CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD

Cambridgeshire County Council

Date:Thursday, 17 March 2016

10:00hr

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

Shire Hall
Castle Hill
Cambridge
CB3 0AP

Council Chamber, East Cambridgeshire District Council, The Grange, Nutholt Lane, Ely CB7 4EE [Venue Address]

AGENDA

Open to Public and Press

CONSTITUTIONAL MATTERS

Apologies and Declarations of Interest

Guidance for Councillors on declaring interests is available at http://tinyurl.com/ccc-dec-of-interests

Minutes – 14th January 2016	**5 - 14**
Minutes Action Log Update	**15 - 18**

GENERAL BUSINESS

Update on Cambridge University Hospitals NHS Foundation Trust – strategic impact and direction	**19 - 24**

The Cambridgeshire Health and Wellbeing Board comprises the following members:

Councillor Daryl Brown (Chairman)Councillor Tony Orgee (Chairman) Margaret Berry Councillor Mike Cornwell Councillor Sue Ellington Councillor Richard Johnson Dr John Jones Adrian Loades Chris Malyon Val Moore Dr Sripat Pai Liz Robin and Councillor Joshua Schumann Councillor Paul Clapp Councillor Mervyn Loynes Councillor Lucy Nethsingha and Councillor Joan Whitehead

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

Clerk Name: Ruth Yule

Clerk Telephone: 01223 699184

Clerk Email: ruth.yule@cambridgeshire.gov.uk

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CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD: MINUTES

Date: **14th January 2016**

Time: **10.05 to 13.05**

Place: **Council Chamber, South Cambridgeshire Hall, Cambourne, Cambridge**

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

District Councils
Councillors D Brown (Huntingdonshire), M Cornwell (Fenland), S Ellington (South Cambridgeshire), and J Schumann (East Cambridgeshire)

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

Healthwatch
Val Moore

Also present: Jessica Bawden (Director of Corporate Affairs, CCG) and Andy Vowles (Chief Strategy Officer, CCG)

Apologies: Councillors R Johnson (Cambridge City) and L Nethsingha (CCC); M Berry (NHS Commissioning Board), J Farrow (Voluntary and Community Sector), C Malyon (Section 151 Officer) and N Modha (CCG)

173. INTRODUCTION AND DECLARATIONS OF INTEREST

Councillor Daryl Brown declared an interest in agenda item 9 (minute 181) as Lead Governor of Cambridge University Hospitals NHS Foundation Trust (CUHFT).

174. MINUTES – 19th NOVEMBER 2015

The minutes of the meeting of 19th November 2015 were signed as a correct record.

175. MINUTES ACTION LOG UPDATE

The Board received and noted the Action Log,

176. A PERSON'S STORY

The Board was read three stories of successful weight loss, told in their own words by two men and a woman who had been referred to Everyone Health's ChangePoint service by their GPs when they had sought help with weight loss, in two cases after a history of other unsuccessful attempts to lose weight. All three had been helped by the service's weight management groups, and by support and encouragement to improve fitness and increase their activity levels.

Discussing these stories, Board members

- commented on the difficulty of maintaining motivation once participation in a programme had come to an end

- noted that Everyone Health was expanding its work; it now had health coaches in the community and was able to support people for an additional year

- from a GP perspective, reported that the service had been beneficial to patients, and commented on the benefits to mental health of establishing a good relationship with food and getting back to taking exercise.

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

177. HEALTH AND WELLBEING STRATEGY – PRIORITY 3 UPDATE

The Board received a report updating members on progress with the Health and Wellbeing Strategy Priority 3: 'Encourage healthy lifestyles and behaviours in all actions and activities while respecting people's personal choices'. The presenter thanked her fourteen fellow contributors to the report, commenting that this list illustrated the need for a partnership approach. Priority 3 ran across the lifecourse, and linked into the Board's other priorities; a concerted approach was needed to elicit lifestyle changes.

In the course of discussion, Board members

- sought information on the effectiveness of the programmes described. Officers advised that an evaluation framework was being put in place for the Children and Young People (CYP) work; comprehensive performance data was available for the main programmes, enabling evaluation, and the information in Appendix B could be expanded for future updates to the Board

- commented on the importance of all the different partners being committed and working together in local health partnerships; there was no simple answer to encouraging healthy lifestyles and behaviours without the involvement of a wide range of people, organisations, businesses, GPs and other health professionals

- suggested it might be helpful to contact local boxing clubs to establish exercise sessions for young people; even those with disabilities or not steady on their feet could for example hit a punchbag, with benefit to both physical and mental health. Members noted that Everyone Health was already holding discussions about a pilot for teenagers with a local gym which had a box fit room and spin room

- drew attention to the difficulty, for GPs and members of the public, of knowing what was available, and knowing what the quality was of the different people and organisations offering services

- noted that there were various accreditation schemes, including a register of exercise professionals [www.exerciseregister.org] which provided a system of regulation for instructors and trainers, but there was no legal requirement for practitioners to be qualified or accredited as a condition of offering their services

- commented that information needed to be presented in an easily accessible form, and that it would be helpful to have some form of evaluation of different services on offer – was one slimming group more effective than another, for example

- noted that Fenland had recently produced a directory of services which, while not perfect, gave information on accessing at least some of the services available; other districts might wish to produce something similar

- reported that a recent Cambridge initiative to put funding into attracting girls into sport had been criticised, though there was a gender issue of thinking about a wider range of sports, given that there was already considerable support given to such traditionally boys' sports as football and boxing

- drew attention to the role of public libraries as a source of information, and the desirability of building links between the library service and the health service

- reported that new software was being installed in GP surgeries which would bring up guidance; it would be helpful to ensure that local organisations were included in that system, in particular Everyone Health **Action required**

- noted that Everyone Health had a single telephone number as its point of access, which was answered by staff who were trained to triage and guide callers to the correct service; this number had been sent to all GPs

- stressed the importance of recognising the enormous contribution made by volunteers to supporting healthy lifestyle activities, in some cases over many years

- drew attention to massive variations in lifestyle and health behaviours across the county, which should be taken into account in deciding where to direct resources

The Board noted the update.

178. PREVENTION STRATEGY FOR THE HEALTH SYSTEM TRANSFORMATION PROGRAMME

The Board received the final draft of the Cambridgeshire and Peterborough health system prevention strategy, which had been revised partly in the light of the Board's comments in November. The strategy focussed on initiatives to generate savings for the NHS, and attempted to estimate the likely financial savings which would result.

In the course of discussing the strategy, Board members

- suggested that it would be helpful to make it clear at the beginning of the document that all savings quoted were net savings, i.e. the saving to be made in addition to recouping the initial investment, and to say whether it would be a loss or gain to the whole system and to the individual organisation

- suggested that it might be possible to undertake a broader piece of work in the context of reviewing the Health and Wellbeing Strategy, and look from a public health perspective at for example the scope for making savings to the cost of social care from stroke prevention

- observed that it was necessary to take a balanced approach to issues, for example to remember that however beneficial breast-feeding might be, not all mothers were able to breast-feed and should not be made to feel failures as a result

- pointed out that the costs of illness or injury were not all quantifiable, and suggested that it was important not to be too heavily focussed on the financial return from prevention work

- commented that district councils had opportunities to assist, for example through falls prevention work by housing adaptations; they would be able to do more if there was more evidence that their efforts were helping prevention, which would enable an increase in the amount of public health funding to support district work further. Districts had people available with the skills to undertake prevention work, but were unable to pay them under the present system of distributing finance

- suggested that there was a role for the Board in encouraging join-up of services; there was earmarked one-off public health funding for falls prevention work, but it was proving difficult to identify effective ways of spending it without clarity on the wider falls preventions strategy across health and care organisations

- commented that the Better Care Fund could provide funding for falls prevention and for keeping people in their own homes; falls prevention benefitted the Council as well as the NHS

- expressed surprise at how small some of the savings identified in the strategy were, but noted that there were limitations to the modelling imposed by the extend of economic modelling information available.

It was resolved unanimously to endorse the Cambridgeshire and Peterborough health system prevention strategy attached at Annex A of the report before the Board.

179. PUBLIC HEALTH REFERENCE GROUP UPDATE

The Board received a report updating it on the work of the Public Health Reference Group (PHRG) and its relationship to the Health System Transformation Prevention workstream. Members noted that the PHRG, which was co-chaired by the Director of Public Health and the Chief Executive of Fenland District Council, had adopted two priorities in the current year, obesity prevention and community engagement.

Commenting on the report, a Board member expressed concern that the PHRG appeared to lack accountability in that it was developing its own strategies and

policies without taking them through any public bodies. The Director of Public Health replied that a report on the work of the PHRG would be taken to the Health Committee, because the Group was spending delegated funding from the public health budget, but oversight of the PHRG as a partnership group lay with the Health and Wellbeing Board.

It was resolved unanimously to:

- Note progress with the PHRG short term actions to address obesity/diet/physical activity, and to support implementation of key actions within their organisations.

- Endorse the Public Health Reference Group playing an active role in the partnership aspects of the Health System Transformation Prevention workstream, reporting to the Health and Wellbeing Boards and Cambridgeshire Public Service Board. .

