SEND commissioning strategy in place that ensures robust monitoring of commissioned services	June 2020	
				Commissioning of evidence based interventions within existing resource envelope to close gaps	June 2020 to	

• Services are commissioned / delivered to meet identified agreed needs • Children, young adults and families co-producing strategy ensuring that the views of all are heard and acted upon				with procurement and delivery of services secured	April 2021	
Impact • Young adults and families have positive experiences of services commissioned to meet their needs	1.1b	Establish and undertake an annual 'Family Voice' Survey to seek families views on how well their needs have been met by commissioned services	ER	Establish and record the baseline of family views from implementation of the commissioning strategy	June 2020	
			ER	First Family Voice survey one year on shows improvement in how well they think their needs have been met through commissioned services	July 2021	
Impact • Underperformance challenged and addressed leading to improved services for young adults and families • Priorities outlined to increase family and user confidence in services	1.1c	Develop a data set (using the council for disabled children's framework) to evidence performance of services against the SEND strategy and Plan. Monitor the data set at the SEND Executive Board, celebrating good performance and challenging	ER	Agreed cross agency data set in place	Feb 2020	
				Benchmark of priorities from children and families collated	Feb 2020	

		underperformance and agreeing actions to address.		Quarterly reports to SEND Executive for monitoring performance from April 2020 show progress towards achieving the outcomes in the strategy and feed into commissioning process (1.2)	April 2020	
1.2 **Commissioning issues raised at inspection are prioritised and gaps closed** **Impact** • All services across health, education and social care have knowledge of access to equipment services so that equipment is provided efficiently. • Families and young adults report to professionals, each time the equipment is provided, that they are satisfied with the timeliness of the service	1.2	Develop a local area jointly commissioned (Peterborough and Cambridgeshire) equipment provision service for children and young adults with SEN & Disabilities	AR	Mapping of current arrangements for assessment and provision of all equipment including medical technology	Nov 2019	
				Review and gap analysis complete and presented to JCHCB	Jan 2020	
				Proposed integrated equipment service proposal presented to JCHB with commissioning recommendations taken to JCB and COT	April 2020	
				Service in place	Oct 2020	
Impact • Service delivery provided in line with NICE guidance and national recommendations so that	1.2b	Review the pathway for provision of continence products	ER	Review of referral, assessment and products pathway complete	Dec 2019	

children and young adults are provided with an adequate supply of products				Publication of the revised pathway on the Local Offer website	May 2020	
Impact • SEND children and young adults access to OT and Physiotherapy Services improved in line with agreed key performance indicators (see 4.3)	1.2c	Complete the joint commissioning of the OT and Physiotherapy service Integration and Transformation Plan to ensure improved access to OT services	AR	OT Integration and transformation plan in place	April 2020	
				Joint service specification for OT created	Dec 2020	
				Balanced Model© implemented through series of facilitated workshops	Dec 2020	
Impact • Children and young adults who require services from Community Nursing will benefit from services that provide care up to the age of 18 years	1.2d	Complete a review of Children's Community Nursing Services to identify provision required to meet nursing needs of children with complex health up to the age of 18 years	ER	Complete review and implement recommendations	Oct 2020	
1.3 **An ambitious SEND strategy and action plan (developed jointly with Cambridgeshire) will be in place and the commitment of all partners will be evidenced by their sign up to the 'SEND pledge'** **Impact:** • Families and professionals say that the SEND strategy and Pledge are making a difference in	1.3	Formally launch the joint **Peterborough**/Cambs SEND strategy, Pledge and associated action plan in partnership with parent /carer forums. Set up a SEND communications group to formulate and implement a communication strategy that:	ER	SEND communications group established to coproduce and implement a communication strategy	Sept 2019	Sept 2019
				Formal launch of joint SEND strategy and Pledge	Jan 2020	
				Communications strategy and action plan agreed by SEND Executive Board	Jan 2020	
				Action plan progress monitored at bi-monthly SEND Executive Board	From Feb 2020	

services for SEND, in line with the 2014 Reforms • Feedback from the Peterborough community shows that they are aware of the SEND strategy and vision that "SEND is Everybody's Business"		• supports the implementation of the Strategy, the Pledge and action plan, • includes a clear plan for seeking feedback on how they are making an impact		SEND pledge is circulated to all services involved in delivery to children and young adults with SEND and signed up to by 85% of those circulated	April 2020	
				One year on review of the impact of the Pledge shows clear evidence of commitment and action by key service delivery partners	April 2021	
1.4 **Children, young adults, families and professionals know where to go for help and information** **Impact** • Surveys carried out by Family Voice (having established a baseline) show that families report improvement in knowing how to access services for children and young adults with SEND and the timescales involved leading to greater levels of satisfaction	1.4a	Improve and raise awareness of the Local Offer working with Family voice to: • Create a Parent Participation page on the Local Offer • Information on the Local Offer reviewed and extended to include a new page to describe Short Breaks • Redesign the Local Offer postcards with contact details • Co-produce a guide to panel decision making • Improve the descriptions of the health information including a description of pathways and timescales • Establish a SEND newsletter for parents, schools and professionals • Develop a suite of SEND factsheets, including revised information about and promotion of Personal Budgets and Personal Health budgets	ER	Parent participation page in place	Oct 2019	Oct 2019
				Short breaks information page included	Oct 2019	Oct 2019
				Establish baseline of parent views from Family Voice survey about parental satisfaction regarding service info on the local offer	Dec 2019	
				Postcards redesigned	Dec 2019	
				Agree a system to ensure that information about services on the Local Offer is kept up to date	Jan 2020	
				Health services access arrangements published on the Local Offer	Jan 2020	
				Increasing use of the parent participation page over time as evidenced in reports to Executive Board	From Feb 2020	
				Guide to panels produced	Feb 2020	

				Suite of health information updated	March 2020	
				Suite of SEND fact sheets and SEND newsletter published	Sept 2020	

Workstream 2: SEND Quality Assurance
Senior Accountable sponsor: Jon Lewis/Alison Bennett
Delivery partners: Toni Bailey (AD SEND), SEND quality assurance officer (appointment pending), Siobhan Weaver (DCO), Graham Puckering (Head of 0 – 25 service), Sheelagh Sullivan (Head of SEN and Inclusion Services), Senior officer from attendance team (appointment pending), Family Voice representative, Helen Whyman (Senior Public Health Information Analyst), Tom Barden (Business intelligence), Chris Stronberg (Head of IT), Jess Conway (Peterborough SENCo)
Significant area of weakness that needs to be addressed: Ofsted and CQC said: "There is no quality assurance framework for the local area's work for children and young people with SEND. Intended outcomes for children and young adults are not targeted, measured or evaluated well enough to inform leaders about the impact of the work to implement the reforms effectively."

Outcomes (What we intend to achieve and their impact)	Ref	Implementation (Actions - what are we going to do)	Resource Required	Key milestones (Action tracker)	Deadline	BRAG + date
2.1 **At a strategic level, key decision makers know how well the local area is improving outcomes for children and young adults with SEND and where improvements are required** **Impact** • Reports to and minutes from the SEND Executive Board provide assured evidence of the outcomes for children, young adults and their families from March 2020	2.1	Coproduce a local area quality assurance framework that will include; • collating existing quality assurance arrangements • setting up the system for monitoring quality of provision and outcomes for children and young adults in independent settings • setting up a process for tracking the achievement of the outcomes that matter (see SEND strategy) for children and young adults with an EHCP	AR	Quality assurance post agreed	Sept 2019	Aug 2019
				Quality assurance post holder in place	Feb 2020	
				Current QA arrangements collated	Feb 2020	
				QA framework in place	March 2020	

		• agreeing a quality assurance mechanism for testing satisfaction of children and young adults that services they receive are specific to their needs		Monthly reports to the SEND partnership group are used to track progress	March 2020	
2.2 **All delivery partners understand their responsibilities concerning EHCPs (particularly annual reviews) and annual review processes and timelines conform to statutory expectations** **Impact** • Feedback regarding annual review processes increases and the majority (over 80%) of parent/carers/young people who engage express satisfaction with all aspects of the EHCP process, including the quality and accuracy of advices from all partners • Timeliness of new EHC needs assessments remains high (over 85%) and the majority of decisions regarding annual reviews are made within timelines (over 90%)	2.2a	Improve the quality and timeliness of the EHC needs assessment and review process by: • Production of a targeted recovery plan to address annual review backlog • Implementation of new EHCP processing system • Use of the new QA post to further develop the multi-agency EHCP audit • Review of feedback arrangements to include annual reviews and new ways of engaging with families in receipt of new EHCPs • A rolling programme of training and support around the EHC needs assessment and review process is agreed and implemented with the cooperation and contribution of all partners • Reports to SEND Executive Board are produced by the QA	ER	Targeted annual review recovery plan produced	Nov 2019-	Nov 2019
				Newly received requests for assessment and annual reviews are logged on to the new system	Dec 2019	Nov 2019
				Audit arrangements reviewed and revised plans in place with the support of the new QA post	March 2020	
				Feedback arrangements reviewed and all new arrangements in place	March 2020	
				Data migration to new IT system complete and system fully operational, including reporting facilities	March 2020	
				Rolling multi-agency training programme agreed and implementation started	April 2020	

		post informed by data and feedback from services and families		Comprehensive reports to SEND Executive Board including both quantitative and qualitative data in place	April 2020	
Impact • Sufficient capacity within the local authority to improve timeliness and quality of EHCPs impacting on quality of provision for children and young adults with EHCP's due to quicker delivery of agreed plans / reviews	2.2b	New posts agreed to support statutory responsibilities around EHCPs within the LA, schools and settings and health partners	AR	New posts agreed by SEND Executive Board	Dec 2019	
				Post holders in place	March 2020	
2.3 **Outcomes for children and young adults in out of area placements match the quality and expectation of what was commissioned** **Impact** • Leaders know what is happening from highlight reports to Board of the progress of children and young adults with an EHCP that show that out of area placements deliver commissioned outcomes for children and young adults	2.3	Robust contract monitoring arrangements are developed, agreed and implemented with all partners, including the use of regional arrangements	ER	Contract and monitoring arrangements in place	Feb 2020	
				First highlight report provided to Board to include data about the extent and use of out of area placements, building upon baseline data already available	Feb 2020	
2.4 **There are processes in place to increase leaders understanding about the extent of part time**	2.4	Establish a system for monitoring the use of part time placements for children and young adults with SEND	ER	Guidance developed and presented to schools	Sept 2019	Sept 2019
				Baseline numbers on part time timetables collated for children and young adults with an EHCP	Feb 2020	

placements in schools for children and young adults with SEND **Impact** • The Local Authority is clear about extent of part time placements in schools for children and young adults at SEN support and EHCPs • Reduction in use of part time timetable provisions by 30% by July 2021		Produce and present revised guidance regarding use of part time tables to schools and settings		System established for monitoring use of part time placements	Feb 2020	
				First highlight report to Board	July 2020	
				LA partners agree with providers a focus on reducing part time table provisions by 30%	July 2020	

Workstream 3: Role and arrangements for the DCO
Senior Accountable sponsor: Marek Zamborski
Delivery partners: Karlene Allen (Head of Children and Maternity services Commissioning and Transformation, CPCCG), FV representative, Siobhan Weaver (DCO), Ali Mayern (SEND Health Co-Ordinator, CPCCG), Alison Hanson (Head of Service Speech and Language Therapy, CCS NHST), Lorraine Cuff (Head of CAMHs Neurodevelopment Team, CPfT), members of the SEND Health Advisory Group (C&P)
Significant area of weakness that needs to be addressed: Ofsted and CQC said: "The current arrangements for the DCO in relation to the implementation of the reforms do not allow the postholder to fulfil the obligations of the role sufficiently. "

Outcomes (What we intend to achieve and their impact)	Ref	Implementation (Actions - what are we going to do)	Resource Required	Key milestones (Action tracker)	Deadline	BRAG + date
3.1 **The arrangements in place for the Designated Clinical Officer (DCO) role ensure that the system fulfils the objectives of the SEND reforms.** **Impact** • DCO is able to fulfil the priorities set out in the WSoA and the 1st year priorities of the SEND Strategic Action Plan, measured through milestone target dates (reviewed at the SEND Partnership Group) with quarterly and annual reports to the CPCCG COT on progress of SEND.	3.1	Develop and present a costed options appraisal to CPCCG Chief Operating Team (COT) which details the need to improve the current arrangements and capacity of the DCO role within and Children's Complex Cases service.	AR	Options appraisal for DCO capacity and recommendations presented to COT	Oct 2019	Oct 2019
				Interim arrangements to relieve immediate pressure on DCO with medium term planning for increased resource into service development	Oct 2019	Oct 2019
				Financial agreement for additional resource requirements to increase the capacity of the DCO arrangements	Nov 2019	
				Recruitment processes commenced	Dec 2019	
				Develop a detailed SEND reporting mechanism for COT	Dec 2019	

				(1/4 update and annual reporting)		
				Additional capacity in the Children' Complex Cases team to support the CCG DCO role established	March 2020	
3.2 **Health professionals play an active and equal part in the EHC needs assessment, preparation of EHC plans and review and removal of EHCP's.** **Impact** • Children and young adults will have their health needs, provision and desired outcomes, which are consistent with current professional knowledge, detailed in their EHCP. These will be measured through EHCP audit processes (see 2.3 e) and the 6 monthly 'deep dive' EHCP audits for children and young adults with complex health needs. • Feedback from children, families and schools/FE colleges will indicate that they have had a good experience where healthcare professionals have jointly planned their child or young person's EHCP	3.2	Develop and implement the "*Improving the effectiveness of joint working and planning of health partners, within EHC Plans"* Quality Improvement Initiative project. This QI project will: • Test the established EHCP processes, including the health advice template and training offered, against a new approach to facilitate the physical and mental health sectors to think more joined-up and person-centred for children and young adults (0-25 years) with SEND • Provide individual health services with targeted, facilitated workshops which promote ownership and change of practices to engage with the EHC planning requirements relevant to their own service delivery methods. • Create SEND Health 'Critical Friends' to work alongside providers who	ER	Review and enhance the terms of reference of the SEND Health operational working group to include the role of SEND Health Critical Friends	Nov 2019	
				Use data from audits to identify up to 4 health teams that would benefit from targeted facilitation in the 1st phase of the project	Nov 2019	
				Develop initial workshop session and test with critical friends	Dec 2019	
				Baseline established for each service using the SEND self-assessment tool	Jan 2020	
				Develop the role and facilitation skills of the SEND Health Champions to support delivery of the QI project	Feb 2020	
				Engage with SENCo network to develop feedback mechanism from schools for their experience of health involvement in EHC planning processes	Feb 2020	

• Maintain the compliance of timescales for the EHCP initial request processes measured through monthly data from the CCG EHCP single point of access.		will facilitate ways of working that effectively implement the requirements of EHC planning • Create a set of local good practice examples from stories, data and intelligence gathered by critical friends to inform future facilitation sessions. • Introduce measurements of progress with a SEND self-assessment tool for health provider services. • Develop a process for DCO to monitor and agree final EHC plans.				
3.3 **There is an increase in the uptake of learning disability annual health assessments for 14 – 25 year olds** **Impact** • Increase from 39% to 50% of uptake by the least likely to attend group (14 – 17 year olds) by April 2021 • Increase to 75% from 55% of 14 – 25 year olds attend their annual health check by April 2021	3.3	DCO, with the PfA Health group will facilitate learning disability annual health check workshops to create an action plan for the local area in order to increase the number of young adults aged 14 – 25 who attend their LD AHC	ER	EHCP audit for post 14 years shows that the annual health check has been discussed at the annual review meeting. First report May 2020	May 2020	
				Establish a baseline from feedback from young adults that they know what an annual health check is and how to get one	May 2020	

Workstream 4: Getting support early
Senior Accountable sponsor: Raj Lakshman (Consultant in Public Health Medicine/Karen Moody (Head of Prevention and Early Help Services)
Delivery partners:), Karen Hingston (Head of Early Years), Kathryn Goose (Mental Health Commissioner), Lorraine Cuff (Head of CAMHs Neurodevelopment, CPfT), Joanne Carr (CPfT), Family Voice representative, Siobhan Weaver (DCO), Sarah Bernard (Manager Early Years Specialist Service, including Portage)
Significant area of weakness that needs to be addressed: Ofsted and CQC said: "Early support is well embedded for children in early years, but does not follow through in all areas of the lives of children and young people as they get older. It takes too long for children, young adults and families to get the support they need."