180. COMMUNITY RESILIENCE STRATEGY

The Board received a report presenting Cambridgeshire County Council's Community Resilience Strategy and inviting it to consider whether there were principles to explore in developing a joint approach to building resilient communities; and where there might be opportunities to develop joint activity. Members noted that community resilience formed part of a demand management strategy, addressing the question of what needed to be in place to minimise the impact of withdrawing services.

In the course of discussion, Board members

- recalled earlier discussion (minute 177) about the importance of having trustworthy, readily accessible information for people about facilities and services

- suggested that, if a seminar on community resilience and joint working were held for County Members, District Councillors should be invited too

- stressed the importance of communication, pointing out that a wide range of languages were spoken in some parts of the county

- drew attention to the importance of making money go further, as was happening in the community transport work, where there was evidence of a return to CCC

- commented that the role of County Councillors as community navigators was relevant to this strategy, and noted that work was being done on developing the business case for timebanking

- suggested that it might be helpful to highlight delivery mechanisms within the strategy

- noted that the CCG was continuing to build neighbourhood teams, which could provide a structure to help implement some of the strategy's ideas

- drew attention to the importance of providing support for carers, and noted that the Adults Committee and the Children and Young People Committee were about to consider a Carers' Strategy; there was good evidence that if carers of people with dementia got together to form a support group, the point at which they could no longer provide care would be delayed.

The Service Director: Enhanced and Preventative Services offered to return to the Board in six months' time with a report setting out in greater detail the work being undertaken under the strategy. The Board's District Council support officer undertook to liaise with the Service Director on local planning in South Cambridgeshire, with the aim of avoiding duplication and identifying gaps in what was in place. **Action required**

The Board noted the Community Resilience Strategy and its implications for its work and the delivery of the Health and Wellbeing Strategy.

181. OLDER PEOPLE'S AND ADULT COMMUNITY SERVICES CONTRACT

The Board received a report updating it on the end of the contractual arrangement for Older People's and Adult Community Services in Cambridgeshire and Peterborough. The report set out actions taken to reassure patients and staff and ensure continuity of patient care.

The Board was advised that the CCG's Governing Body had recently reaffirmed its commitment to the outcomes-based approach model. The service model that UnitingCare had been rolling out in partnership with organisations was broadly the model that the CCG would wish to commission, though it was necessary to ensure that the new arrangements would be affordable. The CCG had no intention of returning to previous ways of delivering care.

The CCG's internal auditors were conducting an independent review of the termination of the contract, and would report their findings at the end of January 2016. NHS England was conducting an external review. Its timeline was unknown, but likely to be fairly rapid because other areas in the country were working towards similar arrangements for the provision of community care services.

In the course of discussion, Board members

- noted that the Health Committee was responsible for scrutiny of the NHS, and had examined arrangements for the continuation of patient care at its meeting in December, and would be looking at the termination of the contract at its meeting on 21st January, with a wide range of senior stakeholders attending

- reported, as a governor of Cambridge University Hospitals NHS Foundation Trust (CUHFT), that stakeholder assurance meetings had been held with Monitor in November 2015 and that results from the new model of care were starting to be seen, but the prospect of a deficit of around £8m to £10m in the first year was reason to terminate the contract; it could be worth social care funding that deficit to see what the result might be.

  CCG officers said that the contract had been terminated very reluctantly, because the effort put in to developing the model of care had started to show very promising results, and the model still made sense in terms of reducing emergency admissions and achieving better outcomes for patients and the health system; it was necessary to find a way of financing the model in future

- said that reports were emerging of for example non-use of intermediate care beds at Doddington Court because of such factors as changes in staff, which was annoying to local people because the beds had been provided at considerable cost by a number of partners, and asked what was being done to remedy such gaps.

The CCG Chief Strategy Officer replied that he and the Executive Director: CFAS were examining various issues including Doddington Court; he offered to share his response to the Executive Director with Councillor Cornwell **Action required**

- enquired what steps were being taken to deal with the significant deficit that UnitingCare had accumulated, and whether many staff were being made redundant as a result.

  The Board was advised that it was for the two trusts (CPFT and CUHFT) and the CCG to agree how to deal with it. The CCG and CPFT had both made great efforts to make it clear to staff that what was changing was a contractual change, not a change in services. It was important not to waste what had been developed over the past two years; the boundaries of the OPACS contract had now been removed, opening up the possibilities for conversations about new arrangements, for example without limitation to older people.

The Chairman encouraged those present to attend the next Health Committee, and requested an update on the OPACS contract at the Board's next meeting.

The Board noted the report.

182. PLANNING FOR THE BETTER CARE FUND 2016-17

The Board received a report updating it on the Better Care Fund (BCF) planning process for 2016/17, and seeking a steer on priorities and approach. Members were advised that the framework document had been received, but the full guidance, due to be released by the end of December 2015, had still not appeared. The submission deadline for the first draft of BCF plans for 2016/17 remained 8th February 2016.

The Board noted that there was a lack of certainty around various aspects, including personal budgets, whether non-elective admissions would continue to be measured through the BCF, and whether the disabled facilities grant would remain in the BCF. The termination of the Older People's and Adult Community Services contract with UnitingCare, and the new Vanguard programme, made it necessary to revisit BCF goals and ensure that funding and activity remained relevant. Cambridgeshire Executive Partnership Board would see an early draft plan on 25th January, but the first submission date preceded the Board's next meeting on 17th March, and final submission was due in April.

Commenting on the report and verbal update, Board members

- suggested that the Board should protest at the timetable for submission, which – given the delay in publishing the guidance – did not allow sufficient time for proper discussion to arrive at a considered plan **Action required**

- noted that it was compulsory to complete the plan

- suggested that it would be helpful to see the outcomes from expenditure to date

- welcomed the focus on delayed transfers of care, and suggested that, to address the difficulty of transferring out-of-county patients from Addenbrooke's, the possibility of developing mutually assured assessments of other authorities' patients should be explored

- noted that NICE had recently issued guidance on transition between inpatient hospital settings and community or care home settings

- queried how the timetable for BCF submission would fit with the examination of the OPACS contract, given that the contract was integral to BCF work. Members noted that efforts were being made to identify areas of spending common to the Local Authority and the NHS and make use of the BCF mechanism to move work forward, including work with the voluntary sector and neighbourhood teams

- objected to the habit of referring to BCF funding as 'not new money', because the BCF was about new ways of providing health and social care, and noted that this usage was a hangover from the initial announcement of the BCF as new money when it was money that had been previously committed. It was necessary to move existing budgets and systems into new ways of working

- noted that the largest block of BCF funding came from the CCG's allocation, and the vast majority of that was committed in service contracts with for example Cambridgeshire and Peterborough NHS Foundation Trust; it would only be possible to free up money by reducing the committed spend.

Based on the report and the verbal update provided, and having commented on the suggested principles for Better Care Fund planning in 2016/17, the Board resolved unanimously:

- that the Chairman would write to the appropriate person or department to protest that it was inappropriate and unacceptable to expect Health and Wellbeing Boards to work to the timeframe laid down for submission

- to recommend that other organisations, in considering their priorities for the BCF in 2016/17, bear in mind that the BCF should be regarded not as a means of maintaining the status quo but as a means of transformation.

183. PUBLIC HEALTH BUSINESS PLANNING 2016-17

The Board received a report updating it on Cambridgeshire County Council public health business planning for 2016/17; business planning was due to be discussed at Health Committee on 21st January. The report invited the Board to comment on the public health savings being proposed to meet the savings requirement of £2.7m for 2016-17, and consider how the changed approach to Joint Strategic Need Assessment (JSNA) could be approached most constructively.

Board members noted that about 85% of the public health budget was committed to external contracts. A value-for-money approach was being taken to services and efficiencies, asking questions about how services were being commissioned and what the impact of proposed savings might be on the vulnerable. However, both Healthy Fenland and Falls Prevention had earmarked non-recurrent funding.

Members further noted that substantial savings were proposed for minor projects and the staffing of the Public Health directorate, with a cut of about 23% to staff costs. As a result, It would no longer be possible to maintain the current standard of JSNAs, with their high level of complexity, detail and number of stakeholders. Instead, the proposal was to reduce delivery of JSNAs to a standard closer to the statutory minimum, which would require less input from analysts and from support staff.

In the course of discussion, Board members

- protested at the sudden change in savings requirement imposed by central government at short notice through the Autumn Statement, and the consequent need to identify efficiencies rapidly, resulting in the reduction of services to people who needed them

- suggested that identifying high-quality, easily-accessible data information sources could help to mitigate the effects of reducing JSNA work, perhaps eventually leading to the development of a dashboard of understanding of need

- expressed support for JSNAs being more tightly targeted; one of the most effective JSNAs had been that on Transport and Health, particularly on the issue of air quality

- commented that, while JSNA documentation had been superb, implementation had tended to be slow; if the scope of JSNA work was being reduced, it was important that the findings be translated promptly into service delivery by all the agencies involved

- expressed concern at the reduction in expenditure on health visiting and family nurse partnership. Members noted that the saving proposed was in percentage terms relatively small, and the possibility was being explored of achieving a better-value contract for delivery of these services

- noted that, associated with the reduction in JSNA work, it was proposed to explore the establishment of a joint intelligence unit with the CCG, building on joint work already done by the public health intelligence services in Cambridgeshire and Peterborough, and aiming to ensure widespread access to the unit's findings.

Having commented on the public health savings proposals, including the changed approach to JSNA, the Board resolved

to note the partnership workstreams through which public health business planning was progressing for 2016/17 and 2017/18, which were reported to the Health and Wellbeing Board at themed meetings.

184. FORWARD AGENDA PLAN

The Board noted the forward agenda plan, with the addition of

- a further update on the termination of the Older People's and Adult Community Services contract on either 17th March or 26th May, depending on how quickly further information emerged

- an update on implementation of the Community Resilience Strategy in July 2016.

Action required

185. DATE OF NEXT MEETING

The question of the timing of meetings in the next municipal year was raised, because Thursday morning meetings had proved difficult for some CCG representatives, but moving to other times or days would cause difficulties for other Board members. CCG officers reported that representatives had now been identified who could attend on a Thursday morning, so it was decided to continue the pattern of Thursday morning meetings for the time being. Members were asked to send any further views on meeting dates to the Democratic Services Officer.

Board members noted the date of the Board's next meeting:

- 10am on Thursday 17th March 2016, East Cambridgeshire District Council, The Grange, Nutholt Lane, Ely CB7 4EE

Chairman

Post-meeting note:
Further meetings of the Board are planned for 10am on Thursdays

- 7th July 2016
- 15th September 2016
- 17th November 2016
- 19th January 2017
- 30th March 2017
- 1st June 2017

HEALTH & WELLBEING BOARD MINUTES ACTION LOG AND UPDATES FROM 14 JANUARY 2016

MINUTE & ITEM TITLE	ACTION REQUIRED / UPDATE	STATUS
120. Better Care Fund	Updated Terms of Reference document for Cambridgeshire Executive Partnership Board to be brought to a future Health and Wellbeing Board meeting. **Action: G Hinkins / R Yule** **UPDATE:** On HWB Agenda Plan as to be scheduled.	**ONGOING**
136. Addressing the Findings of the Transport and Health JSNA	This JSNA to be sent to the Leaders of the County Council, Cambridge City Council, and South Cambridgeshire District Council **Action: I Green** **UPDATE:** The JSNA has been raised at Cambridgeshire Public Service Board (CPSB); officers are working with District Councils to arrange briefings to their management teams and/or members. **FURTHER UPDATE:** The Director of Public Health has attended the Huntingdonshire District Council management team to provide a briefing on the JSNA and discuss next steps.	**ONGOING**
	Iain Green to liaise with Jess Bawden about other partnership groups this JSNA should be shared with. **Action: J Bawden / I Green** **UPDATE:** The JSNA was presented to the CCG's Clinical and Management Executive Team (CMET)	**COMPLETE**
149. Progress on HWB Priority 4	Circulate a briefing to HWB members on the work being done on universal credit and provision of support in benefits sanction cases in Children, Families and Adults Services (CFA) and in the District Councils **Action: A Loades/ I Green** **UPDATE:**	**ONGOING**

MINUTE & ITEM TITLE	ACTION REQUIRED / UPDATE	STATUS
154. Safeguarding Adults Board (SAB) Annual Report 2014/15	Incorporate into HWB Agenda Plan a report from the Service Director, Adult Social Care on work in relation to safeguarding being undertaken with the universities **Action: C Bruin / A Lyne / R Yule** **UPDATE:** On HWB Agenda Plan for 7 July 2016	**COMPLETED**
164. HWB Strategy – Priority 1	The Service Director undertook to find out more about FACET's (Fenland Area Community Enterprise Trust's) provision of courses for people with autism and convey the answer to the Member reporting that these courses had ceased. **Action: M Teasdale** **UPDATE:** Enquiries continue; the findings will be reported to the Member.	**ONGOING**
177. HWB Strategy – Priority 3	Ensure that local organisations, particularly Everyone Health, are included in the new software being installed in GP surgeries which would bring up guidance **Action: V Thomas/CCG** **UPDATE**: Links are being made with the NHS lead for the local 'Directory of Services' and details of relevant public health commissioned services will be provided. In addition, new software which is being introduced into GP practices to support delivery of the NHS Health Check Programme enables practices to record if a referral has been made to lifestyle services following a health check. Provide link to website of Register of Exercise Professionals **Action: R Yule** **UPDATE:** Link included in minutes of meeting	**ONGOING**
178. Prevention Strategy for the Health System Transformation Programme	Set out at start of document how savings are presented, making it clear that they are net savings on top of the sum invested **Action: E de Zoete** **UPDATE:** This change has been incorporated into the latest version of the plan.	**COMPLETED**
180. Community Resilience Strategy	The Service Director: Enhanced and Preventative Services to return to in six months' time with a report setting out in greater detail the work being undertaken under the strategy. **Action: S Ferguson/R Yule** **UPDATE:** On agenda plan for 7 July 2016	**ONGOING**

MINUTE & ITEM TITLE	ACTION REQUIRED / UPDATE	STATUS
	The Board's District Council support officer undertook to liaise with the Service Director on local planning in South Cambridgeshire, with the aim of avoiding duplication and identifying gaps in what was in place **Action: S Ferguson/I Green** **UPDATE:**	
181. Older People's and Adult Community Services Contract	The CCG Chief Strategy Officer and the Executive Director: CFAS were examining various issues including Doddington Court; Chief Strategy Officer to share his response to the Executive Director with Councillor Cornwell **Action: A Vowles** **UPDATE:** Termination of OPACS contract on agenda for 17 March (agenda item 8)	**ONGOING**
182. Planning for the Better Care Fund 2016-17	Chairman to write to the appropriate person or department to protest that it was inappropriate and unacceptable to expect Health and Wellbeing Boards to work to the timeframe laid down for submission **Action: T Orgee/G Hinkins** **UPDATE:** The deadline was cancelled so a letter was not issued on this occasion.	**COMPLETED**
184: Forward Agenda Plan	Add OPACS update to March or May – see 181 above Add update on implementation of Community Resilience Strategy to July – see 180 above **Action: R Yule**	**COMPLETED**
185: Date of Next Meeting	Hold meetings at dates and times identified on County Council Meetings Card **Action: R Yule** **UPDATE:** Electronic invitations sent for 10am on 7 July, 15 September and 17 November 2016, and for 19 January, 30 March and 1 June 2017	**COMPLETED**

Agenda Item No: 4

UPDATE ON CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST – STRATEGIC IMPACT AND DIRECTION

To: Health and Wellbeing Board

Date: 17thMarch2016

From: Jill Houghton, Director of Quality, Safety and Patient Experience, Cambridgeshire and Peterborough Clinical Commissioning Group

1.0 PURPOSE

1.1 This paper outlines the Cambridge University Hospitals NHS Foundation Trust (The Trust; CUHFT) Improvement Plan for quality improvement. This Plan has been designed in order to address issues raised by theCare Quality Commission's (CQC's) Inspection Report, dated 22 September 2015.

2.0 BACKGROUND

2.1 The CQC carried out an announced inspection at CUHFT on 21-24 April and 7 May 2015. This was part of the regular inspection programme. The final report was presented at the Quality Summit in September 2015.

2.2 CUHFT achieved an overall rating of Inadequate. The CQC domain for Caring was rated as Outstanding. However, Effectiveness was rated as Required Improvement, with Safe, Responsive and Well-Led being rated as Inadequate.

2.3 Services for children and young people were rated as Good, with Maternity and Gynaecology, Outpatients, and diagnostic imaging Inadequate. Other services were rated as Requires Improvement.

2.4 The key findings of the CQC report were:

- There was a significant shortfall of staff in a number of areas, including critical care services and those caring for unwell patients. This often resulted in staff being moved from one area of a service to another to make up staff numbers. Although gaps left by staff moving were back-filled with bank or agency staff, this meant that services often had staff with an inappropriate skills mix and patients were being cared for by staff without training relating to their health needs. Despite this patients received excellent care.
- Pressure on surgical services meant routine operations were frequently cancelled and patients were waiting longer than the 18-week referral to treatment standard for operations. Pressure on the outpatients department meant long delays for some specialties and not all patients being followed up appropriately, particularly in ophthalmology and dermatology. There were some outstanding maternity services but significant pressures led to regular closures and a midwife to birth ratio worse than the recommended level.
- Disconnected governance arrangements meant that important messages from the clinical divisions were not highlighted at trust board level.

Introducing the new EPIC IT system for clinical records had affected CUHFT's ability to report, highlight and take action on data collected on the system. Although it was beginning to be embedded into practice, it was still having an impact on patient care and relationships with external professionals.

Medicines were not always prescribed correctly due to limitations of EPIC, although the CQC was assured this was being remedied.

2.5 The full CQC report can be accessed via: http://www.cqc.org.uk/provider/RGT

3.0 SUPPORTING PARAGRAPHS

3.1 CUHFT has developed an action plan – The Trust Improvement Plan – to address the issues raised by the CQC, in collaboration with the CCG and other stakeholders. This is being monitored by the CCG at the Clinical Quality Reviews with the Trust, and these meetings take place monthly. Scrutiny will continue to be provided at the CUHFT Quality and Safety Oversight Group which includes representation from CUHFT, Cambridgeshire and Peterborough CCG, Bedfordshire CCG, NHS England, Health Education England, Monitor, Public Health England and Healthwatch.