Outcomes (What we intend to achieve and their impact)	Ref	Implementation (Actions - what are we going to do)	Resource Required	Key milestones (Action tracker)	Deadline	BRAG + date
4.1 **The principles of Early Support are effectively embedded for children and young adults as they get older in line with the SEND Code of Practice** **Impact** • Fewer part time timetables and increased access to reception for children with SEND due to better	4.1a	Extend the opportunity to stay on or be accepted onto the Early Support pathway for children up to the end of Reception Undertake survey, in partnership with Family Voice, to establish baseline data to track the immediate and future impact of the change in approach	ER	Targeted training, advice and support provided for early years and reception staff	August 2020	
				Support for children to the end of Reception and their families in place	Sept 2020	
				Survey and evaluation of extended offer to inform further roll out completed	July 2021	

understanding and available support • Families report in the Family Voice annual survey a better transition experience for their child from early years settings to reception • For the first time the Healthy Child and BSiL programmes have a sharper focus on children and young adults with SEND	4.1b	Support for SEND is clearly set out in Best Start in Life (BSiL) and Healthy Child Programme (0 – 19) to: • improve identification of need • improve coordination of support for SEND across children and young adults' services and • identify KPIs in order to measure progress towards improving outcomes	ER	Clear reference to SEND is within the Every Contact Counts work stream of Best Start in Life and Healthy Child Programme.	March 2020	
				Evaluation framework developed for the BSiL programme	March 2020	
4.2 Children and young adults with SEND are identified early to ensure they can access the holistic range of help they need in a timely manner Impact • Feedback in Early Help reports shows that children / young adults with SEND and parents and carers of children with SEND understand how to access Early Help support and demonstrate success in navigating towards required support	4.2	Review access to support via Early Help and other routes to identify potential blockages or delays to include: • review of available information • review of multiagency pathways and access to support • establish processes for collecting and evaluating data for children and young adults with SEND receiving Early Help	ER	A review of all professionals and parent / carer information leaflets on Early Help pathways to support	April 2020	
				Implementation of a multi-agency review panel in Early Help for all requests for support to ensure children / young adults with SEND receive support in a timely manner	April 2020	
				Baseline of child / young person and parent/carer views on clarity of pathways to access support; provision of support and timeliness of support established	April 2020	

				Baseline of numbers of children and young adults with SEND in receipt of Early Help recorded	April 2020	
4.3 **Children and young adults with SEND have access to health services, in particular mental health services in a timely manner** **Impact** • Access targets are clearly defined and measured which allow timely interventions for children and young adults **Impact** • Agreed access targets from mental health services are met so that children and young adults are supported by mental health services that identify needs early and provide information advice and support that improves outcomes for them • Parents/carers report improvement from 2019/2020 baseline that they are listened to and given consistent advice	4.3a	Co-Produce a set of SEND Key Performance Indicators across health services to introduce a common approach to measuring performance in SEND which includes reference to equitable waiting time targets for children with SEND.	ER	Initial contractual proposals to providers based on initial evaluation	Dec 2019	
				Finalise initial set of KPIS and monitor monthly	March 2020	
				Monitor KPIS via monthly contract meetings – ongoing in 2020	Ongoing from March 2020	
				Providers collect data	April 2020	
				Review and calibration of KPIS	Dec 2020	
				Adjustments and business as usual performance mgt	April 2021	
	4.3b	Implement the CPFT Children's Mental Health remedial action plan (NHSE/I) so that children and young adults who require assessment and treatment from NHS mental health services will have access to these services within nationally agreed targets. Redesign workstreams to achieve routine and urgent appointments in a timely manner	ER	2 weekly remedial action plan meetings to monitor progress of reduction in waiting times are set up	Jan 2020	
				Joint action learning events agreed between CAMHs services and the SENCO network to promote the graduated response within the emotional health and wellbeing pathway delivered across services	Aug 2020	

				Children will be assessed within 18 weeks from referral for routine appointments	April 2020	
				Children will be assessed within 12 weeks from referral for routine appointments	April 2021	
				Workstreams are redesigned	April 2021	
	4.3c	Understand the population of children and young adults with a mental health need including a specific focus on children and young adults with SEND. Undertake baseline assessment of parental awareness in regard to mental health services Develop information delivery for parents / carers to outline graduated response to Mental Health support	ER	Update and refresh the NHS Mental Health Local Transformation Plan and use NHSE Key Lines of Enquiry (KLoE's) to ensure focus on sections relevant to SEND	Dec 2019	
				Complete a Mental Health Needs assessment to identify whole population needs and how SEND is highlighted in the mental health Local Transformation Plans key lines of enquiry	March 2020	
				Focus groups with Children and Young adults to develop outcomes	July 2020	
				Use NHSE Key Lines of Enquiry (KLoE's) with focus on sections relevant for SEND to create an action plan	Sept 2020	

Workstream 5: Provision and opportunities for young adults aged 18 - 25
Senior Accountable sponsor: Debbie McQuade
Delivery partners: Graham Puckering (Head of 0-25 Service), Elizabeth Sullivan Ash (Post 16 Lead SENI Services), Matt Oliver (Service Manager Community and Interventions for Targeted Youth Support Service), Family Voice, Special school and College representative x 2 tbc, Siobhan Weaver DCO
Significant area of weakness that needs to be addressed: Ofsted and CQC said: "The provision for young people aged 18 to 25 is not sufficiently developed to make sure that young people have the full range of opportunities and support that they need as they move through into adulthood."

Outcomes (What we intend to achieve and their impact)	Ref	Implementation (Actions - what are we going to do)	Resource Required	Key milestones (Action tracker)	Deadline	BRAG + date
5.1 **There is clarity about the range and availability of opportunities across the local area for 16 – 25 year olds with SEND** **Impact** • Surveys conducted through the local offer and young adults' groups show that young adults and their families say that the Local Offer provides them with the information they need to access opportunities and the services available **Impact**	5.1a	Review the local offer to ensure: a) that there is clarity for young adults and their families about what support is available from health, social care and education b) any gaps are identified c) that there is a clear education offer d) that transition pathways across each service from children's to adult services are clearly described e) that support and opportunities for 19 – 25 year olds are well represented f) that there are clear descriptions of the range of options for activity across 5 days for young adults Post 16 with an EHCP g) conduct survey focussing on effectiveness of the local offer	ER	Gaps in information on the Local offer are identified	Feb 2020	
				Gaps in the information about (c,d,e and f) are closed	Sept 2020	
				First survey of views of young adults on additional information reported on the Local Offer	Sept 2020	

• Coordinated and streamlined approach to developing opportunities leading to more young adults accessing support to lead independent lives • Young adults experience more holistic 5 day planning across all services and in the community	5.1b	Integrate all strategic work across the Preparation for Adulthood (PfA) arena to: • Establish one steering group • Endorse existing workstreams and identify gaps • Identify agreed outcomes for all activity • Ensure integrated partnership working in every workstream so that all offers are holistic	ER	New PfA steering group in place and overarching action plan agreed	Feb 2020	
				All agreed PfA workstreams established	April 2020	
	5.1c	Explore and trial a transitions post in at least one local special school in partnership with local colleges	AR	Plans for transition officer role explored and agreed with potential trial implementation from September 2020	April 2020	
5.2 **In order to address one of the specific areas of weakness identified during the inspection a priority focus will be to ensure that:** **Health services transition arrangements for 16-25 year olds with the most complex health needs are person centred and organised well** **Impact** • Children and young adults experience clear and person	5.2a	Transition Arrangements (movement from children to adult services) for each provider service are clear through: • Review of the CCG improvement plan to ensure this area is addressed • Production and implementation of a transitions protocol for all services provided through CCG for children and young adults with SEND	ER	Review the 2017 Improvement Plan for CCG provider services	Nov 2019	Nov 2019
				Ensure all current transition pathways are detailed on the local Offer	Jan 2020	
				Strategic transitions protocol coproduced with CCG and providers	June 2020	
				All new transition protocols implemented	April 2021	
	5.2b	Develop the role of the Mental Health Transitions worker to support children and young adults with complex Mental	AR	SEND training required for Mental Health Transition worker identified and delivered	March 2020	

centred transition arrangements between children's and adults health services		Health and SEND to transition into adult services		Establish and implement measurement of key performance indicators as per milestones in section 4.3a	July 2020	

Appendix A

Membership of the Peterborough SEND Partnership Group	Membership of the Joint SEND Executive Board
Head of SEN and Inclusion Services	Independent Chair
Clinical Lead for Children with Complex Needs/Designated Clinical Officer	Executive Director – People & Communities, Cambridgeshire & Peterborough Local Authorities (CCC/PCC)
Chief Operating Officer, Family Voice	Chief Operating Officer, Cambridgeshire & Peterborough Clinical Commissioning Group
Head of 0 – 25 service	Clinical Lead for Children with Complex Needs, Cambridgeshire & Peterborough Clinical Commissioning Group
Specialist Commissioner	Service Director, Children's & Safeguarding, CCC/PCC
Children's Commissioner	Service Director, Education, CCC/PCC
Head of Early Years	Cabinet Member for Childrens Services, Education, Skills and University, Peterborough City Council
Head of Early Help	Chair of Childrens and Young People's Committee, Cambridgeshire County Council
Head of Targeted Youth Support	Assistant Director, SEND & Inclusion, CCC/PCC
Customer Feedback Manager	Assistant Director, School Standards and Effectiveness, CCC/PCC
	Assistant Director, Childrens Quality Assurance & Safeguarding
	Assistant Director, Adults Social Care Operations, PCC
Area SENCo	Heads of Service, SEN and Inclusion, CCC and PCC

	Heads of Service 0-25 Service / Children with Disabilities, CCC and PCC
Head of Corporate Parenting	Skills and Employment Representative
Business Intelligence Manager	Communications and Marketing Manager, CCC/PCC
Head of Therapies	Representatives from primary, secondary and special schools and further education establishments Cambridgeshire and Peterborough
SENCo rep	PinPoint (Cambridgeshire)
SEND consultant	Family Voice (Peterborough)
Team manager Integrated Neurodevelopmental Service CAMHS	Partnership Manager, CCC/PCC

Appendix B

Making SEND everybody's business

A strategy to provide inclusion for children and young people aged 0-25 with special educational needs and disabilities

Cambridgeshire and Peterborough 2019-2024

Contents

With special thanks to everyone who worked on this strategy. They are too numerous to name them all here but include local authority teams from Cambridgeshire and Peterborough, the Cambridgeshire and Peterborough Clinical Commissioning Group and other health organisations, the SEND parent carer forum for Peterborough – Family Voice and Pinpoint the parent carer forum for Cambridgeshire, the children, young people and families who took part in the engagement workshops and online survey, as well as to the elected members of Cambridgeshire and Peterborough Councils and the schools, youth groups and other organisations in Cambridgeshire and Peterborough who have been involved.

Foreword

We have listened to what children and young people with Special Educational Needs and Disabilities (SEND) and their families and carers have told us about their experiences and views. We have worked together with them to develop this strategy. It is part of our commitment to improve the life outcomes for children and young people from across the local area.

The strategy has a clear vision that:

Special Educational Needs and Disabilities (SEND) is Everybody's Business.

A wide range of people are playing an important part in delivering this vision. Elected members, schools and childcare settings, leaders and managers from education, health and social care services together with parents/carers, children and young people are driving our ambition forward.

The work is led by the Cambridgeshire and Peterborough SEND Executive Board. This is the local partnership that brings together organisations and parent carer forums responsible for services and support for children, young people and families in a shared commitment to achieving our vision.

The purpose of this strategy is to set out our vision, principles and priorities to ensure that we are working together effectively to identify and meet the needs of Cambridgeshire and Peterborough's children and young people with Special Educational Needs and/or Disabilities (SEND) from birth to the age of 25.

The strategy aims to meet the requirements of the Children and Families Act in a way that is ambitious, inclusive and realistic and makes best use of the resources available to us.

We have high aspirations for all our children and young people and want to ensure they have the right support, that is provided in the right place and at the right time so that they can thrive and be the best they can be.

Wendi Ogle-Welbourn

Introduction

This document sets out a vision and strategy for children and young people (0 - 25 years) with special educational needs and disabilities (SEND) in Cambridgeshire and Peterborough. The strategy is built upon a shared belief that considering and providing for the needs of children and young people with SEND should be 'everybody's business'. The collective desire is to ensure a holistic and inclusive approach evidenced by high quality, multi-agency services and provision focused upon enabling children and young people with SEND to thrive.

The strategy was co-produced with key partners and draws upon data from:

- Feedback from children, young people and their parent/carers
- National and local data on trends in special educational needs and disability
- Information from an externally commissioned sufficiency analysis
- Peterborough and Cambridgeshire local area self evaluations and SEND action plans
- Feedback from schools and settings
- Data from health, social care and other key agencies
- Early Years Peer review (2018)

This strategy is intended to cover the 'local area' which is defined as the geographical area of both Cambridgeshire and Peterborough and includes the local authority, clinical commissioning groups (CCGs), public health, NHS England for specialist services, early years settings, schools and further education providers.

The legal definitions outlined in the Equality Act 2010, Children and Families Act 2014 and SEND Code of Practice 2015 (see appendix 1) are used in the strategy to identify what we mean by children and young people with SEND.

This strategy covers the issues that are common to both Cambridgeshire and Peterborough local areas at a strategic level. The intention is to help us work better together, in the interests of children and young people, but it also recognises that some actions will be responsive to issues specific to Cambridgeshire or Peterborough.

The strategy recognises the need to acknowledge, and link with, other pending work across both local authorities e.g. Joint Early Years Strategy.

A shared vision

The shared vision and purpose was co-produced through a series of workshops held with representatives from Cambridgeshire and Peterborough in 2017-18. The shared vision was for children and young people to:

- Lead happy, healthy and fulfilled lives, having choice and control over decisions about their health, education, employment, friendships and relationships
- Achieve in line with, or better than, expectation in their early years, school, further education and training
- Successfully participate in the community and access meaningful occupation, employment and life-long learning opportunities

The diagram below was developed at a parent lead workshop with subsequent involvement from children and young people, and illustrates what families sought as the 'lived experience' of parents/carers, children and young people that would be the outcome of a successful SEND strategy:

In summary this means children and young people will be able to:

Dream big - Achieve well - Have choice - Control - Lead happy and fulfilled lives

Principles

In order to achieve this vision, families, support services and educational settings across Cambridgeshire and Peterborough have agreed the attitudes we expect each other to adopt when working with or caring for children and young people with special educational needs and/or disabilities (SEND). These are described in detail in the document "Cambridgeshire and Peterborough Expects – Our Pledge."

We believe that the culture promoted by adopting the agreed attitudes is crucial to ensuring that SEND is everybody's business. The commitments that we expect everyone to adopt and sign up to are summarised below

Our commitment is that everybody can be:

Aspirational - Confident - Healthy - Included - Respected - Safe - Successful

We will work together to

- Have high expectations
- Make everyone welcome
- Have a 'CAN-DO' approach
- Listen
- Celebrate success
- Work in ways that build trust
- Be transparent and honest
- Be positive and constructive
- Value individuality and celebrate diversity
- Build resilience and self confidence
- Offer opportunities to experience excellent support
- Have the skills to achieve
- Be a positive part of the local community
- Stay as healthy and well as we can be

What do we need to do?

In order to understand what we need to do and what our priorities for the strategy should be, we have drawn on a number of sources of information. These include:

- Review of the national and local context and data that outlines trends in the pupil population
- Analysis of the local data and the joint sufficiency exercise
- What families have said through surveys and their own evaluative reports
- What children and young people said through 'Big Youth Shout Out'

- Self evaluation processes and tracking progress through SEND Implementation action plans
- Regular analysis of statutory performance e.g. meeting timescales
- Response to statutory duties and requirements including compliance review of implementation of the Code of Practice
- What other practitioners including health, social care and schools and educational settings have said
- Ofsted and CQC SEND inspection of Cambridgeshire
- Peer review
- Social, Emotional and Mental Health (SEMH) review
- Transforming Care review
- Local offer reports/data

The key concerns that arose:

- The growth in overall numbers and trends for the future
- The need to ensure SEND is “everybody’s business” and not just the concern of the few
- Ensuring that the participation of children and young people in services development and commissioning should becomes routine, part of ‘the way that we work’
- The need for the development of a graduated response and access to services that prevent escalation including school to school support
- The growth in post 16 young people with an EHCP – there is a need for improved preparation for moving into adulthood and associated service development
- The lack of a cohesive, co-ordinated offer at transition points from services working together, particularly the issues that arise from the misalignment between health services (0-18) and Local Authority (LA) services for 0-25 year olds
- The patchiness and fragility of current integrated and collaborative working which needs to further develop including joint decision making, funding arrangements etc

- The need to further develop joint robust commissioning processes/commissioning cycle (e.g block and school contracts, mental health services)
- Gaps in provision across all services (health, education and social care) - joint commissioning ensures that children are being educated as close to home as possible – there is a need to rebalance spend and use all resources to deliver in the appropriate setting
- Need to better understand severity and extent of needs and develop a good local offer re: early help, children in need and those with more complex needs including the care offer from all social care services
- Use and allocation of financial resources needs to be more transparent

The three priority areas for action were identified as:

1 **SEND is everybody's business - embedding the vision of the SEND Strategy into the practice of everyone who works with children and families in ways that strengthen families**

2 **Identify and respond to needs early - a holistic and joined up early identification of and graduated response to needs**

3 **Deliver in the right place at the right time - improving outcomes for children and young people through making best use of resources, ensuring a graduated response and high quality local support and provision**

How are we going to deliver the strategy?