3.2 **Introduction to the Plan.**The Trust Improvement plan is set out to provide a single document that brings together the plurality of plans that have been put in place to improve the delivery and efficiency of services and supporting infrastructure at the Trust. It allows the Trust Board of Directors to drive delivery of the range of improvement activities in place, and can be used by the Trust Board of Directors, Internal workstream leads and external stakeholders to track progress in delivering the improvement that the Trust recognises is necessary to provide safe and excellent quality care for all our patients.

3.3 The undertakings agreed with Monitor as a result of the Trust being in breach of its licence across the trust include the need to provide or refresh a series of detailed plans (including but not limited to): a Quality Improvement Plan, a Financial Recovery Plan, the A&E Plan, the Cancer Plan and the RTT(Referral to Treatment) Plan and if deemed necessary a Governance Action Plan (together the 'plans'), which are under development. In totality these plans seek to address the financial, governance, and performance issues the Trust is facing, as well as the concerns raised in the CQC Quality report following their inspection of the Trust.

3.4 Supporting governance arrangements are in place to enable the Trust Board of Directors to:

- Be clear on the progress towards delivery of each plan
- Be clear on the risks to successful delivery of the plans and the mitigations to those risks required; and
- Hold individuals to account for delivery.

3.5 **Purpose.** The improvement plan is in place to enable clear understanding by the Trust of the progress the trust is making in delivering improvement across the whole of its portfolio, and by doing so provide assurance to its regulators and other external stakeholders that it is addressing the deficiencies that have led to it being in Breach of Licence and Special Measures as declared by Monitor on 22nd September 2015. It is an overarching document that summarises the detailed underpinning action plans in place to address discrete areas

of improvement and seeks to both ensure and assure that the interdependencies between plans are being managed effectively. The improvement plan is a dynamic document to be:

- Updated on a monthly basis to demonstrate progress being made against each action; and
- Refreshed on a quarterly basis to ensure it remains fit for purpose and is reflective of the improvement priorities of the Trust.

3.6 **Structure.** The Trust has identified five thematic priority areas for improvement over the next 12 months. For ease of use these have been colour coded within the Improvement Plan as follows:

- Leadership and Accountability
- Strategy
- Quality Improvement
- Operational Capacity
- Financial Recovery

3.7 E-hospital has been pulled out specifically as a key enabler in support of each of these themes.

3.8 The Trust Board of Directors actively agreed undertakings with Monitor and it is therefore the case that these encompass at a high level the areas of concern to be addressed by the Trust. This was signed off by The Trust and submitted to the Care Quality Commission on 7 October 2015.

3.9 In considering the actions specific to Quality Improvement, the Trust has mapped the five priorities within its existing quality strategy, which are mirrored in the Trust's current objectives at all levels of the organisation against the five domains (Well-led, Safe, Effective, Caring, Responsive) used by the CQC in determining the quality of the organisation through inspection. Whilst there are some differences in emphasis there is consensus – and the Trust is therefore confident that the actions being taken to improve quality will both address the concerns of the CQC and support delivery of the Trust's quality strategy.

3.10 Under each priority area the required actions are sub-divided into high-level workstreams which describe:

- The area of concern being addressed
- The action(s) required
- The target date for completion of the action
- The accountable executive sponsor
- The workstream lead responsible for implementing the action (where this is different)
- The RAG (Red, Amber, Green) rating and description of progress
- Key risks and mitigations
- The outcome sought by the action and measurable KPI(Key Performance Indicator)

3.11 Whilst relevant financial analysis is being undertaken, the plan also reflects whether there is likely to be a direct financial impact of the action being taken (e.g. cost of resources to deliver the change required). These financial impacts will be costed and the plan updated accordingly.

3.12 **Progress.** The Trust has been demonstrating and sharing progress against the Improvement Plan through regular Stakeholder Assurance meetings. Recruitment is under way for 9 extra midwives as well as 6 Midwifery Assistants, and the Trust has agreed to invest in recovering Referral to Treatment waiting times. The risks to recovery include: essential refurbishment of theatres which will affect theatre capacity, the junior doctor strike, difficulties in recruitment in certain specialities and increased pressure on the Emergency Department during January/February.

3.13 The Care Quality Commission is inspecting all the areas of the Trust previously rated as inadequate on 9 and 10 February 2016 and will subsequently report on any improvements made since the last inspection. For recent figures and an update on: A&E 4 Hour Performance, Cancer Standards, Diagnostics, and Referral to Treatment (18 weeks), please see Appendix 1. These are so far on a generally positive trajectory.

4.0 RECOMMENDATION/DECISION REQUIRED

4.1 The Board is asked to note the Trust's Improvement Plan for quality improvement, its progress to date, and continued commitment to addressing the issues raised by the CQC.

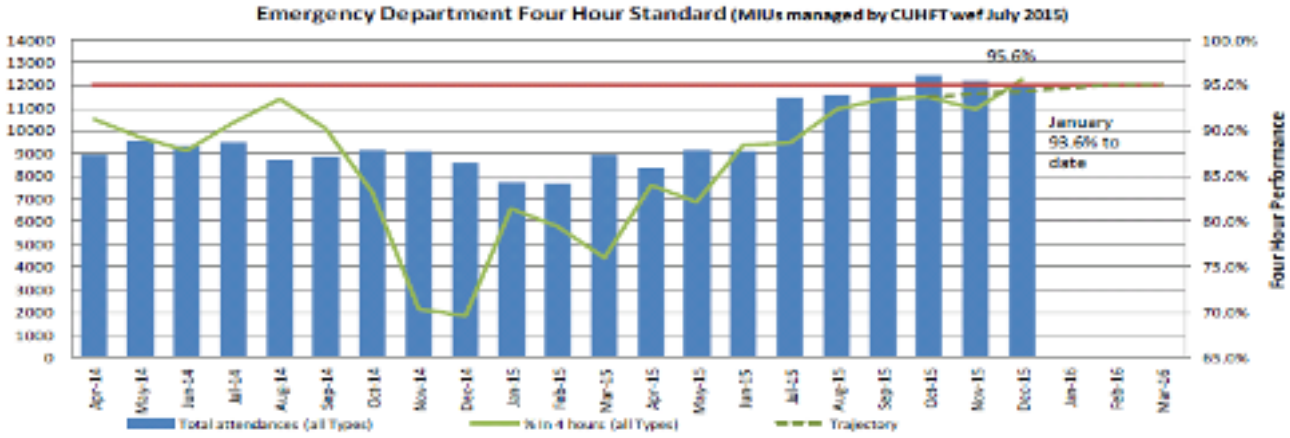
Source Documents	Location
CQC Inspection Report of CUHFT, September 2015	http://www.cqc.org.uk/provider/RGT

Jill Houghton, Director of Quality, Safety and Patient Experience
17 February, 2016

APPENDIX 1 - A&E 4 Hour Performance, Cancer Standards, Diagnostics, and Referral To Treatment (18 weeks): CUHFT (Addenbrooke's) current position

1.1 **A&E 4 Hour Performance**

This performance measure was below the standard prior to the eHospital programme and as you can see from the chart below, performance has steadily improved (green line) over the 2015 calendar year culminating in achievement of the standard in December 2015.



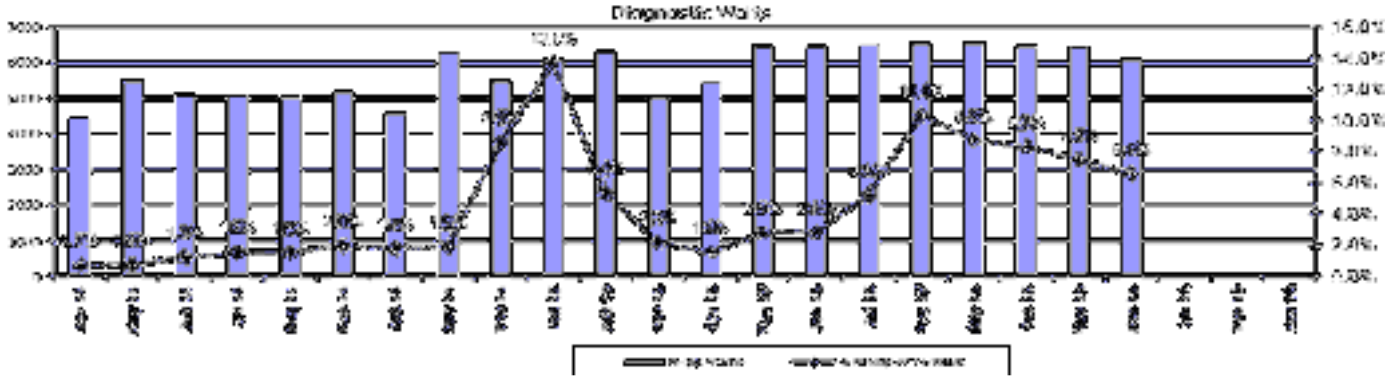
1.2 **Cancer Standards**

Cancer performance has improved dramatically across the Trust over the financial year, culminating in them achieving the required performance levels from October 2015 onwards. The data for December also shows achievement of the standards.