Making SEND everybody's business

This is a 5 year strategy. It will be reviewed and progress monitored, through the governance arrangements outlined in section 5. The strategy will be updated as appropriate in response to changes in local needs and issues.

Examples of the issues that we will aim to address under the three priority areas of the strategy include:

- Promoting a shared vision and expectation of responsibility across all service providers who come into contact with children and young people with SEND that "SEND is everybody's business" and not just the concern of the few
- Ensuring that every service is signed up to the principles of the SEND strategy - a multi service integrated approach that ensures child and family are engaged and families and carers feel they only need to tell their story once
- Sharing and aligning our practice to present have a stronger joined up services working with families and carers in response in key areas like such as early identification, assessment, personal budget arrangements; transitions and person centred and/ outcomes oriented approaches
- Ensuring our workforce have the skills and knowledge required and access to appropriate training

Identify and respond to needs early

- Promoting an inclusive, timely and graduated response to improve confidence, capacity and trust in local support
- Ensuring that everyone is able to identify and respond to needs early, from pre-birth to 25 years, from the earliest point of contact e.g including health visitors, midwifery, hospital staff, GP and early years
- Ensuring that we can improve outcomes for children and young people

Deliver in the right place

- Embedding a strategic approach to seeking the views of children, young people and their families in order to improve their personal experience of service delivery and also to inform the wider development and/or commissioning of services

- Promoting alignment, collaboration and creative solutions across all services in both Local Areas to make best use of available resources and so that children and young people can be supported locally

- Ensuring families feel confident that there is a good and appropriate local choice option for children and young people in all but the most exceptional cases

- Addressing the issues arising from the growth in demand and population, particularly the 16 years plus age group

- Ensuring a broad range of opportunities is available for young people over the age of 16 years

- Focus all local resources (health, education and social care) to enhance the total provision so that children and young people can be supported locally

- Reviewing and re-modelling our resources so that they are sufficient to meet current and future need

A strategic action plan will be developed from the issues identified. The actions will be driven by key lead champions who will coordinate work programmes and/or task and finish group working as required.

Work will to a large extent involve Cambridgeshire and Peterborough colleagues working together with other partners but there will be some discrete areas that require a more local response. These will be noted in the plan and cross refer to the individual SEND action plans for each council.

How will we recognise success?

We have agreed a number of success criteria to enable us to measure our progress.

The measures are intended to keep a balance between being aspirational but also realistic.

SEND is everybody's business

- Parents/carers report increased confidence at transition points between services and when there are changes in provision (e.g primary to secondary school)
- Annual monitoring of joint commissioning contracts shows that arrangements take a person centred approach
- Data from all agencies (e.g referrals data, SEN audit) shows timely identification of need
- The majority of children and young people with an education, health and care plan (EHCP) are educated in their local mainstream school - nationally published data shows that the balance of those with an EHCP in mainstream is in line with national, regional and statistical neighbours
- All professionals know the local offer and what the contribution of their service and other services should be
- There is a reduction year on year in the number of fixed term and permanent exclusions of children and young people with SEND
- Key data shows proportionate representation of children and young people with SEND (e.g. elective home education, attendance data, youth offending, emergency health admissions, social care services)
- Annual survey carried out by parent/carer forums shows evidence that year on year parents/carers have increasing confidence in the system and, where issues persist, there is clear evidence of follow-up action to address
- Service development/provision and commissioning of services clearly reflects user feedback

Identify and respond to needs early

- Feedback from parents/carers shows satisfaction with early identification of need, by all agencies
- Data shows less conflict in the system e.g. number of Tribunals registered, number of appeals
- Numbers of children and young people identified will be in line with population expectations
- Healthy child programme quarterly report shows all checks carried out note SEND issues
- Quality of all assessments will reflect a child centred approach and demonstrate joined up working
- Annual local authority and parent/carer survey data shows that there is a continuing increase in the number of parents/carers, children and young people who report a positive experience of, and confidence in, the SEND support system
- Practitioners report they are confident and have the tools, resources and access to CPD they need to be effective
- The progress and attainment of children and young people receiving SEND support is as good as or better than their peers in comparable authorities at all key stages
- The progress and attainment for children and young people with an EHCP is as good as, or better than, their peers in comparable authorities at all key stages

Deliver in the right place

- A termly audit of EHCPs and other plans related to SEND shows that they reflect a holistic package that enables families to flourish locally
- Children and young people have their needs met locally, reducing reliance on out of county places with a reduction in travel time and number of reported incidents during travel
- Data systems are in place that enable appropriate measurement of the timeliness and quality of input to EHCP processes and other plans from all statutory agencies

- Quarterly reports/audits show an increase in the number of creative, collaborative and flexible packages of support with a clear link between the identified needs/outcomes in plans and decision making processes

- There is a year on year increase in the take up of personal budgets particularly by young people post 16

- There is evidence that the increases in take-up of personal budgets is stimulating the market range

- Improved outcomes for vulnerable groups with SEND (looked after children, children in need, children in the youth justice system) are demonstrated as a result of an increase in collaborative commissioning

- There is good planning for adult life with young people and their families reporting increased choice and control with regard to living independently, having good health and opportunities to take part in a range of activities including employment

- All children and young people leave school with an option of further education, employment or training - there is a drop in numbers of those with EHCP who are not in education, employment or training (NEET)

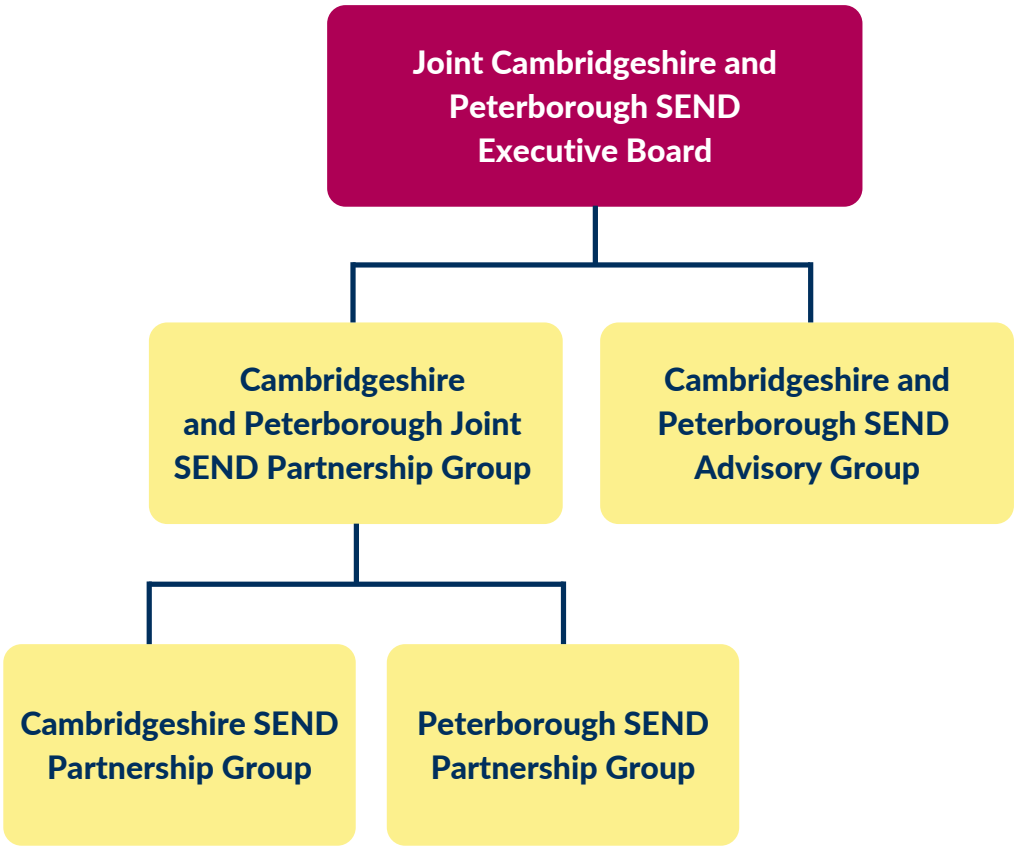
- The commissioning of SEND services and provision is based upon data and considers the needs of both local authorities

- The number of children and young children with a diagnosable mental health condition receiving treatment increases in line with NHS targets

Who will oversee the strategy?

The joint Cambridgeshire and Peterborough SEND Executive Board is responsible for the governance and commissioning of services to support children and young people with SEND and will be key to the delivery of this strategy. Membership of the Board include the parent forums, Cambridgeshire County Council, Peterborough City Council and the joint Clinical Commissioning Group (CCG).

A Cambridgeshire and Peterborough SEND Partnership Group provides the mechanism for tracking and monitoring the joint SEND strategic action plan. The Partnership Groups are accountable to the Executive Board enabling a clear link between strategic and operational action.



With special thanks to everyone who worked on this strategy. They are too numerous to name them all here but include local authority teams from Cambridgeshire and Peterborough, the Cambridgeshire and Peterborough Clinical Commissioning Group and other health organisations, the SEND parent carer forum for Peterborough – Family Voice and Pinpoint the parent carer forum for Cambridgeshire, the children, young people and families who took part in the engagement workshops and online survey, as well as to the elected members of Cambridgeshire and Peterborough Councils and the schools, youth groups and other organisations in Cambridgeshire and Peterborough who have been involved.

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HEALTH AND WELLBEING BOARD	AGENDA ITEM No. 8
25 FEBRUARY 2020	PUBLIC REPORT

Report of:	Director of Public Health	
Cabinet Member(s) responsible:	Councillor Wayne Fitzgerald, Cabinet Member for Adult Social Care, Health and Public Health	
Contact Officer(s):	Dr Liz Robin, Director of Public Health	Tel. 01733 207176

PETERBOROUGH ANNUAL PUBLIC HEALTH REPORT (2019)

RECOMMENDATIONS	
FROM: Director of Public Health	**Deadline date:**

It is recommended that the Health and Wellbeing Board:

1. Discusses and comments on the information outlined in the Annual Public Health Report 2018
2. Considers any recommendations the Committee may wish to make based on the content of the Report

1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Wellbeing Board following a request from the Director of Public Health

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to present the Peterborough Annual Public Health Report 2019 to the Health and Wellbeing Board for consideration of the Report's findings.

2.2 This report is for the Health and Wellbeing Board to consider under its Terms of Reference No. 2.8.3.5

To consider the recommendations of the Director of Public Health in their Annual Public Health report.

2.3 This report links to the Children in Care Pledge to children we take into our care 'to help encourage you to be healthy'

3. TIMESCALES

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

4. BACKGROUND AND KEY ISSUES

4.1 The Health and Social Care Act (2012) includes a requirement for Directors of Public Health to prepare an independent Annual Public Health Report (APHR) on the health of local people.

4.2 The previous APHR (2018) focussed on two specific themes:

- Achieving the 'Best start in life' for babies and young children in Peterborough, and reviewing some key factors which affect health and development up to the age of five.
- The international Global Burden of Disease study (GBD), which for the first time (funded by Public Health England) had provided an analysis of health and disease at English local authority level. The GBD emphasised the importance of smoking as an ongoing cause of premature deaths, and the importance of poor diet and high body mass index as a cause of both premature deaths and of disabling health conditions, with associated use of health and care services.

4.3 The APHR (2018) identified the following findings for review going forward:

Issues identified in the Section of the Report on 'Health in the Early Years', which are known to perpetuate inequalities in health and other outcomes across generations. These include:

- High rates of teenage pregnancy in Peterborough
- Higher than average rates of smoking in pregnancy
- Low rates of school readiness at age five

The findings of the Global Burden of Disease Study that for Peterborough residents:

- More than one in six years of life lost to premature death is the result of smoking (17.5%)
- More than one in seven years of life lost is the result of dietary factors ((13.5%)
- High blood pressure (11.5%) and drug/alcohol use (10%) each account for over one in ten years of life lost.

There has been improvement in the teenage pregnancy rate in Peterborough, with the most recent figures (2017) having fallen to a level similar to the national average. Rates of school readiness at age five have also improved although still below the national average.

4.4 This year's APHR 2019 (Annex A) focusses on the following issues

- The new Index of Deprivation IoD (2019), which reviews the social, economic and environmental circumstances of communities across England, and has just been updated for the first time in four years. The IoD (2019) scores a range of indicators for all geographical areas in England, to provide a deprivation ranking from the most to the least deprived. Because there is a very close relationship between social and economic deprivation and poor health, information in the IoD (2019) is key to understanding the health and wellbeing of Cambridgeshire residents.
- An update on recent trends in the lifestyles and health behaviours of local residents, which are likely to impact on future health and wellbeing, including those areas identified for review in 2018.
- A brief review of key health outcomes, with a focus on mental health and life expectancy.

4.5 The APHR 2019 identifies the following issues for ongoing review:

- The overall Index of Deprivation (2019) for Peterborough highlights a number of challenges in the wider social and environmental factors which affect health and wellbeing. Education/skills and crime are both highlighted as areas of particular concern. There has been an increase in homeless households placed in temporary accommodation and in rough sleepers in recent years, which is a national as well as a local issue.
- While there was an improvement in the school readiness of Peterborough's children in the 2017/18 school year, this remains significantly below the national average. The early development of children and their confidence and readiness to start school is key to their

future life chances and outcomes. This issue will have ongoing focus and review through our multi-agency 'Best Start in Life' programme.

- Other issues of concern for children and young people highlighted in this year's report include a fall in uptake of childhood immunisations seen in 2017/18. Young people's mental health is still of concern, with local hospital admission rates for self-harm among 10-24 year olds remaining higher than the national average, although there has been some improvement.
- The percentage of adults who smoke and who are overweight or obese are both higher than the national average in Peterborough, and if not addressed, this will lead to higher rates of cardiovascular disease (heart disease and stroke), diabetes and some cancers in our population. Rates of preventable deaths from cardiovascular disease in Peterborough are significantly above the national average, with a high level of local inequality between our most and least deprived communities.
- Overall, the wide diversity and range of social and economic factors within the Peterborough City Council area highlight the need for public services to focus on place-based approaches, working with local communities. This will be taken forward through Peterborough's 'Think Communities' approach, which has sign up from a range of local organisations.

5. CONSULTATION

5.1 The Annual Public Health Report is an independent report, with a focus on providing information about the main health issues and trends in Peterborough. Therefore it is not subject to consultation.

6. ANTICIPATED OUTCOMES OR IMPACT

6.1 The anticipated outcome of this Report is that the information on health related issues and trends provided in the Report, together with the recommendations at the end of the Report, will influence relevant decisions made by the Health and Wellbeing Board and its member organisations, and will be useful for community groups and voluntary organisations with an interest in health and wellbeing.

7. REASON FOR THE RECOMMENDATION

7.1 The Annual Public Health Report gives context for the wider work of the Health and Wellbeing Board, by providing information on the health issues in Peterborough which local NHS and Council services are working to address.

8. ALTERNATIVE OPTIONS CONSIDERED

8.1 The alternative option would be for the Health and Wellbeing Board not to review the findings of the Annual Public Health Report 2019. This would be a missed opportunity to ensure that updated information about the determinants of health, and trends in key health related behaviours and outcomes in Peterborough could be considered by the Board.

9. IMPLICATIONS

Financial Implications

9.1 The Annual Public Health Report is a statutory report on the Health of the Population and does not have specific financial implications.

Legal Implications

9.2 Under the Health and Social Care Act (2012) the Director of Public Health has a statutory duty to produce an annual report on the health of the population and the City Council has a duty to

publish it

Equalities Implications

9.3 Many of the issues described in the report have an impact on health inequalities in Peterborough

10. BACKGROUND DOCUMENTS

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

10.1 Peterborough Annual Public Health Report (2018)
http://cambridgeshireinsight.org.uk/health/aphr

11. APPENDICES

11.1 Peterborough Annual Public Health Report 2019

PETERBOROUGH

ANNUAL PUBLIC HEALTH REPORT 2019

CREATING A HEALTHY CITY

PETERBOROUGH CITY COUNCIL

TABLE OF CONTENTS

INTRODUCTION

When Annual Public Health Reports were first produced in the nineteenth century by local authority Medical Officers of Health, they were the main source of available information about health statistics in the local area. This is no longer the case - as detailed and frequently updated health statistics are available on the internet, both for Peterborough and nationally.

Over the past year, Peterborough City Council and Cambridgeshire County Council have worked together on the website Cambridgeshire Insight https://cambridgeshireinsight.org.uk/, which now holds a wealth of up to date information about the health and wellbeing of Peterborough residents. Annex A of this report provides more details about the information available.

This Annual Director of Public Health Report (2019) focusses on a small number of topics where new information has become available in the past year. The first is the new Index of Deprivation IoD (2019), which reviews the social, economic and environmental circumstances of communities across England, and has just been updated for the first time in four years. The IoD (2019) scores a range of indicators for all geographical areas in England, to provide a deprivation ranking from the most to the least deprived. Because there is a very close relationship between social and economic deprivation and poor health, information in the IoD (2019) is key to understanding the health and wellbeing of Peterborough residents.

The second focus of the report will be to provide an update on recent trends in the lifestyles and health behaviours of local residents, which are likely to impact on future health and wellbeing. This will include reviewing issues of concern raised in the 2018 Annual Public Health Report.

Finally, the Report will review trends for some key health outcomes, and will make a small number of recommendations for issues to focus on in the coming year.

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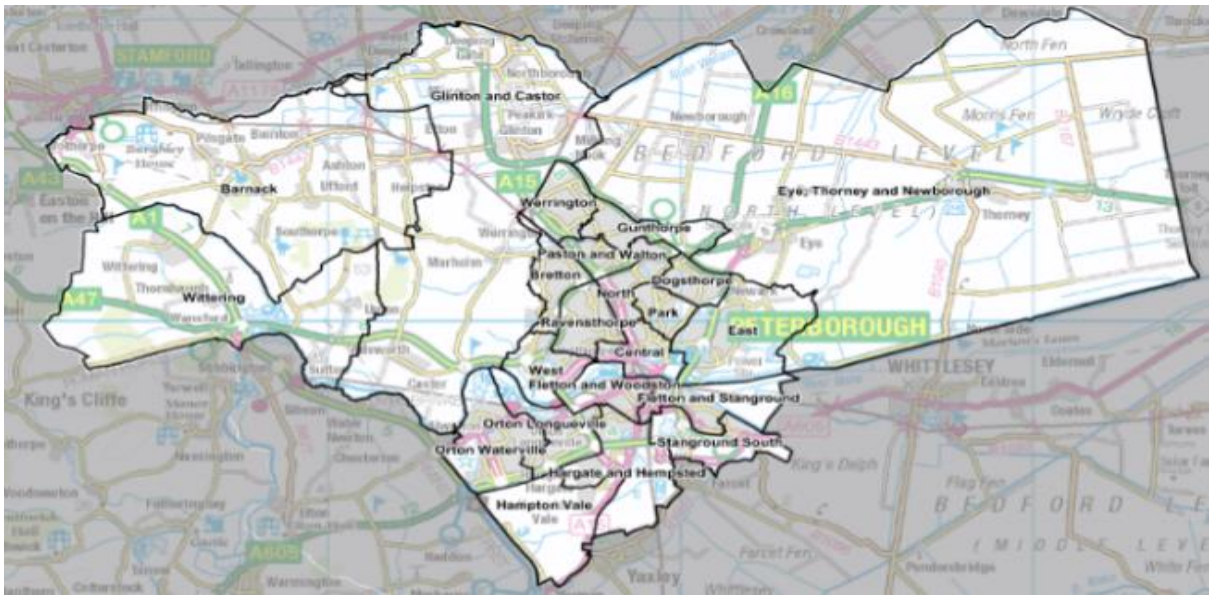
Dr Liz Robin
Director of Public Health
Peterborough City Council

SECTION 1: PETERBOROUGH'S POPULATION

Peterborough City Council covers the area outlined on the map below. Most Peterborough residents live in the central urban areas coloured grey/green on the map – but many residents also live in the countryside in rural areas to both the East and West of the City. In 2018 it was estimated that about 200,000 people lived in Peterborough overall.

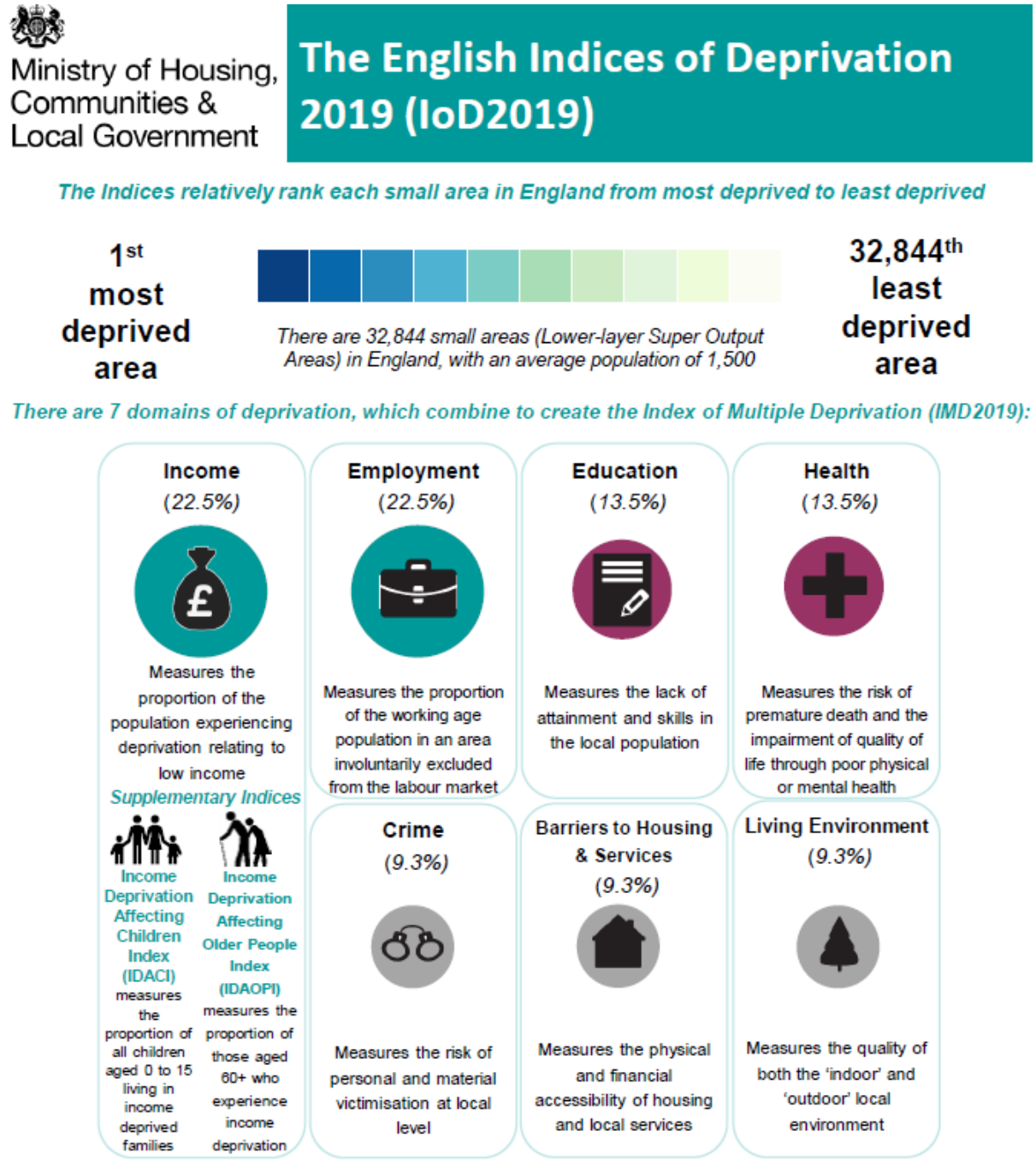
Peterborough's resident population is younger than the national average and has grown consistently over recent years. The population is ethnically diverse, including significant Pakistani heritage and Eastern European communities. In 2018, nearly half (47%) of the 2851 births in Peterborough were to women born outside the UK. In primary schools in Peterborough, it is estimated that around 41% of pupils (two in five) speak a first language other than English, compared to the national average of 21% (one in five). For secondary school pupils, this figure is 30% compared to 17% for England.

There is wide variation in social and economic circumstances between different areas within Peterborough – and in general the rural areas to the west of the city are the most affluent, while some urban areas have high levels of deprivation. This will be explored further in the next section on the Index of Multiple Deprivation (2019) and you may find it useful to compare the maps in that section with this map of Peterborough and its electoral wards.



SECTION 2: HEALTH DETERMINANTS AND THE INDEX OF DEPRIVATION 2019

People's health outcomes are closely linked with their social and economic circumstances. The latest Index of Deprivation IoD (2019) provides nationally benchmarked information on key social and economic factors as outlined in the infographic below. The overall IoD score for an area is correlated with health outcomes such as life expectancy, which is lower in more deprived areas. Residents of more deprived areas are also more likely to have long term illness or become depressed.

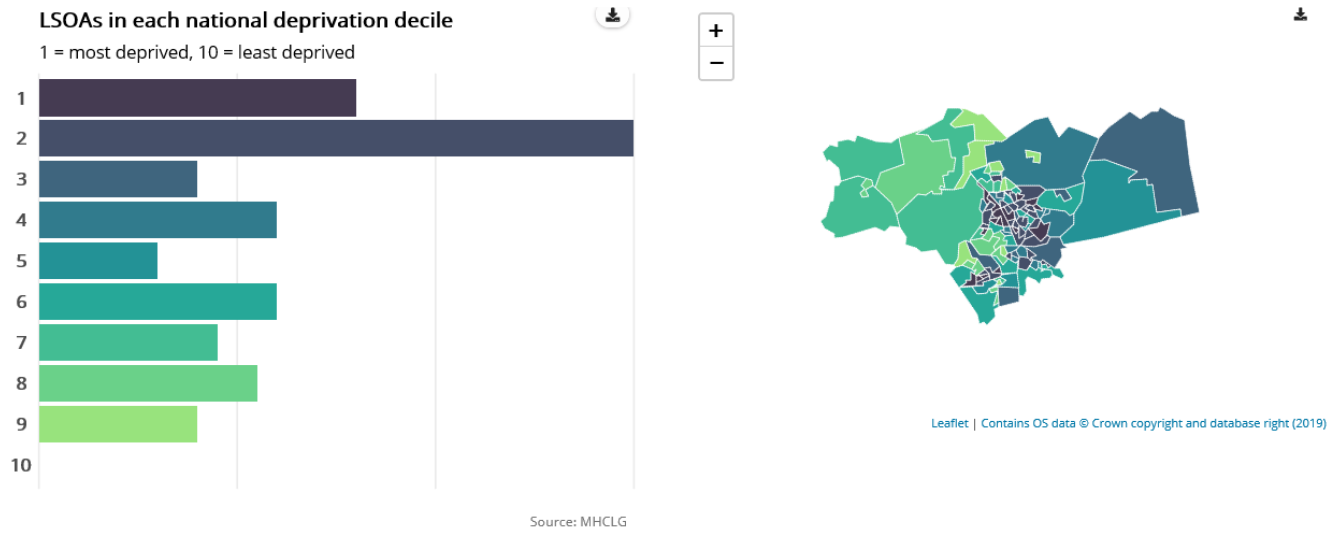


2.1 Peterborough overall IoD (2019) rank

While the IoD (2019) is calculated for small areas with about 1,500 residents (LSOAs), these scores can be grouped to give an overall deprivation ranking for each local authority. This can be done in different ways, which give slightly different results. If the rank of the average IoD (2019) score across Peterborough is used, Peterborough ranks as the 51st most deprived out of 317 district and unitary councils nationally. Peterborough is therefore in the most deprived 20% (quintile) of local authorities in England. This is a slight change from 2015, when Peterborough ranked as the 58th most deprived out of 327 local authorities.

The map below shows that at the level of small areas with around 1,500 residents (LSOAs), there is a lot of variation in deprivation levels across Peterborough communities. Some communities with the highest levels of deprivation are towards the centre of the City, but others are in more outlying urban areas such as the Ortons. Overall 14.3% of the small areas (LSOAs) in Peterborough are in the most deprived 10% of areas in England on their IoD (2019) score.

Peterborough: Overall IoD (2019)



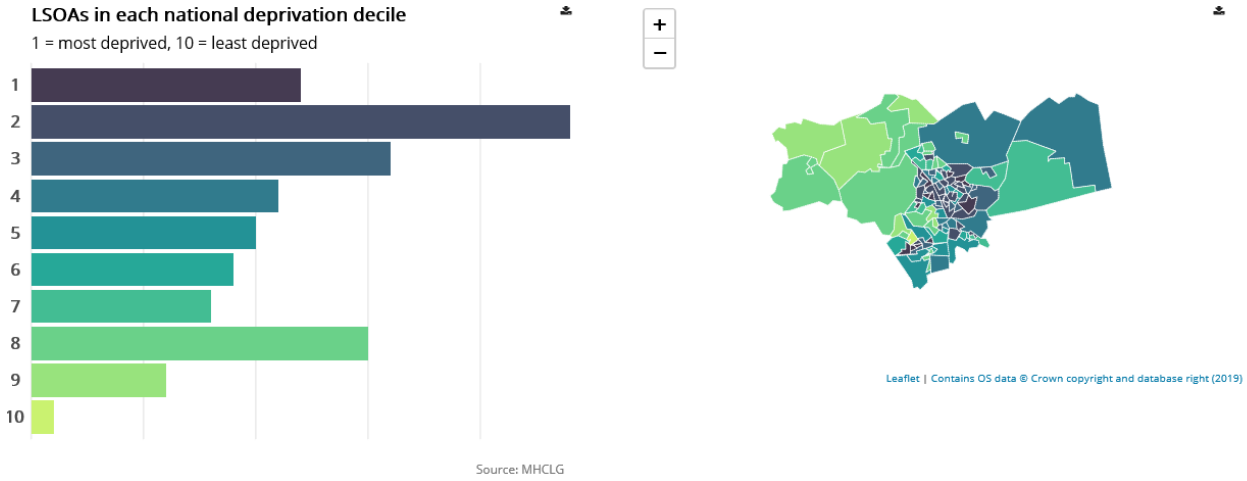
It's possible to look at each individual 'domain' of the IoD (2019) - such as employment, living environment or health, for Peterborough, and to map this for small areas. An overview of what each IMD (2019) domain covers is outlined in the infographic on page 3, and a more detailed technical description of the factors considered in each IMD domain is provided in Annex B. An interactive version of the maps in this section can be found on (https://cambridgeshireinsight.org.uk/deprivation/map/)

This report will now review the individual IoD (2019) domains for Peterborough, all of which are relevant for residents' health and wellbeing.

2.2 Income and Employment

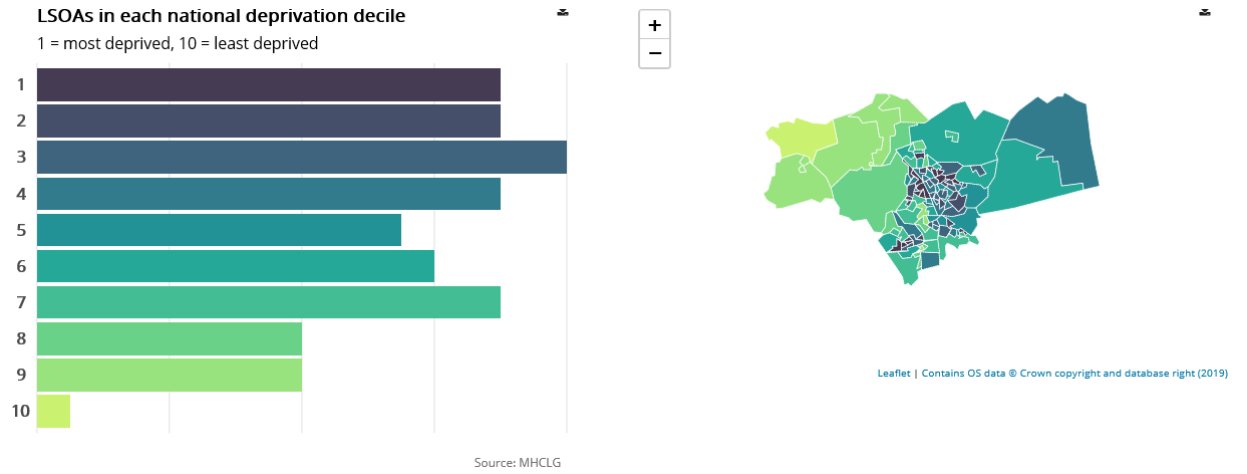
Income and employment are the two most significant domains in the IoD (2019) making up 45% of the total scoring. The 'Income' domain measures the proportion of the population experiencing deprivation relating to low income, and the employment domain measures the proportion of people excluded from the labour market. For the 'Income' domain, Peterborough ranks as the 64th most deprived local authority out of 317 in England, and for the 'Employment' domain Peterborough ranks as the 83rd most deprived local authority. This means that for both income and employment deprivation, Peterborough is not in the most deprived 20% of local authorities nationally, although still in the most deprived 30%. This reflects some improvement in Peterborough's ranking for these domains compared to other local authorities since 2015.