Cancer Standards 15/16	15-16 Q1	15-16 Q2	Oct-15	Nov-15
2Wk Wait (93%)	85.9%	92.3%	97.3%	96.6%
2wk Wait SBR (93%)	88.2%	93.5%	98.8%	97.1%
31 Day FDT (96%)	93.8%	94.5%	96.1%	97.7%
31 Day Subs (Anti Cancer) (98%)	99.5%	100.0%	100.0%	100.0%
31 Day Subs (Other) (93%)	100.0%	100.0%	100.0%	100.0%
31 Day Subs (Radiotherapy) (94%)	98.1%	97.3%	98.8%	98.4%
31 Day Subs (Surgery) (94%)	86.3%	91.7%	98.0%	98.1%
62 Day from Screening Referral (90%)	93.5%	82.5%	92.6%	100.0%
62 Day from Urgent Referral (85%)	74.9%	77.4%	83.5%	81.1%
62 Day from Urgent Referral with reallocations (85%)	**76.9%**	**79.8%**	**87.1%**	**86.4%**
62 Day from Screening Referral with reallocations (90%)	**93.5%**	**82.5%**	**92.6%**	**100.0%**
62 Day from Consultant Upgrade with reallocations (50% - CCG)	64.3%	100.0%	100.0%	80.0%

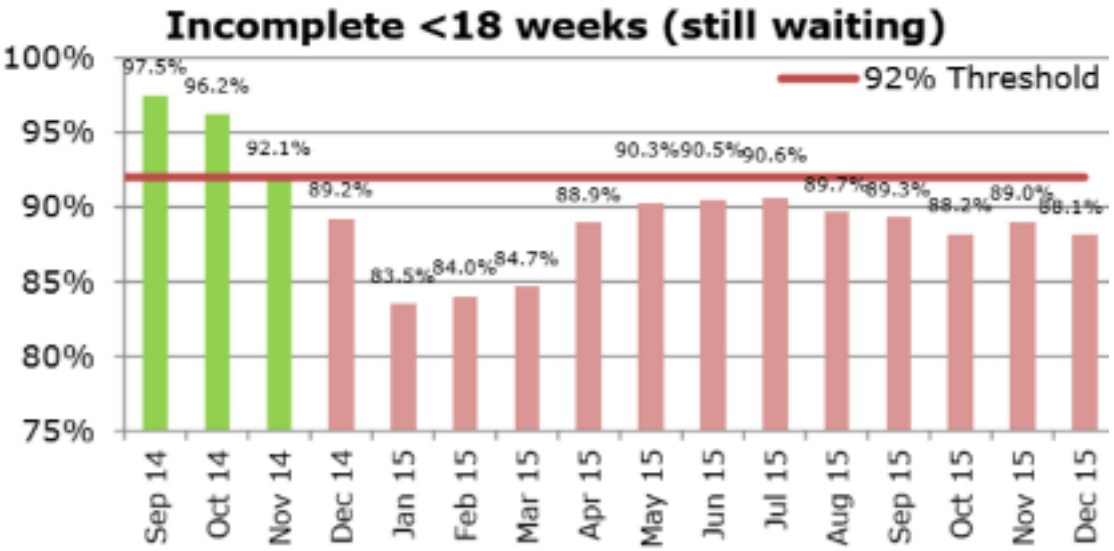
1.3 **Diagnostics**

Diagnostics performance deteriorated in two main areas at the beginning of 2015/16; MRI and Neurophysiology. The chart below shows the gradual improvement since Aug 2015 as more MRI capacity has been brought on stream and further Neurophysiology consultants have been appointed. This is expected to be back within the 99% standard by the end of February 2016.



1.4 **Referral To Treatment (18 weeks)**

The Trust has invested £2.25m in recovery of this area and has agreed a recovery trajectory of March 2016. However issues with recruitment in key specialties namely Ophthalmology and Cardiology mean that this recovery date is unlikely. They have also had to close their Neurology theatres for maintenance.



Agenda Item No: 5

A PERSON'S STORY

To: Health and Wellbeing Board

Date: 17 March 2016

From: Cornelia Guell, Centre for Diet and Activity Research (CEDAR)

1.0 PURPOSE

1.1 To outline the person's story being presented to the Health and Wellbeing Board.

2.0 BACKGROUND

2.1 The Cambridgeshire Health and Wellbeing Board have requested that a person's story be presented at the start of each meeting. The stories being presented at this meeting will set out three individuals' experiences with active living in Cambridgeshire and Norfolk, taken from personal stories shared in qualitative research projects undertaken by CEDAR.

2.2 The stories are illustrations of how people experience their physical and social environments for healthy living. A discussion regarding the specifics of these people's experiences is not envisaged; the generalised learning and insight that can be taken from the experience being more pertinent.

3.0 SUPPORTING PARAGRAPHS

3.1 The story being told offers the Health and Wellbeing Board an opportunity to consider the experiences of individuals with supportive and supportive environments for physical activity in Cambridgeshire and adjacent counties. It will provide information about some of the challenges experienced in trying to engage in active living and what has been most helpful. It will identify the opportunities that could be created to facilitate health-promoting environments.

4.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

4.1 The case studies relate to Priority 5 of the Cambridgeshire Health and Wellbeing Strategy; to create a sustainable environment in which communities can flourish.

4.2 They also relate to Priority 3; to encourage healthy lifestyles and behaviours in all actions and activities while respecting people's personal choices.

5.0 IMPLICATIONS

5.1 There are no direct implications arising from this report.

6.0 RECOMMENDATION

6.1 The personal stories are being told as context for the remainder of the meeting.

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

Agenda Item No: 6

PROGRESS REPORT ON HEALTH & WELL-BEING STRATEGY PRIORITY 5: CREATE A SUSTAINABLE ENVIRONMENT IN WHICH COMMUNITIES CAN FLOURISH

To: Health and Wellbeing Board

Date: 17 March 2016

From: Iain Green, Senior Health Improvement Specialist, Cambridgeshire County Council, Public Health

1.0 PURPOSE

1.1 The purpose of this report is to update members on progress with the Health & Wellbeing (HWB) Strategy Priority 5: Create a sustainable environment in which communities can flourish.

2.0 BACKGROUND

2.1 Background information is provided in the associated HWB themed meeting template, which is attached as an appendix to this paper.

3.0 SUPPORTING PARAGRAPHS

3.1 Aims set out in Priority 5

For ease of reference, the aims set out in Priority 5 were as follows:

Develop and maintain effective, accessible and affordable transport links and networks, within and between communities, which ensure access to services and amenities and reduce road traffic accidents.

Ensure that housing, land use planning and development strategies for new and existing communities consider the health and wellbeing impacts for residents in the short and long term.

Encourage the use of green, open spaces including public rights of way, and activities such as walking and cycling.

Seek the views of local people and build on the strengths of local communities, including the local voluntary sector, to enhance social cohesion, and promote social inclusion of marginalised groups and individuals.

The progress on priority 5 has mainly focused on the production of two Joint Strategic Needs Assessments and the embedding of those findings within other strategies and the work of partners.

For ease these aims above have been grouped into, Transport, Housing & Land Use Planning, and Road Safety.

3.2 Transport

3.2.1 Transport and Health Joint Strategic Needs Assessment (T&HJSNA)

Introduction

At its meeting on 30 April the Health and Wellbeing Board agreed and adopted the Transport and Health Joint Strategic Needs Assessment (JSNA) 2015. The Board commented and agreed that "*There was widespread support for the proposal that officers should investigate and identify those areas of partnership strategic work / delivery strategies / work streams that the JSNA could help influence. These could include planning, transport strategies, City Deal etc.*" Officers were tasked with further investigative work and were asked to report back to a future Board.

Progress to Date

Communication of overall findings

The T&HJSNA has been presented at:

- East Cambridgeshire District Council (ECDC) Joint Planning and Transport Steering Group, 25th September 2015.
- Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) Clinical and Management Executive Team, 16 October 2015
- *Ongoing action: continued communication of transport and health issues to key stakeholders*

Dates to take the JSNA to the other District Council Management Teams are still to be confirmed.

3.2.2 Input into the Local Transport strategies

Transport Strategy for East Cambridgeshire

- Presentation on the T&HJSNA findings to ECDC Joint Planning and Transport Steering group to coincide with the presentation of the Transport Strategy for East Cambridgeshire (TSEC)
- Public Health have worked with colleagues in the Economy, Transport and the Environment, department at the County Council to embed public health outcomes into the TSEC.
- Consultation with the public on the TSEC will take place during February-March to which public health have had an input.

A similar approach is likely to be taken for the Local Transport Strategies for Huntingdonshire and Fenland in due course.

3.2.3 Air Quality

Low Emission Bus Bid support

- Public Health provided support to the Stagecoach Low Emission Bus bid through a letter of support from DPH and data on the health impacts of air pollution

Defra consultation around Local Air Quality Management guidance

- Public Health through the local air quality management meeting of Scientific officers from the districts have formally responded to the Defra consultation on air pollution, using the JSNA as an evidence base.