IoD (2019) Income domain



For the IoD (2019) Income domain, 11% of Peterborough's small areas (LSOAs) are in the most deprived 10% in England.

IMD (2019) Employment domain

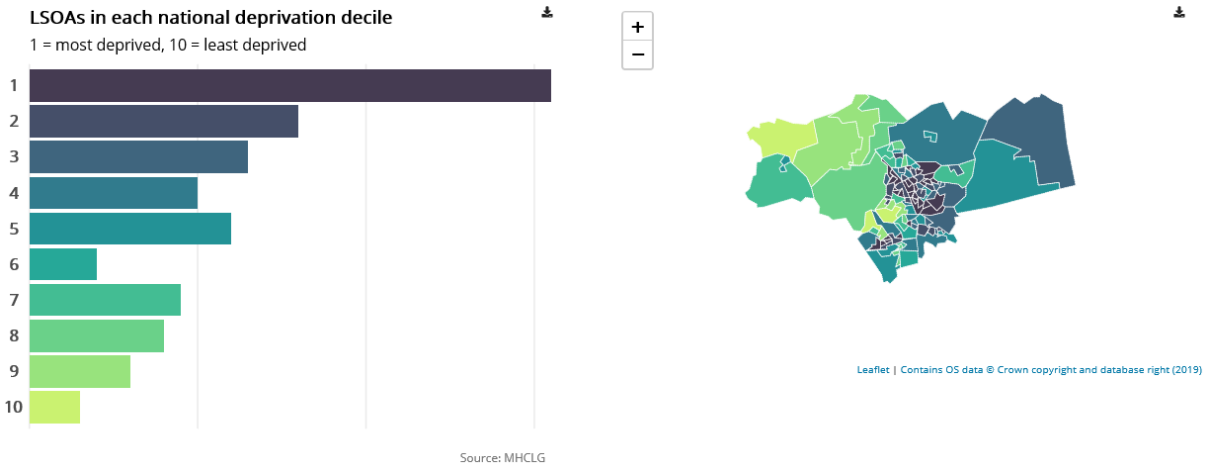


For the IoD (2019) Employment domain, 12.5% of Peterborough's small areas (LSOAs) are in the most deprived 10% in England.

For an individual, employment is one of the most important determinants of physical and mental health; the long-term unemployed have a lower life expectancy and worse health than those in work. An adequate income helps individuals and families to live a healthy lifestyle – including being able to afford a varied diet with good levels of fruit and vegetables, and keeping their homes warm in winter.

2.3 Education training and skills domain

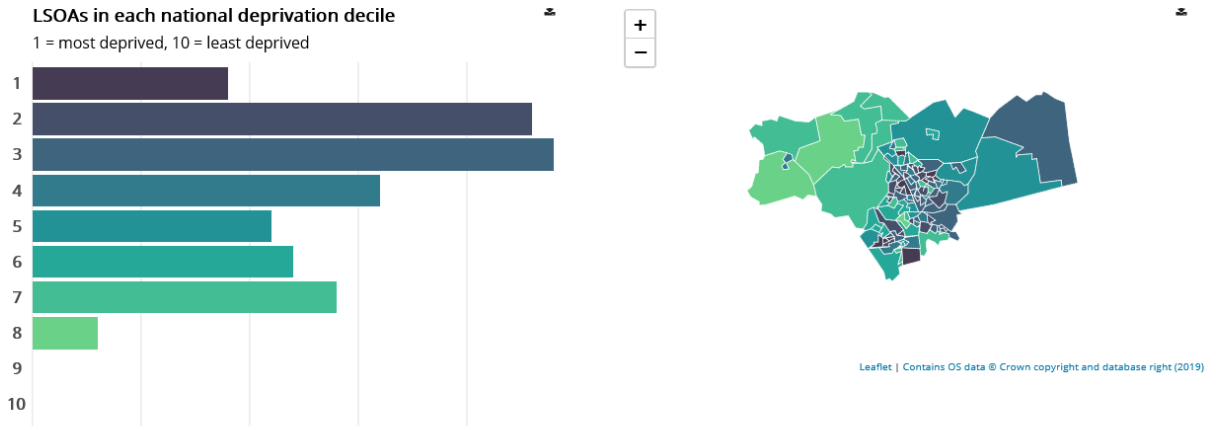
The Education, Training and Skills domain makes up 13.5% of the total IMD (2019) score. It measures the lack of educational attainment and skills in a population. Peterborough ranks 25th out of 317 local authorities in England, meaning that it is in the most deprived 10% of authorities nationally for this domain. The ranking has worsened slightly compared to other authorities since IMD (2015)



For the IMD (2019) Education, Skills and Training domain, 28% of Peterborough's small areas (LSOAs) are in the most deprived 10% in England. Low educational attainment is linked with poorer health in later life. It means a significant number of local residents will find it more difficult to access, understand and act on information which would help them to stay healthy, and to manage their illnesses.

2.4 Health and Disability

The IoD (2019) Health and Disability domain makes up 13.5% of the total IMD (2019) score. It measures the risk of premature death and the impairment of quality of life through poor physical or mental health. Peterborough ranks 70th out of 317 local authorities in England for this domain, meaning that it is not in the 20% most deprived local authorities nationally, although still in the most deprived 30%. There has been a small improvement in rank since IMD (2015).

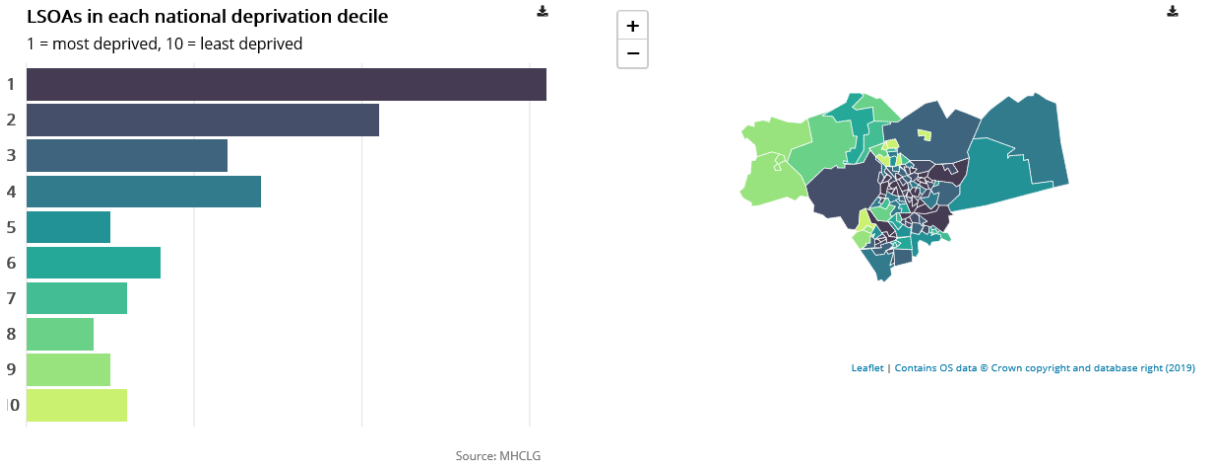


Source: MHCLG

For Health and Disability, 8% of small areas (LSOAs) in Peterborough are in the 10% most deprived nationally, but none are in the 20% least deprived.

2.5 Crime

The IoD (2019) Crime domain makes up 9.3% of the total IMD (2019) score. It measures the risk of personal and material victimisation at the local level. Peterborough ranks 30th out of 317 local authorities in England for the Crime domain, meaning that it is in the 10% of most deprived local authorities nationally. Peterborough's Crime deprivation rank compared to other local authorities has worsened since IMD (2015).

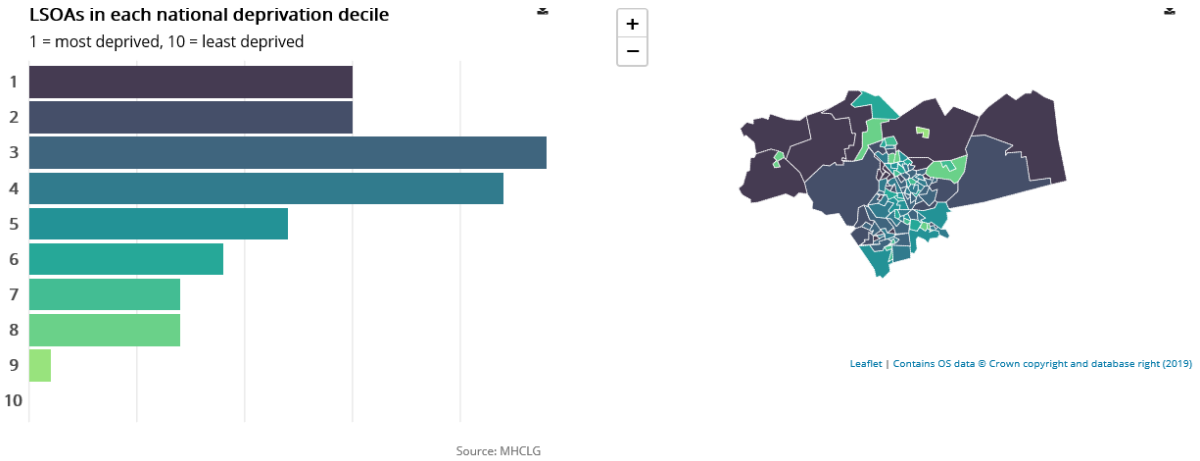


Source: MHCLG

For Crime deprivation, 28% of Peterborough's small areas (LSOAs) are in the most deprived 10% nationally.

2.6 Barriers to housing and services

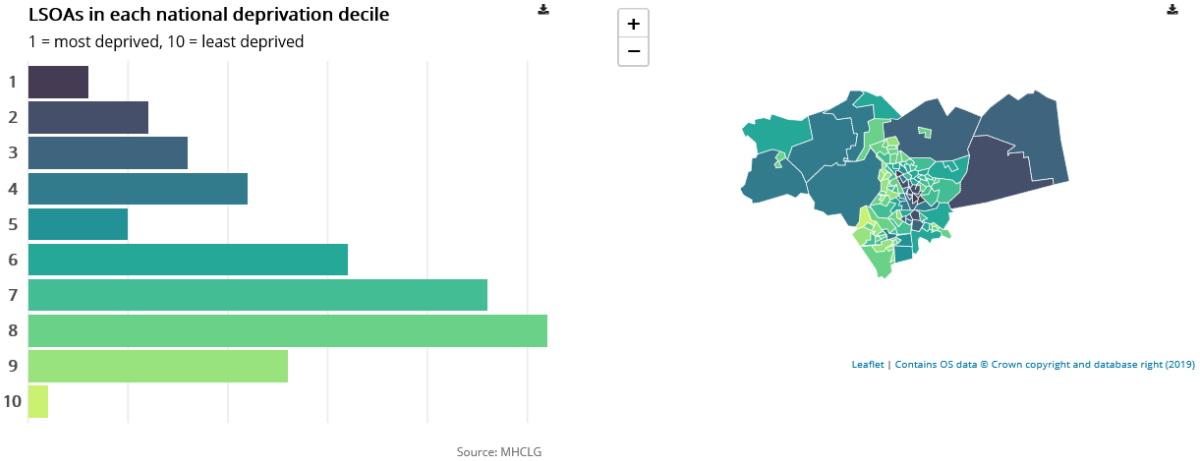
The IoD (2019) Barriers to Housing and Services domain makes up 9.3% of the total IoD (2019) score. It measures the physical and financial accessibility of housing and local services. Peterborough ranks 54th of 317 local authorities in England for this domain, meaning it is in the 20% most deprived local authorities nationally. Peterborough's ranking for the Barriers to Housing and Services domain has worsened since IMD (2015).



For Barriers to Housing and Services, 13% of Peterborough's small areas (LSOAs) are in the most deprived 10% nationally. The pattern of deprivation is different to the other domains, as rural residents are more likely to live some distance from local services, which is part of the scoring. Housing affordability is also included in the score, as well as overcrowding and homelessness.

2.7 Living Environment

The IoD (2019) Living Environment domain makes up 9.3% of the total IMD (2019) score. It measures the quality of both the 'indoor' and 'outdoor' local environment, both of which are important for healthy living. Peterborough ranks 181st out of 317 local authorities, which is slightly better than the England average. Peterborough's Living Environment ranking has improved a small amount since IMD (2015).



For Living Environment only 3% of small areas (LSOAs) in Peterborough are in the worst 10% nationally, which reflects the overall positive ranking.

2.8 Homelessness and rough sleeping

A key determinant of health and wellbeing is having stable and good quality housing. In recent years there has been an increase in the number of vulnerable families or individuals in Peterborough who have become homeless and are placed in temporary accommodation by the Council. In 2017/18 this increase meant that Peterborough moved significantly above the national average, with 360 households placed in temporary accommodation at the end of March 2018. The more recent figure for March 2019 is similar at 349 households.

1.15ii - Statutory homelessness - households in temporary accommodation Peterborough — Crude rate - per 1000

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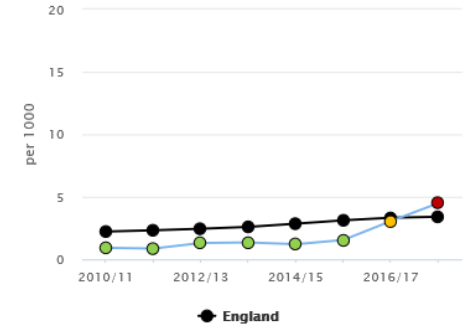


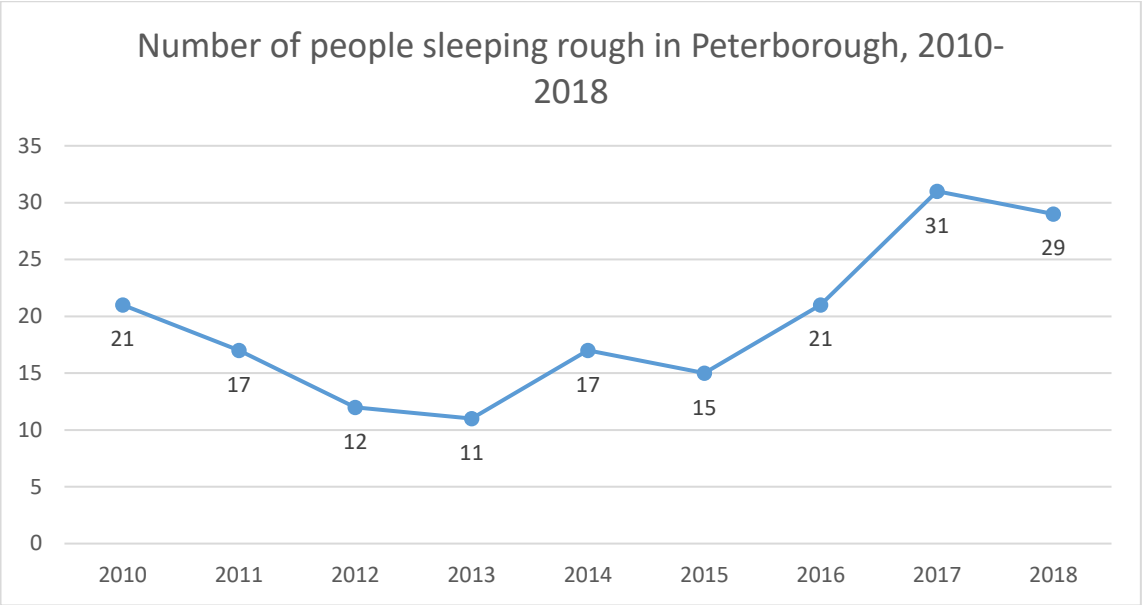
Recent trend:

Period		Peterborough				East of England region	England
		Count	Value	Lower CI	Upper CI		
2010/11		66	0.9	0.7	1.2	1.1	2.2
2011/12		62	0.9	0.7	1.1	1.3	2.3
2012/13		99	1.3	1.1	1.6	1.4	2.4
2013/14		103	1.3	1.1	1.6	1.5	2.6
2014/15		93	1.2	1.0	1.5	1.6	2.8
2015/16		121	1.5	1.3	1.8	1.9*	3.1
2016/17		242	3.1	2.7	3.5	2.2*	3.3
2017/18		360	4.5	4.0	5.0	2.3	3.4

Source: Ministry of Housing, Communities & Local Government

Some of the most vulnerable homeless individuals are those who sleep rough – and most have health needs related to mental health, drug and/or alcohol misuse. People who sleep rough are often more vulnerable to infectious diseases such as chest infections, tuberculosis and blood born viruses. For diseases such as tuberculosis, there are particular challenges in managing ongoing treatment, which needs to continue for months or in some cases up to two years.

In Peterborough the estimated number of people sleeping rough based on an autumn count, has risen in recent years, which has also been the case nationally.



SECTION 3: TRENDS IN LIFESTYLES AND HEALTH BEHAVIOURS

3.1 The Best Start in Life

The Annual Public Health Report (2018) looked in detail at the health of Peterborough's children from pre-birth to age 5.
https://www.peterborough.gov.uk/healthcare/public-health/annual-public-health-report/

Issues of concern recommended for ongoing follow up and monitoring were:

- High rates of teenage pregnancy in Peterborough
- Higher than average rates of smoking in pregnancy
- Low rates of school readiness at age five

3.1.1 Teenage pregnancy

There has been some recent improvement in the rates of teenage pregnancy in Peterborough, with only 74 pregnancies among under 18 year olds in 2017 (the latest data available). This is the lowest number since 1998, and is similar to the national average. Data for more years is needed before we can be certain this is a sustainable improvement.

C02a - Under 18s conception rate / 1,000 Peterborough — Crude rate - per 1000

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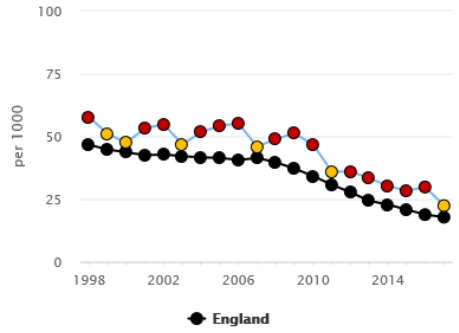

Recent trend:

Period		Peterborough Count	Value	Lower CI	Upper CI	East of England region	England
1998		185	57.7	49.7	66.6	37.9	46.6
1999		158	51.0	43.4	59.6	36.4	44.8
2000		147	47.4	40.1	55.7	35.1	43.6
2001		167	53.3	45.5	62.0	34.2	42.5
2002		179	54.8	47.1	63.5	34.6	42.8
2003		155	46.8	39.7	54.7	33.1	42.1
2004		175	51.7	44.3	59.9	32.4	41.6
2005		184	54.2	46.7	62.7	32.4	41.4
2006		190	55.1	47.6	63.6	33.1	40.6
2007		155	45.9	39.0	53.8	33.0	41.4
2008		168	48.9	41.8	56.9	31.1	39.7
2009		171	51.3	43.9	59.5	30.7	37.1
2010		161	46.6	39.7	54.3	29.1	34.2
2011		127	36.0	30.0	42.8	26.6	30.7
2012		128	35.9	29.9	42.6	23.2	27.7
2013		118	33.4	27.6	40.0	21.0	24.3
2014		102	30.2	24.6	36.7	20.2	22.8
2015		95	28.3	22.9	34.6	18.8	20.8
2016		99	29.8	24.2	36.3	17.1	18.8
2017		74	22.4	17.6	28.1	16.0	17.8

Source: Office for National Statistics (ONS)

3.1.2 Smoking in pregnancy

The percentage of women in Peterborough still smoking at the time their babies were delivered has also shown some recent improvement. In April – June 2019, 11.1% of women from Peterborough and Cambridgeshire whose babies were delivered at Peterborough City Hospital smoked, compared with 12.6% of women in April-June the year before. The national average is 10.6%. Again, this needs ongoing monitoring before we can be certain that improvement will be sustained.

3.1.3 School readiness at age 5

Peterborough's high level of education, training and skills deprivation demonstrated in the IoD (2019) emphasises the importance of helping local children to be confident and ready to learn when they start school. Although children's 'school readiness' at the end of reception is still significantly below the national average in Peterborough, there was some improvement in the 2017/18 school year. The percentage of children achieving a 'good level of development' at the end of Reception rose from around 63% in 2016/17 to almost 67% in 2017/18. The national average is 71.5%. The Peterborough and Cambridgeshire 'Best Start in Life' Strategy and developing service model aim to provide families with the information, encouragement and help that they need to further improve the school readiness of their children.

B02a - School readiness: percentage of children achieving a good level of development at the end of Reception

Peterborough — Proportion - %

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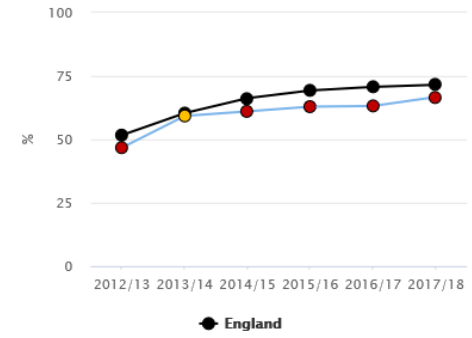


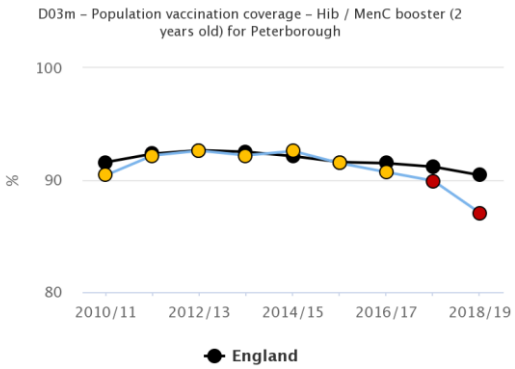
Recent trend: ↑

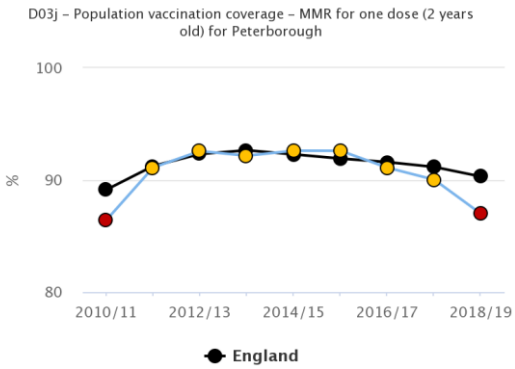
Period	Peterborough					Third more deprived decile (IMD2015,4/19 geo)	England
		Count	Value	Lower CI	Upper CI		
2012/13		1,348	46.7%	44.9%	48.6%	-	51.7%
2013/14		1,730	59.2%	57.5%	61.0%	-	60.4%
2014/15		1,878	61.1%	59.3%	62.8%	-	66.3%
2015/16		1,937	62.9%	61.2%	64.6%	-	69.3%
2016/17		1,999	63.2%	61.5%	64.8%	-	70.7%
2017/18		2,094	66.7%	65.0%	68.3%	-	71.5%

Source: Department for Education (DfE), EYFS Profile: EYFS Profile statistical series

3.1.4 Childhood immunisations

Childhood immunisations are an important way to protect children and adults against potentially life threatening infectious disease. The childhood immunisation programme in England is delivered by GP practices. Recently, there has been a worrying fall in the numbers of children in Peterborough who are up to date with their immunisations. The national benchmark is for at least 90% (preferably 95%) of children to be vaccinated, and this helps to protect all children by reducing the risk a disease will spread. Peterborough is no longer achieving 90% for some childhood immunisations – including the Hib/MenC booster against some types of meningitis and the MMR vaccine against measles mumps and rubella.





3.2 Risk factors and health behaviours

The Annual Public Health Report 2018
https://www.peterborough.gov.uk/healthcare/public-health/annual-public-health-report/
identified that for Peterborough residents:

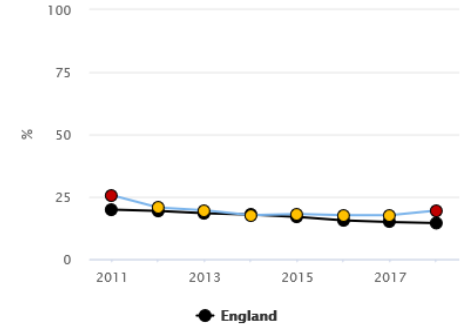
- More than one in six years of life lost to premature death is the result of smoking (17.5%)
- More than one in seven years of life lost is the result of dietary factors (13.5%)
- High blood pressure (11.5%) and drug/alcohol use (10%) each account for over one in ten years of life lost.

3.2.1 Smoking

Trends in the percentage of adults who smoke in Peterborough are measured through a national survey, which interviews a sample of local residents. Because different residents are interviewed each year, short term year on year changes should be regarded with caution, although longer term trends are more likely to be valid. The trend chart raises concern that smoking rates among adults in Peterborough are not falling at the same rate that they are falling nationally, and in 2018 the percentage of adults who smoked was significantly above the national average.

C18 - Smoking Prevalence in adults (18+) - current smokers (APS) Peterborough — Proportion - %

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

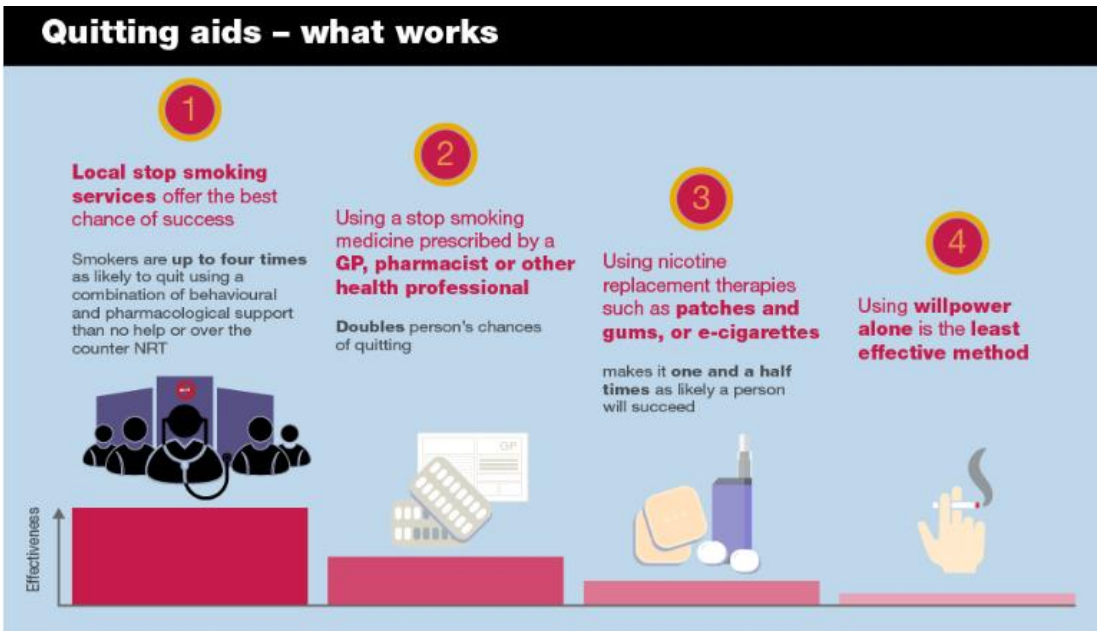


Recent trend: –

Period		Peterborough Count	Value	Lower CI	Upper CI	Third more deprived decile (IMD2015,4/19 geo)	England
2011		35,768	25.6%	22.6%	28.6%	-	19.8%
2012		29,281	20.7%	17.6%	23.8%	-	19.3%
2013		27,908	19.6%	16.8%	22.4%	-	18.4%
2014		25,368	17.6%	14.8%	20.5%	-	17.8%
2015		26,413	18.1%	15.4%	20.8%	-	16.9%
2016		26,043	17.6%	14.7%	20.6%	-	15.5%
2017		26,226	17.6%	14.7%	20.6%	-	14.9%
2018		29,207	19.5%	16.2%	22.8%	-	14.4%

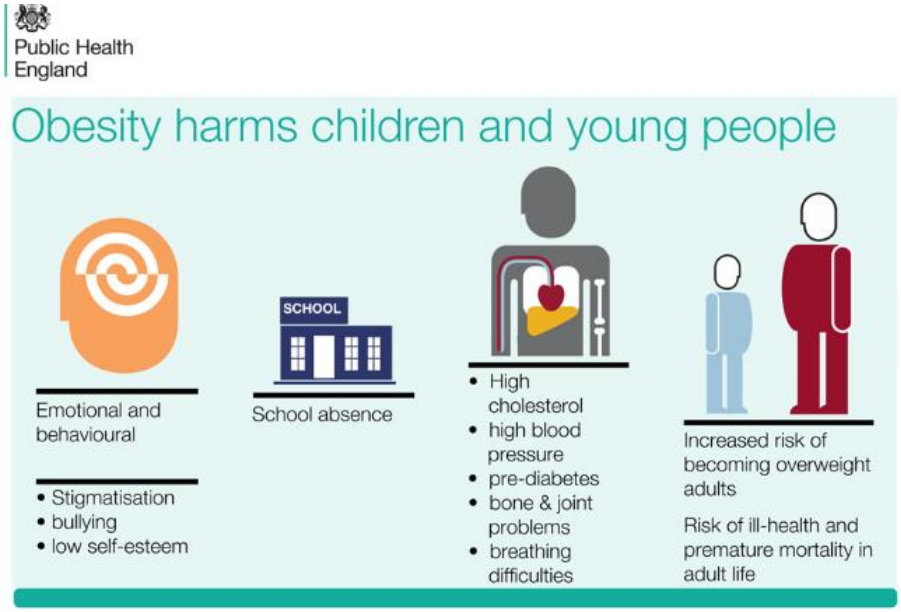
Source: Annual Population Survey (APS)

GP practice records hold information on whether their patients smoke, and local GP data shows that smoking rates vary widely across different communities in Peterborough. The percentage of adult patients recorded as smoking by their GP practice ranges from 14% to 39%. The percentage of adults who smoke is closely associated with the level of social and economic deprivation of the community served by the GP practice.



3.2.2 Dietary factors

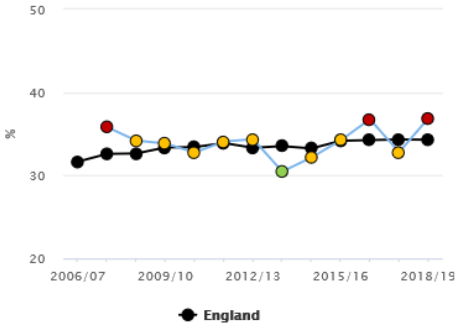
The most reliable information collected on overweight and obesity in Peterborough is the national childhood measurement programme – which weighs and measures children in reception year and year 6 of primary school. Childhood overweight is linked to physical activity levels as well as diet, but diet plays a key role.



Recently, the levels of overweight and obesity among children in Peterborough have stayed fairly steady at reception age (similar to the national average) but shown an increasing trend for children in year 6 and have been significantly above the national average for two of the past three years.