3.2.4 Non-emergency Patient Transport Services (NePTS)

The NePTS procurement is ongoing at the CCG with contract due to start in September 2016. Bid is for approximately £6 million and approximately 180,000 trips, air quality

concerns and links to the "Total Transport" have been made to ensure the procurement takes a wide approach to transport and access to health care.

3.2.5 Active Transport

Local Sustainable Transport Fund (LSTF)

- The findings of the T&HJSNA are now used as a criterion for awarding bids made under the LSFT.

Active Travel – Fenland discussion

- Discussion and provision of Fenland data and maps regarding areas of low active travel to Fenland District Council

Public Health Reference Group

- Active Travel is an element of the Public Health Reference Group's Implementation Planning and projects are being taken forward with District Councils as part of a wider Workplace programme.
- It will also be addressed in the developing Healthy Weight strategy which includes both physical activity and diet

Transport for Cambridgeshire (TfC)

- Liaison is ongoing with TfC regarding their program

3.2.6 Engage with local authorities and CCG teams around patient transport

Cambridgeshire Future Transport and the Total Transport Pilot Key areas of interest include collaboration/integration with NHS both in terms of NePTS the potential for the use of a single number for contacting both Community Transport and NePTS. There are links to improved hospital discharge transport options and the use of travel buddies to build independence.

Working with Fenland District Council and the acute hospitals to see if transport is an issue with both do not attend rates and delayed transfers of care.

3.3 Housing and Land Use Planning

3.3.1 New Housing Developments and the Built Environment JSNA 2016

The JSNA has been produced and is due to be agreed at this meeting. It provides an overview and context of the new growth in Cambridgeshire and summarises the key demographics for the main growth areas that are being built now along with population forecasts for the new areas of development. It provides an evidence base on the links between the Built Environment and Health.

3.3.2 Cambridgeshire Sub Region Housing Board, links have been made between the Cambridgeshire Sub Region Housing Board and Public Health to further embed public health outcomes into the work of the board, with an open invite for Public Health to sit on the Board.

3.3.3 Walking, Cycling and green space – the Local Nature Partnership is looking at a "Green Prescription" service for people to exercise in nature.

3.4 Road Safety

The key themes for the Cambridgeshire and Peterborough Road Safety Partnership are in place to guide the work of road safety professionals across the partnership area in meeting the Partnership's casualty reduction targets.

The key themes are:

- Collisions involving young people (age 17-25)
- Collisions involving pedal cycles
- Collisions involving motorcycles
- Collisions on rural roads (including inappropriate speed)

The key themes are targeted through partnership working, incorporating all organisations included in the Cambridgeshire and Peterborough Road Safety Partnership (CPRSP). The partnership has commenced to allow closer working between CPRSP and medical professionals including trauma specialists at Addenbrooke's Hospital. This involves using a victim's NHS number to track longer term recovery through the health and social care system from point of collision and beyond.

4.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

4.1 This is an update on Priority 5 of the HWB strategy.

5.0 IMPLICATIONS

5.1 This is an update paper for members, so there are no new proposals contained within it.

6.0 RECOMMENDATION/DECISION REQUIRED

6.1 Members are asked to note this update.

Source Documents	Location
Cambridgeshire and Peterborough Road Safety partnership Handbook ANNUAL STATISTICS SUMMARY – 2014	http://www.cambridgeshire.gov.uk/info/20081/roads_and_pathways/136/road_safety
Health and Wellbeing Strategy	http://www.cambridgeshire.gov.uk/info/20004/health_and_keeping_well/548/cambridgeshire_health_and_wellbeing_board
Transport and Health JSNA	http://www.cambridgeshireinsight.org.uk/JSNA/Transport-and-Health-2014/15

Appendix A: Health and Wellbeing Board themed meeting template

	Meeting theme: ***Priority 5 – Create a sustainable environment in which communities can flourish.***	
	Focus areas: • Develop and maintain effective, accessible and affordable transport links and networks, within and between communities, which ensure access to services and amenities and reduce road traffic accidents. • Ensure that housing, land use planning and development strategies for new and existing communities consider the health and wellbeing impacts for residents in the short and long term. • Encourage the use of green, open spaces including public rights of way, and activities such as walking and cycling. • Seek the views of local people and build on the strengths of local communities, including the local voluntary sector, to enhance social cohesion, and promote social inclusion of marginalised groups and individuals.	
1.	**Overarching partnership delivering against this priority and how this links to the Health and Wellbeing Board**	Active Travel is an element of the Public Health Reference Group's Implementation Planning, and projects are being taken forward with District Councils as part of a wider Workplace programme. There are a number of partnerships that oversee different aspects of transport and land use planning, use of green space etc. The overarching partnership is the Health and Wellbeing Board. The five local Health Partnerships (LHP) are linked to the Health and Wellbeing Board by elected members from each of the District and City Authorities. **Cambridgeshire and Peterborough Road Safety Partnership** – Which guide the work of road safety professionals across the partnership area in meeting the Partnership's casualty reduction targets. **Cambridgeshire Future Transport –** is a County Council Member Group with District partners looking at possible synergies for socially necessary subsidized transport, both within the Council and with other public bodies and voluntary sector transport providers.

		District and City Local Health Partnerships The District and City Councils host and sponsor the local Health partnerships. **Remit and Governance** Each Partnership has its own governance structure and Terms of Reference. The key themes being: • To provide a forum for the wider engagement of parties interested in health and wellbeing, including health inequalities so that they may jointly evolve solutions to protect and improve the health and wellbeing of residents • To provide leadership and strategic direction to local strategic partner organisations to enable them to contribute to improving health and well-being • To provide local information, to the Cambridgeshire Health and Wellbeing Board and Districts' Forum, related to health and well-being and advise on the impact of any relevant policy changes, service changes, proposals and/or identified need. • To consider existing issues or those likely to arise, that may require interventions to protect the health of people determinant of health, improve public health or affect change to services impacting on health/care services. **Membership of the Partnerships** The LHPs have representation from a wide range of partners, and the makeup of each LHP represents local need. • Elected Members from District/City/County Councils • Officers from the Councils • Cambridgeshire Health and Well-Being Board • Cambridgeshire County Council Adult (Children, Families and Adults – Social Care, Adult Learning, Public Health) • Cambridgeshire and Peterborough Clinical Commissioning Group and Local GP Commissioning Groups • GP Patient Representation Groups • Hinchingbrooke Health Care NHS Trust

		• Cambridge University Hospitals Foundation Trust • Older People Services • HealthWatch Cambridgeshire • Community Voluntary Service, including; Age UK, CareNetwork, CAB • Housing Associations
2.	**Recent Joint Strategic Needs Assessments (JSNAs)**	Transport and Health JSNA 2015 http://www.cambridgeshireinsight.org.uk/JSNA/Transport-and-Health-2014/15 New Housing Developments and the Built Environment JSNA 2016 (*Draft - to be presented for agreement*)
3	**a) Integrated partnership strategy or strategies in the health and care system delivering on this priority**	Most, if not all, of this work falls outside the traditional health and care system, and the strategies tend to be either a statutory requirement on one organisation or tend to be narrowly focused on one topic, however these strategies will have had input from a wide range of organisations but public and non-public as part of a public consultation exercise in drafting these strategies/plans. The main applicable strategies are: • The Cambridgeshire Local Transport Plan • The Local Plans (Planning and Development Control) for each of the 5 District/City Councils in Cambridgeshire. • The Cambridgeshire and Peterborough Road Safety Action Plan.
4.	**Joint commissioning and section 75 arrangements**	Not applicable to this priority
5.	**Alignment of NHS Cambridgeshire and Peterborough Clinical Commissioning Group's (CCG) commissioning plans with this priority**	**Cambridgeshire and Peterborough CCG Non-Emergency Patient Transport Procurement** - engagement and agreement with CCG around Non-Emergency Patient Transport (NePTS) to ensure that the Transport and Health JSNA findings and Total Transport pilot are considered as part of the procurement process.

CAMBRIDGESHIRENEW HOUSING DEVELOPMENTS AND THE BUILT ENVIRONMENT JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)

To: Health and Wellbeing Board

Date: 17March 2016

From: Iain Green, Senior Health Improvement Specialist

1.0 PURPOSE

1.1 This report is to introduce the CambridgeshireJSNA on New Housing Developments and the Built Environment. The full JSNA is attached for the Board's approval.

2.0 BACKGROUND

2.1 The Health and Wellbeing Board,at their meeting on 15 January 2015, requested a JSNA on "New Communities".The impacts of new housing developments and the built environment on health are complex, and each new development poses very different challenges. The largest and most complex such as Northstowe will be built over relatively long periods of time (15+ years). This prolonged period will likely have unpredictable impacts on community identity and cohesion, and in turn on mental health and wellbeing, the "needs" of a new community in year one of occupation are likely to be different from the "needs" at the end of the construction many years later.

A scoping paper was submitted and approved by the Health and Wellbeing Board on 17 September 2015agreeing that the New Housing Developments and the Built Environment JSNA should focus on these priority areas where the new developments and/or the built environment impacts health: Built Environment; Social Cohesion; Assets and Services; and NHS Commissioning with a focus on case studies on existing new communities.