C09b - Year 6: Prevalence of overweight (including obesity) New data Peterborough Proportion - %

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



Recent trend:

Period		Peterborough Count	Value	Lower CI	Upper CI	East of England region	England
2006/07		-	*	-	-	*	31.7%
2007/08		511	35.8%	33.4%	38.3%	30.9%	32.6%
2008/09		651	34.2%	32.1%	36.4%	30.7%	32.6%
2009/10		669	33.8%	31.8%	36.0%	31.4%	33.4%
2010/11		647	32.8%	30.7%	34.9%	31.7%	33.4%
2011/12		690	34.1%	32.0%	36.2%	31.7%	33.9%
2012/13		712	34.4%	32.3%	36.4%	31.0%	33.3%
2013/14		675	30.5%	28.6%	32.4%	31.1%	33.5%
2014/15		620	32.2%	30.1%	34.3%	30.7%	33.2%
2015/16		794	34.2%	32.3%	36.2%	31.7%	34.2%
2016/17		852	36.8%	34.8%	38.7%	31.5%	34.2%
2017/18		860	32.8%	31.0%	34.6%	31.7%	34.3%
2018/19		1,021	36.9%	35.1%	38.7%	31.4%	34.3%

Source: NHS Digital, National Child Measurement Programme

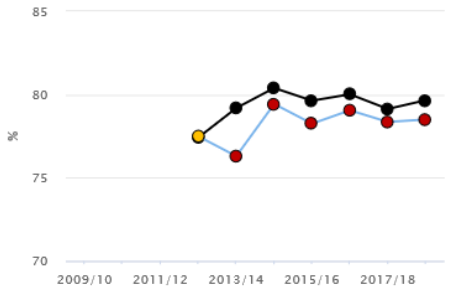
A sample of adults in Peterborough is asked about their eating habits, weight and physical activity in a national survey every year. The most recent figures for 2018 show that Peterborough's adult residents are less likely to eat five fruit and vegetables a day and more likely to be overweight or obese than the national average. The percentage of adults with diabetes in Peterborough, which is closely related to obesity, is also high at 7% compared with 6.8% nationally.

3.2.3 High blood pressure (Hypertension)

High blood pressure (hypertension) is an important risk factor for cardiovascular disease, stroke and kidney disease. Some cases are not diagnosed, and when diagnosed not all cases are treated effectively. For GP practices in Cambridgeshire & Peterborough Clinical Commissioning Group, the proportion of patients with high blood pressure treated successfully, to achieve a blood pressure of 150/80 or less is slightly worse than the national average and has been stable over the past four years.

HYP006: Blood pressure <= 150/90 mmHg in people with hypertension NHS Cambridgeshire and Peterborough CCG Proportion - %

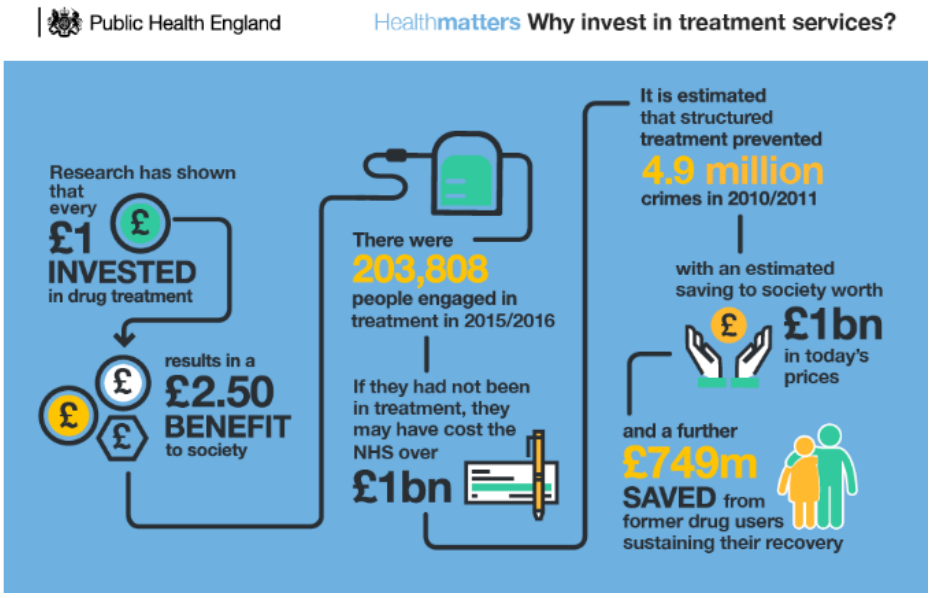
Export chart as image | Show confidence intervals | Export table as CSV file



Period		NHS Cambridgeshire and Peterborough CCG Count	Value	Lower CI	Upper CI	East of England (East) NHS region	England
2012/13		87,550	77.5%	77.2%	77.7%	77.3%*	77.4%
2013/14		87,140	76.3%	76.0%	76.5%	78.3%*	79.2%
2014/15		92,035	79.4%	79.2%	79.7%	80.1%*	80.4%
2015/16		92,165	78.2%	78.0%	78.5%	79.3%*	79.6%
2016/17		94,766	79.1%	78.8%	79.3%	79.4%*	80.0%
2017/18		95,863	78.4%	78.1%	78.6%	78.4%*	79.1%
2018/19		98,004	78.5%	78.3%	78.7%	79.3%	79.7%

Source: Quality and Outcomes Framework (QOF), NHS Digital

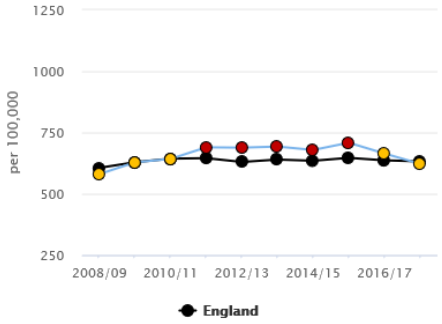
3.2.4 Alcohol and drug misuse.



While the supply of illicit drugs remains an issue of concern, linked to the relatively high level of 'Crime' deprivation in Peterborough, there have been some positive trends relating to treatment of drug and alcohol problems in Peterborough. The hospital admission rates of Peterborough residents related to alcohol have decreased recently and have been similar to the national average for two years. Rates of death caused by drug misuse have remained similar to the national average.

C21 - Admission episodes for alcohol-related conditions (Narrow) Peterborough — Directly standardised rate - per 100,000

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



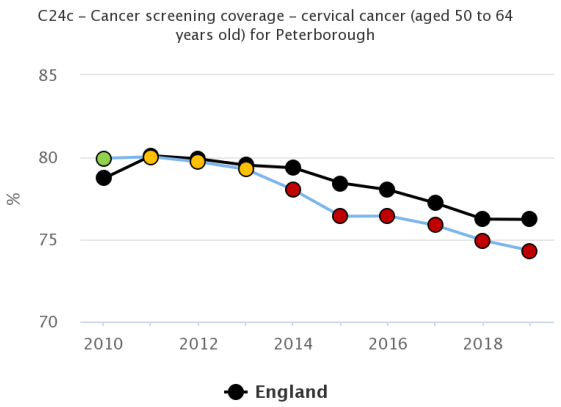
Recent trend: –

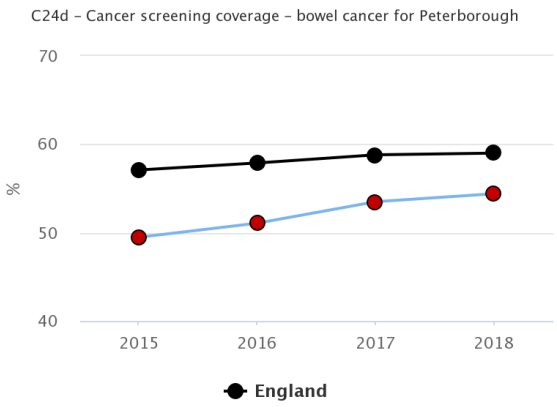
Period		Peterborough Count	Value	Lower CI	Upper CI	Third more deprived decile (IMD2015,4/19 geo)	England
2008/09	●	934	580	543	620	-	606
2009/10	●	1,042	628	590	669	-	629
2010/11	●	1,069	643	604	683	-	643
2011/12	●	1,167	690	650	731	-	645
2012/13	●	1,171	688	649	730	-	630
2013/14	●	1,194	693	653	734	-	640
2014/15	●	1,169	679	640	719	-	635
2015/16	●	1,245	708	669	749	-	647
2016/17	●	1,180	664	626	704	-	636
2017/18	●	1,106	622	586	661	-	632

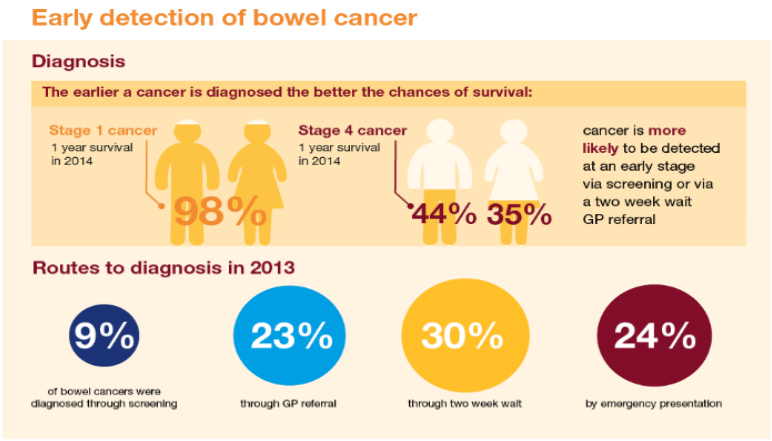
Source: Calculated by Public Health England: Population Health Analysis (PHA) team using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.

3.2.5 Uptake of cancer screening

Cancer screening programmes are offered to all residents of Peterborough when they reach the relevant age. These programmes help to identify cancers at an early stage when they are more likely to be treatable. In Peterborough the percentage of residents who take up screening is significantly below the national average for all three national cancer screening programmes. Uptake by women of both breast cancer and cervical cancer screening is falling, with about one in four women not screened. The uptake of bowel cancer screening is gradually improving, but only about one in two eligible residents are screened.

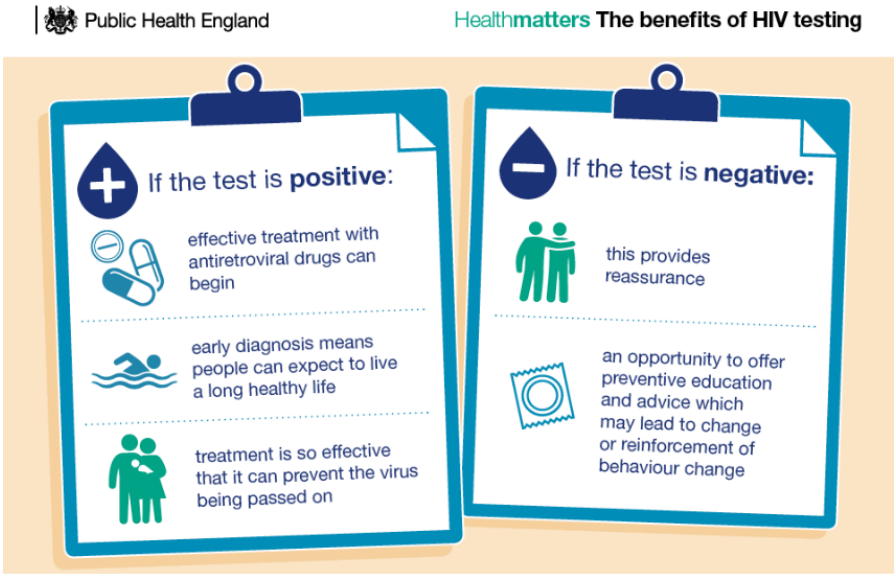






3.2.6 Sexual health: testing and treatment

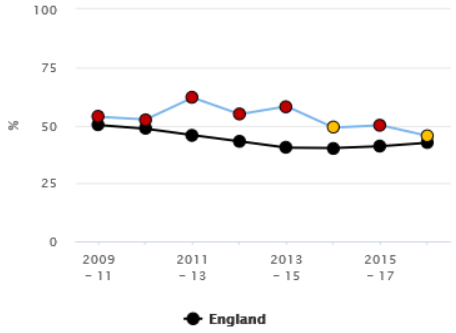
Easy access to clinics and/or on-line tests for sexually transmitted infections (STIs) is important, to make sure that these infections are identified and treated promptly and don't spread further within the local population. It is particularly important to identify HIV infections early, as late treatment increases the risk of complications and life threatening disease.



In recent, years Peterborough has faced challenges achieving the national standard that fewer than 50% of HIV diagnoses should be made at a late stage. The rate of late diagnosis has been improving and for 2016-28 the 50% standard was met.

D07 - HIV late diagnosis (%) Peterborough — Proportion - %

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



Recent trend: –

Benchmarking against goal: <25% | 25% to 50% | ≥50%

Period		Peterborough				East of England region	England
		Count	Value	Lower CI	Upper CI		
2009 - 11	●	22	53.7%	37.4%	69.3%	52.3%	50.1%
2010 - 12	●	21	52.5%	36.1%	68.5%	51.4%	48.5%
2011 - 13	●	26	61.9%	45.6%	76.4%	52.1%	45.7%
2012 - 14	●	23	54.8%	38.7%	70.2%	52.1%	43.1%
2013 - 15	●	25	58.1%	42.1%	73.0%	50.5%	40.3%
2014 - 16	●	24	49.0%	34.4%	63.7%	48.0%	40.2%
2015 - 17	●	23	50.0%	34.9%	65.1%	48.2%	41.0%
2016 - 18	●	20	45.5%	30.4%	61.2%	48.4%	42.5%

Source: Public Health England

SECTION 4: KEY HEALTH OUTCOMES

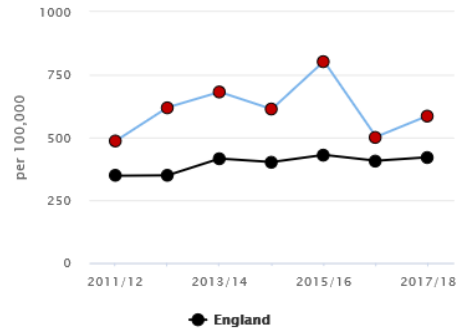
This section of the Annual Public Health Report reviews trends in a small number of key health outcomes, using benchmarked data from Public Health England

4.1 Mental Health

The Peterborough Annual Public Health Report 2017 highlighted rising rates of hospital admission for self-harm among young people as a concern. While rates have fallen since the peak in 2015/16 described in that report, they remain significantly above the national average.

Hospital admissions as a result of self-harm (10-24 years) Peterborough — Directly standardised rate - per 100,000

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



Recent trend: –

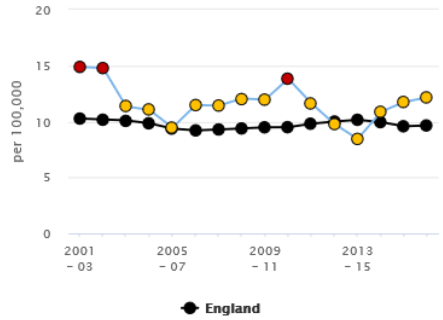
Period		Peterborough				East of England region	England
		Count	Value	Lower CI	Upper CI		
2011/12	●	172	485.2	415.4	563.4	262.7	347.4
2012/13	●	215	619.4	539.4	708.0	291.4	348.9
2013/14	●	232	681.1	596.2	774.6	378.5	415.8
2014/15	●	208	612.7	532.2	701.9	354.8	401.9
2015/16	●	273	803.7	711.1	905.0	411.2	430.5
2016/17	●	167	502.2	428.8	584.5	353.1	407.1
2017/18	●	197	587.2	507.9	675.3	387.9	421.2

Source: Hospital Episode Statistics (HES) Copyright © 2016, Re-used with the permission of The Health and Social Care Information Centre. All rights reserved.

Suicide rates among adults in Peterborough have remained similar to the national average in recent years.

E10 - Suicide rate New data Peterborough — Directly standardised rate - per 100,000

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



Recent trend: –

Period		Peterborough Count	Value	Lower CI	Upper CI	East of England region	England
2001 - 03		60	14.9	11.3	19.2	9.6	10.3
2002 - 04		58	14.8	11.1	19.2	9.6	10.2
2003 - 05		46	11.3	8.2	15.2	9.3	10.1
2004 - 06		46	11.0	8.0	14.8	9.1	9.8
2005 - 07		43	9.4	6.8	12.8	8.8	9.4
2006 - 08		53	11.5	8.5	15.1	9.0	9.2
2007 - 09		53	11.4	8.5	15.0	8.9	9.3
2008 - 10		55	12.0	9.0	15.8	8.9	9.4
2009 - 11		55	12.0	8.9	15.6	8.8	9.5
2010 - 12		65	13.8	10.6	17.7	8.9	9.5
2011 - 13		56	11.6	8.7	15.1	8.9	9.8
2012 - 14		48	9.8	7.2	13.0	9.0	10.0
2013 - 15		42	8.4	6.0	11.5	9.3	10.1
2014 - 16		54	10.9	8.1	14.2	9.7	9.9
2015 - 17		59	11.7	8.9	15.2	9.3	9.6
2016 - 18		61	12.2	9.3	15.6	10.0	9.6

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

4.2 Life expectancy

Average life expectancy for men and women in Peterborough is significantly below the national average, although comparable with other local authorities with similar levels of deprivation. For women in Peterborough, average life expectancy has stayed fairly constant since 2009/11, while for men in Peterborough average life expectancy improved until 2012/14, but since then has levelled off with a small decrease in 2015/17 which is the most recent period for which data is available.