3.0 SUPPORTING PARAGRAPHS

3.1 The full JSNA report is attached. Pages 1-14 provide an executive summary.

3.2 This JSNA focuses on four aspects of new communities that impact health: the built environment, Social Cohesion/Community Development, assets and services, and NHS Commissioning. The JSNA has a demography section at the beginning of the document which outlines the key profiles for the GP practices in the existing new communities. For each section, the JSNA provides:

- **Key Findings.**
- **Introduction**: a review of the evidence and literature of the health impact.
- **Local Data:** analysis of local Cambridgeshire data.
- **Case studies** relevant to the section are incorporated within the body of the section.

3.3 The new housing developments and the built environment stakeholder workshop was held on 28 July 2015and was well-attended withapproximately 40 representatives from Cambridgeshire County Council, District Councils, NHS organisations, academic groups, 3rd sector organisations and Healthwatch. The aim of this workshop was to:

- Capture stakeholders' perspectives on the scope of this JSNA – priorities, questions to be answered and how to approach these
- Increase awareness and understanding of the purpose of the JSNA
- Identify stakeholder priorities and "place making" intentions (including commissioning and service delivery.

Feedback from this event significantly shaped the specific focus for each priority area.

3.4 Working groups were subsequently created forNHS Commissioning, Assets and Service, Community Cohesion. These working groups had significant input from Cambridgeshire County Council (Children, Families and Adults), District Councils, 3rdsector organisations.

4.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

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

5.0 IMPLICATIONS

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

5.2 This JSNA highlights the opportunities for future focus on:

Demography:

- The age profile breakdown for GP Practice populations serving new developments show the that majority have an age structure similar to the Clinical Commissioning Group(CCG) area, except for Cambourne which shows spike in the 0-14, and 25-44 age groups

- Average Household size in new developments ranges from 2.6-2.8 the multiplier currently used is 2.5

- Birth rates per 1000 female population aged 15-44 in all but one of the growth areas are higher than the CCG area. The rate in Loves Farm is twice the CCG area rate and the rate in the southern fringe area is lower

- The population forecasts for the new developments all show a similar pattern with a steep increase in the population aged 20-64 in the first 10-20 years of the development with a slow decline then onwards. The 0-19 population has a steady increase during this time but not so steep, reflecting that not all residents moving into a new develop have or will have children. The 65+ age group shows a steady increase year on year but starts from a low base, suggesting that the increase a mainly due to a naturally ageing population rather than a large influx of older people moving into new developments.

The Built Environment

- There is a lack of consistency across the Local Authority Local Plans with regard to the inclusion of policies to improve health. The main policies to include in future plans need to focus on green infrastructure, active travel, suicide prevention, Health Impact Assessment requirements.

- There is a lack of consistency and understanding on the funding of Primary Care facilities and securing Community Infrastructure Levy/Section 106 funding

- Importance of accessible green space and parks, which need to be designed to maximise potential use. There is a need for an open spaces specific design code to complement the policies on open space within Local Plans, design code should cover provision of paths, cycleways and unstructured routes through and to the green space, provision of toilets and other facilities.

- The importance of providing infrastructure to enable people to make more active travel choices.

- Securing what can be perceived as "nice to have" infrastructure as part of the overall design of new development to support healthy ageing, e.g. street furniture, public toilets.

- The need to consider suicide prevention and public mental health as part of the design of high rise private and public buildings to limit their access and opportunities for suicide.

Social Cohesion and Community Development

- Community development work needs to continue to focus on building resilient empowered communities rather than dependent communities. This should be done together with other key agencies. Responsibility lies with all stakeholders and that all statutory agencies can benefit from active participation in building resilient empowered communities

Assets and Services

- Planning processes – A joint strategy is needed to develop a way to engage and attract the leisure market into new communities early in the development. This could be through ensuring the units are built early, opening units at discounted/nil business rate, allowing locals to use the units as pop up shops etc.

- Further research to understand the length that referral to Social Services cases are open, and what was the primary reason for referral to better conclude if there are particular social reasons for referrals that can help establish whether new communities are prone to certain social needs.

- During the pre-application stage of the planning process, services and the community should be engaged and a working group of people centred support established so that there is a clear co-ordinated effort and communication channels between services and the planning of the new community. This will enable co-ordinate response to planning applications through to service/support delivery. Where possible these groups should be led by the community whether this is parish council, residents association etc. with

support from the local authority. Where the community is not willing or able to lead, the local authority will lead but with a clear handover strategy for when the community is able to lead. These groups will have engagement from the widest group of services (but not necessarily attending physically) and agree, achievable action and communication plans

- Additional support to be provided to schools to enable them to deal with the additional challenges that new community schools can expect to face. Ensure that during the selection process these challenges are clearly detailed and ask how the prospective sponsor of the school would face these challenges and work with the community to help secure positive outcomes for all new community schools.

- Provide incentives to attract full day care/early years providers to developments, such as free plots of serviced land etc.

- Further research into categories of crime committed and to look into other new communities and compare them to the County.

NHS Commissioning

- The current engagement between Planning Authorities, CCG and NHS England need to be improved.

- NHS England/CCG need a robust case when seeking Section 106/Community Infrastructure Levy (CIL) contributions with a defined need and costed solution.

- Ensure that all health partners including Primary Care Practices are consulted on planning applications. In addition, health partners should come together at the earliest opportunity to discuss needs at strategic sites.

6.0 RECOMMENDATION/DECISION REQUIRED

6.1 The Health and Wellbeing Board is asked to approve the JSNA and to note the findings and the areas which are highlighted for further work.

Source Documents	Location
Transport and Health JSNA 2015 Housing JSNA (will be published on Cambridgeshire Insight website once approved)	http://www.cambridgeshireinsight.org.uk/jsna Room 112, Shire Hall, Cambridge

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Cambridgeshire
County Council

New Housing Developments and the Built Environment JSNA

2015/16

TABLE OF CONTENTS

EXECUTIVE SUMMARY

DEMOGRAPHY

Cambridgeshire was the fastest growing county authority between 2001 and 2011 and isexpected to continue to grow. The number of people living in the county is expected to increase from 627,000 in 2012 to 769,000 in 2031.

This forecasted 25% increase in the size of Cambridgeshire's population (to just over 800 thousand) over the next 20 years linked to the expected changing demographic shape of the county are key considerations for health and social care service providers, local authorities, developers, the voluntary and community sector.

A common emerging development across the districts is the rapid growth of the older population, and its increasing share of the total population over the next 20 years. The over 65s are forecast to grow by almost 80% between 2013 and 2036, within this the over 90s to grow by more than 250%, from 5,600 to 19,700.

Summary – key demographic and health data

- It is estimated that there are 627,000 people living in Cambridgeshire, with a bulge seen in 40-49 year olds, which is due to high births in the 1960, and a higher number of 60-69 year olds are the post war baby boomers.
- Forecasts suggest that the population of Cambridgeshire is set to increase by 25% over the next 20 years, with the majority of the increase seen in Cambridge City and South Cambridgeshire. This is associated with a forecast increase in the number of new dwellings between up to 2036 of 73,000.
- Population trends in the GP Practice populations serving new developments show a steady increase each year from 2006 to 2015, except the Bar Hill Practice, which has remained constant indicating that the population in Bar Hill has matured and is settled.
- The age profile breakdown for GP Practice populations serving new developments show the that majority have an age structure similar to the CCG area, except for Cambourne which shows a spike in the 0-14, and 25-44 age groups.
- The average household size in new developments ranges from 2.6 to 2.8.

THE BUILT ENVIRONMENT

Place and space have an impact on health and wellbeing and individual actions to improve lifestyle or health and wellbeing status are likely to be influenced by the environmental and socioeconomic context in which they take place. The term "built environment" includes open space, networks and connectivity between areas as well as the physical structures. This includes the places where people work, live, play and socialise. The connections between these spaces, both manmade and natural features are also important. The built environment includes several material determinants of health, including housing, neighbourhood conditions and transport routes, all of which shape the social, economic and environmental conditions for which good health and wellbeing is dependent.

There is strong evidence that the following aspects of the environment affect heath and wellbeing:

- Generic evidence supporting the built impact on health
- Green space
- Developing sustainable communities
- Community design (to prevent injuries, crime, and to accommodate people with disabilities)
- Connectivity and land use mix
- Communities that support healthy ageing
- House design and space
- Access to unhealthy/“Fast Food”
- Health inequality and the built environment

The planning system involves making decisions about the future of cities, towns and the countryside. This is vital to balance the desire to develop the areas where we live and work with ensuring the surrounding environment isn't negatively affected. It includes considering the sustainable needs of future communities.

In order to ensure health impacts are assessed and successful outcomes are achieved, the opportunities to include health related policies in local planning policy documents and local planning guidance should be sought.

The main findings from both the evidence and the review of the five local plans within Cambridgeshire show that:

- There is a lack of consistency across the Local Authority Local Plans with regard to the inclusion of policies to improve health. The main policies to include in future local plans need to focus on green infrastructure, active travel, suicide prevention, Health Impact Assessment requirements.

- There is a lack of consistency and understanding on the funding of Primary Care facilities and securing Community Infrastructure Levy/Section 106 funding.