A01b - Life expectancy at birth (Female) Peterborough — Life expectancy - Years

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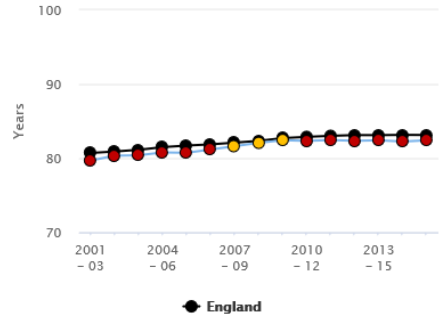

Recent trend: –

Period		Peterborough Count	Value	Lower CI	Upper CI	East of England region	England
2001 - 03		-	79.7	79.1	80.2	81.4	80.7
2002 - 04		-	80.3	79.8	80.9	81.6	80.9
2003 - 05		-	80.4	79.9	80.9	81.8	81.1
2004 - 06		-	80.8	80.2	81.3	82.2	81.5
2005 - 07		-	80.7	80.2	81.3	82.4	81.7
2006 - 08		-	81.2	80.7	81.7	82.6	81.9
2007 - 09		-	81.6	81.1	82.1	82.8	82.1
2008 - 10		-	82.1	81.6	82.6	83.0	82.3
2009 - 11		-	82.4	81.9	82.9	83.4	82.7
2010 - 12		-	82.3	81.8	82.8	83.5	82.9
2011 - 13		-	82.4	81.9	83.0	83.6	83.0
2012 - 14		-	82.3	81.8	82.8	83.7	83.1
2013 - 15		-	82.4	81.9	82.9	83.7	83.1
2014 - 16		-	82.2	81.7	82.7	83.7	83.1
2015 - 17		-	82.4	81.9	82.9	83.7	83.1

Source:
Office for National Statistics (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/healthstatelifeexpectanciesuk/2015to2017)
Index of Multiple Deprivation 2010 and 2015 (IMD 2010 / IMD 2015) scores from the Department for Communities and Local Government.

A01b - Life expectancy at birth (Male) Peterborough — Life expectancy - Years

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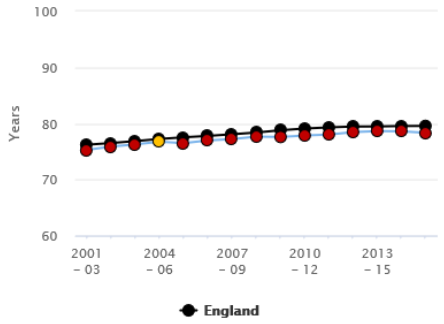


Recent trend: –

Period		Peterborough				East of England region	England
		Count	Value	Lower CI	Upper CI		
2001 - 03	●	-	75.3	74.7	75.8	77.3	76.2
2002 - 04	●	-	75.9	75.3	76.4	77.6	76.5
2003 - 05	●	-	76.3	75.7	76.8	77.9	76.8
2004 - 06	●	-	76.7	76.2	77.3	78.2	77.2
2005 - 07	●	-	76.5	75.9	77.0	78.5	77.5
2006 - 08	●	-	77.0	76.4	77.5	78.8	77.8
2007 - 09	●	-	77.2	76.7	77.7	79.1	78.1
2008 - 10	●	-	77.6	77.1	78.2	79.3	78.4
2009 - 11	●	-	77.6	77.0	78.1	79.7	78.8
2010 - 12	●	-	77.8	77.3	78.4	80.0	79.1
2011 - 13	●	-	78.0	77.5	78.5	80.2	79.3
2012 - 14	●	-	78.5	77.9	79.0	80.3	79.4
2013 - 15	●	-	78.6	78.1	79.1	80.3	79.5
2014 - 16	●	-	78.6	78.1	79.1	80.4	79.5
2015 - 17	●	-	78.3	77.8	78.8	80.4	79.6

Source:
Office for National Statistics (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/healthstatelifeexpectanciesuk/2015to2017)
Index of Multiple Deprivation 2010 and 2015 (IMD 2010 / IMD 2015) scores from the Department for Communities and Local Government.

Nationally, changes in life expectancy since 2012/14 have been closely correlated with the Index of Multiple Deprivation, with an ongoing increase in life expectancy in the least deprived areas but some decrease in life expectancy in the most deprived 30% of communities (Office for National Statistics).

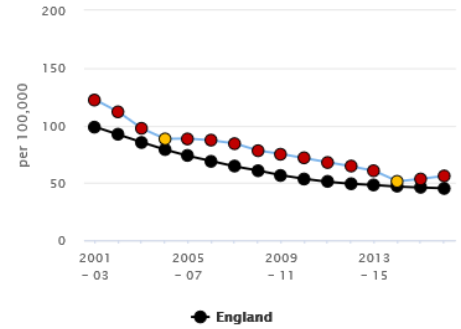
4.3 Premature death from cardiovascular disease

In Peterborough, premature death from cardiovascular disease (heart disease and stroke) is a particularly significant cause of years of life lost, and preventable deaths remain above the national average:

E04b - Under 75 mortality rate from cardiovascular diseases considered preventable New data Peterborough

Directly standardised rate - per 100,000

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



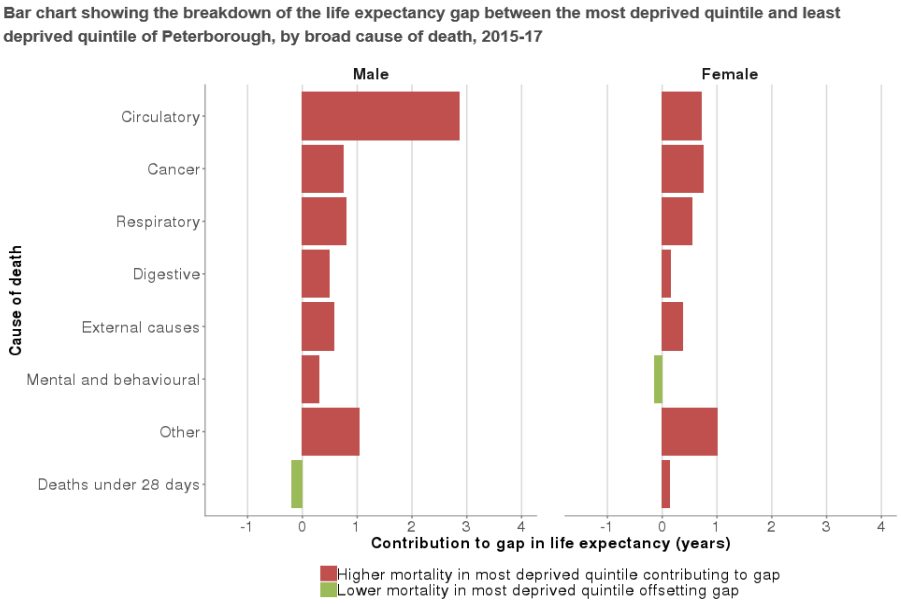
Recent trend: –

Period		Peterborough				Third more deprived decile (IMD2015,4/19 geo)	England
		Count	Value	Lower CI	Upper CI		
2001 - 03	●	403	122.3	110.6	134.9	-	98.6
2002 - 04	●	371	111.6	100.5	123.6	-	91.9
2003 - 05	●	328	97.3	87.0	108.5	-	85.3
2004 - 06	●	300	88.3	78.5	99.0	-	78.9
2005 - 07	●	302	88.6	78.8	99.2	-	73.4
2006 - 08	●	300	87.0	77.3	97.5	-	68.9
2007 - 09	●	299	84.3	74.9	94.5	-	64.3
2008 - 10	●	284	78.1	69.2	87.8	-	60.7
2009 - 11	●	278	75.1	66.4	84.6	-	56.6
2010 - 12	●	266	71.4	63.0	80.7	64.2	53.5
2011 - 13	●	257	67.9	59.8	76.9	61.2	50.9
2012 - 14	●	250	64.4	56.6	73.0	59.2	49.2
2013 - 15	●	240	60.4	52.9	68.6	57.4	48.1
2014 - 16	●	210	51.3	44.5	58.8	55.7	46.7
2015 - 17	●	226	53.5	46.7	61.0	54.8	45.9
2016 - 18	●	245	56.0	49.1	63.5	53.8	45.3

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

There is a very significant inequality in cardiovascular (circulatory) deaths between the most deprived 20% of areas in Peterborough (most deprived quintile) and the least

deprived 20% of areas as shown on the chart below. For men, cardiovascular disease account for nearly three years of the total life expectancy gap of seven years between the most deprived 20% and least deprived 20% of areas.



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

SECTION 5: KEY FINDINGS FOR ONGOING REVIEW

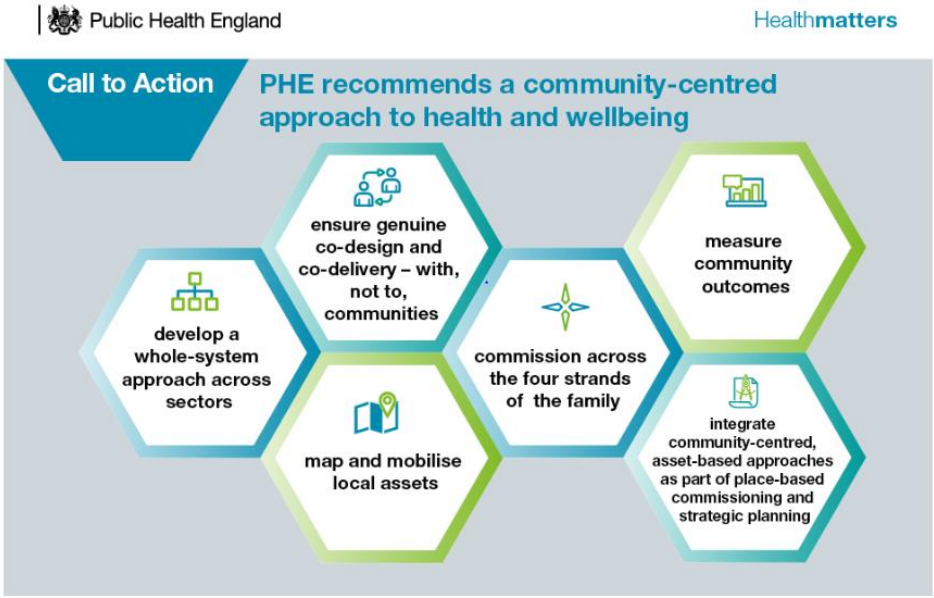
The overall Index of Deprivation (2019) for Peterborough highlights a number of challenges in the wider social and environmental factors which affect health and wellbeing. Education/skills and crime are both highlighted as areas of particular concern. There has been an increase in homeless households placed in temporary accommodation and in rough sleepers in recent years, which is a national as well as a local issue.

While there was an improvement in the school readiness of Peterborough's children in the 2017/18 school year, this remains significantly below the national average. The early development of children and their confidence and readiness to start school is key to their future life chances and outcomes. This issue will have ongoing focus and review through our multi-agency 'Best Start in Life' programme.

Other issues of concern for children and young people highlighted in this year's report include a fall in uptake of childhood immunisations seen in 2017/18. Young people's mental health is still of concern, with local hospital admission rates for self-harm among 10-24 year olds remaining higher than the national average, although there has been some improvement.

The percentage of adults who smoke and who are overweight or obese are both higher than the national average in Peterborough, and if not addressed, this will lead to higher rates of cardiovascular disease (heart disease and stroke), diabetes and some cancers in our population. Rates of preventable deaths from cardiovascular disease in Peterborough are significantly above the national average, with a high level of local inequality between our most and least deprived communities.

Overall, the wide diversity and range of social and economic factors within the Peterborough City Council area highlight the need for public services to focus on place-based approaches, working with local communities. This will be taken forward through Peterborough's 'Think Communities' approach, which has sign up from a range of local organisations.



ANNEX A: FINDING INFORMATION ON PUBLIC HEALTH OUTCOMES

LOCAL INFORMATION

Peterborough City Council website public health section
https://www.peterborough.gov.uk/healthcare/public-health/ provides local information on a range of local public health issues and outcomes for Peterborough.

Peterborough City Council: Joint Strategic Needs Assessment
https://www.peterborough.gov.uk/healthcare/public-health/JSNA/ provides an annually updated core dataset from the statutory joint strategic needs assessment (JSNA) across health and social care outcomes, together with JSNAs on specific health and wellbeing topics.

Cambridgeshire Insight: Interactive map https://cambridgeshireinsight.org.uk/ lets you click on your electoral ward or enter a postcode and see a short report on your area's population, economy, housing, education and health outcomes.

Cambridgeshire Insight: Public Health Intelligence reports & data

https://cambridgeshireinsight.org.uk/health/localphi/resources/ contains an array of Peterborough-specific public health intelligence data, including a local health profile, Public Health Outcomes Framework (PHOF) summaries, annual public health report and a link to Peterborough's Health & Wellbeing Strategy. Links are also included to Public Health England (PHE) and Cambridgeshire & Peterborough Clinical Commissioning Group

Cambridgeshire Insight: Children and young people and older people

https://cambridgeshireinsight.org.uk/health/popgroups/ provides further information on health outcomes for children and young people and older people in Cambridgeshire and Peterborough.

Cambridgeshire Insight: Health Topics

https://cambridgeshireinsight.org.uk/health/topics/ brings together detailed information on specific health topics, such as risk factors for ill health and specific diseases and conditions.

Cambridgeshire Insight: Indices of Multiple Deprivation

https://cambridgeshireinsight.org.uk/deprivation/indices-of-multiple-deprivation/#IMD2019 provides an array of maps, summaries and detailed reports relating to the Index of Multiple Deprivation 2019, including district, local authority and primary care network (PCN) analysis.

Healthy Peterborough https://www.healthypeterborough.org.uk/2018 provides information on how to look after your own health and wellbeing, including local services and opportunities which support you in maintaining a healthy lifestyle, and day to day social media communications.

NATIONAL INFORMATION

The Public Health Outcomes Framework https://fingertips.phe.org.uk/profile/public-health-outcomes-framework is the main portal for Public Health England's Knowledge and Intelligence service. It provides interactive profiles on a wide range of public health outcomes and is updated every three months. Through the easy to use interactive functions it is possible to:

- Compare public health outcomes in Peterborough to national and regional averages, and to groups of similar local authorities
- Look at trends in public health outcomes in Peterborough over time
- Create charts, profiles and maps of public health outcomes in a specified area.

It is also possible to do this for individual District/City Council areas in neighbouring Cambridgeshire, although for a more limited set of outcome indicators.

Local Health at www.localhealth.org.uk/ is the Public Health England portal which provides information at electoral ward level. It can be used to produce electoral ward health profiles and charts, or group wards together to make a health profile of a larger area.

ANNEX B:

Figure 3: Summary of the domains, indicators and data used to create the Indices of Deprivation 2019

26 The English Indices of Deprivation 2019 - Statistical Release

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Updated on: 25 January 2020

HEALTH AND WELLBEING BOARD
AGENDA PLAN 2019/2020

MEETING DATE	ITEM	CONTACT OFFICER
Monday 24 June 2019	● SEND Peer Review ● Peterborough Pharmaceutical Needs Assessment Delegated Authority. ● Creation of Joint Health and Wellbeing Board Sub Committee with Cambridgeshire County Council o Feedback from the Joint Development Session o Proposal to update the Terms of Reference for the Peterborough Health and Wellbeing Board and to create a further joint sub-committee with the Cambridgeshire Board ● Peterborough Health Protection Annual Report ● Peterborough Health and Wellbeing Strategy 2016-2019 o Performance monitoring report o Annual Outcome metrics report • North Alliance update on neighbourhood working, including links with Think Communities ● Update on health and social care integration **For information**: Diverse Ethnic Communities JSNA – South Asian Communities Supplement	Sheelagh Sullivan / Siobhan Weaver Iain Green/Liz Robin Liz Robin Tiya Balaji Helen Gregg Ryan O'Neill Amy Venner (STP Delivery Unit / Ian Phillips Caroline Townsend / Will Patten Liz Robin
Monday 10 December 2019	• Annual Public Health Report 2019 • Update Terms of reference • Local Authority SEND update • Think Communities Update • The Big Conversation	Liz Robin Dan Kalley Helen Gregg Adrian Chapman Jess Bawden (CCG)

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