- Importance of accessible green space and parks, which need to be designed to maximise potential use. There is a need for an open spaces specific design code to complement the policies on open space within Local Plans, design code should cover provision of paths, cycleways and unstructured routes through and to the green space, provision of toilets and other facilities.

- The importance of providing infrastructure to enable people to make more active travel choices.

- Securing what can be perceived as “nice to have” infrastructure as part of the overall design of new development to support healthy ageing, e.g. street furniture, public toilets.

- The need to consider suicide prevention and public mental health as part of the design of high rise private and public buildings to limit their access and opportunities for suicide.

- The NHS Local Estates Plan should be reflected in the District/City Councils local plans and Infrastructure Delivery Plans.

SOCIAL COHESION/COMMUNITY DEVELOPMENT

There is a marked difference between those occupying private rented market homes and other tenures in the amount of time those occupiers intend to stay in those properties, with the majority intending to stay less than three years.

The occupiers in new developments show a difference in occupations compared to the working population as a whole with more residents employed in the: managers and senior officials, associate professional and technical occupation sectors and less in the skilled trade, sales and customer service, process, plant and machine, and elementary occupationsectors.

The main findings from the evidence show that the evidence on the need for community development in the early stages of new developments is strong, however, more research is needed locally into the measures of and approaches taken to improve social cohesion and community resilience in new developments, and the funding opportunities available to secure this. In addition, community development work needs to continue to focus on building resilient empowered communities rather than dependent communities. This should be carried out with other key agencies. Responsibility lies with all stakeholders and that all statutory agencies can benefit from active participation in building resilient empowered communities.

ASSETS AND SERVICES

Of the larger new communities in Cambridgeshire, feedback from some frontline practitioners, including housing, children's social care and family workers, report that they are seeing higher needs in the initial years in new communities. Using data from some of the new communities in Cambridgeshire we have analysed whether these reports of higher needs in new communities are translating into increased utilisation of health and social care services.

From data available, in three of the four new communities there are higher referral rates to higher tier children's services, expected/average referrals to lower tier children's services and very low use of adult social care. For children's services, Orchard Park has very low usage of any children's services at all tiers (data was not available to assess adult social care).

The main findings from the evidence show that a joint strategy is needed to develop a way to engage and attract the leisure market into new communities early in the development. This could be through ensuring the units are built early, opening units at discounted/nil business rate, allowing locals to use the units as pop up shops etc.

Further research to understand the length that referral to Social Services cases are open, and what was the primary reason for referral to better conclude if there are particular social reasons for referrals that can help establish whether new communities are prone to certain social needs.

During the pre-application stage of the planning process, services and the community should be engaged and a working group of people centred support established so that there is a clear co-ordinated effort and communication channels between services and the planning of the new community. This will enable co-ordinate response to planning applications through to service/support delivery. Where possible these groups should be led by the community

whether this is parish council, residents association etc. with support from the local authority. Where the community is not willing or able to lead, the local authority will lead but with a clear hand over strategy for when the community is able to lead. These groups will have engagement from the widest group of services (but not necessarily attending physically) and agree, achievable action and communication plans

Additional support to be provided to schools to enable them to deal with the additional challenges that new community schools can expect to face. Ensure that during the selection process these challenges are clearly detailed and ask how the prospective sponsor of the school would face these challenges and work with the community to help secure positive outcomes for all new community schools.

Provide incentives to attract full day care/early years providers to developments, such as free plots of serviced land etc.

Further research into categories of crime committed and to look into other new communities and compare them to the rest of the county.

NHS COMMISSIONING

The NHS Commissioning landscape is complex with commissioners at different levels (from local to regional to national) commissioning different services which make up the NHS.

The main findings from the evidence show that the current engagement between Planning Authorities, CCG and NHS England need to be strengthened, with NHS England and the CCG needing robust cases when seeking Section 106/CIL contributions with a defined need and costed solution. In addition all health partners including Primary Care Practices are consulted on planning applications. and health partners should come together at the earliest opportunity to discuss needs at strategic sites.

1. INTRODUCTION

1.1. CONTEXT – WHAT IS THE BACKGROUND TO THIS JSNA?

1.1.1 What is the scale of growth across Cambridgeshire?

Table 1: Cambridgeshire and Districts population estimates mid-2013 (Totals may not add due to rounding))

Local Authority Area	2011 census	2012 Mid-year estimate	2013 Mid-year estimate	% Change 2011-2013	% Change 2012-2013
Cambridge City	123,900	126,500	128,000	3.3%	1.2%
East Cambridgeshire	83,800	84,700	85,600	2.1%	1.1%
Fenland	95,300	95,600	95,600	0.3%	0.0%
Huntingdonshire	169,500	171,100	175,700	3.7%	2.7%
South Cambridgeshire	148,800	149,300	150,200	0.9%	0.6%
Cambridgeshire	**621,200**	**627,200**	**635,100**	**2.2%**	**1.3%**

Source: CCC R&P 2013 mid-year estimates & ONS 2011 Census figures

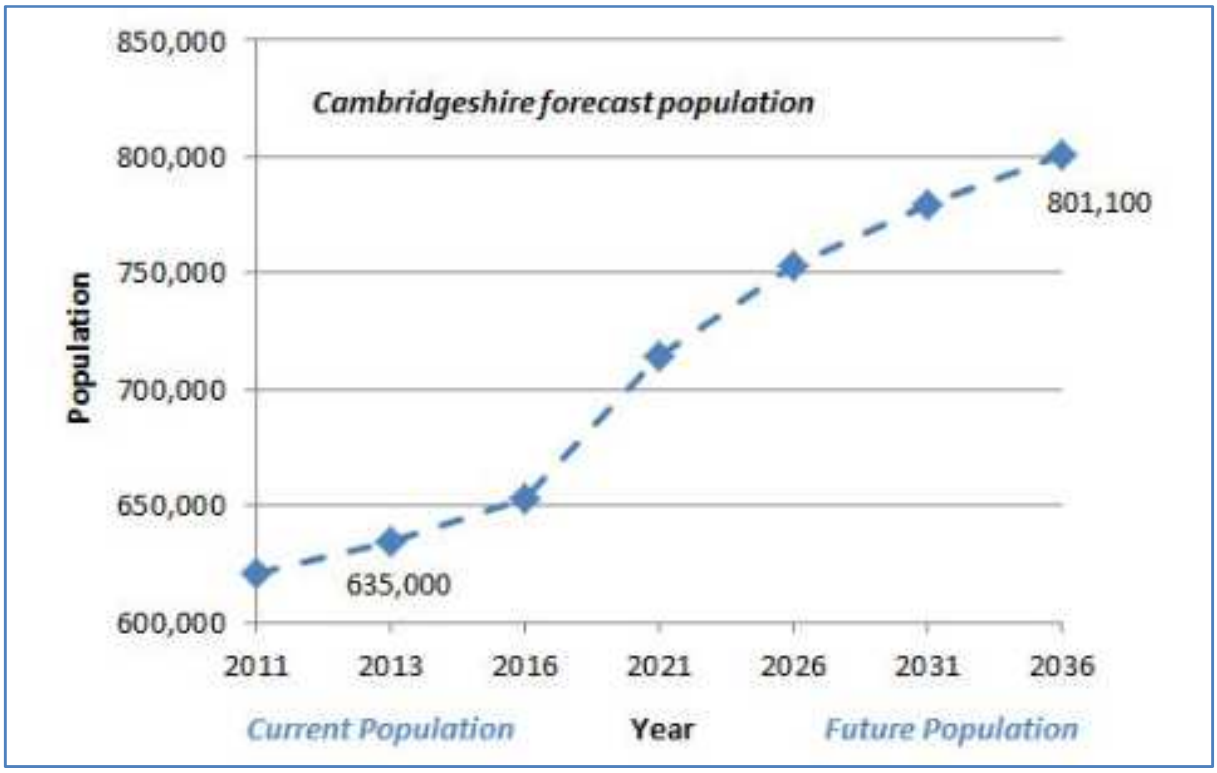
Cambridgeshire was the fastest growing county authority between 2001 and 2011 and isexpected to continue to grow. The number of people living in the county is expected to increase from 627,000 in 2012 to 769,000 in 2031.

This forecasted 25% increase in the size of Cambridgeshire's population (to just over 800 thousand) over the next 20 years linked to the expected changing demographic shape of the county are key considerations for health and social care service providers, local authorities, developers, the voluntary and community sector to name but a few.

Cambridgeshire's settlement pattern is dominated by Cambridge City, which accounts for 20% of the county's population. Most settlements are small, with only 19 of Cambridgeshire's 238 parishes (including Cambridge) having populations larger than 5,000 residents, and only 10 cities/parishes with more than 10,000. Three fifths (60%) of Cambridgeshire's population live in those 19 parishes

The 2013 mid-year estimates show that the development in the new parish of Cambourne now places it above Littleport in order of ranked population size compared to 2012.

Figure 1: The Cambridgeshire Research Group's 2013 mid-year population estimates, along with CRG's forecasts for 2016, 2021, 2026, 2031 and 2036



Source: Cambridgeshire County Council Research Group

The population pyramids for each of the five districts, Cambridge City, East Cambridgeshire, Fenland, Huntingdonshire and South Cambridgeshire, show some variations across the districts, notably a higher population in their 20s in Cambridge City (due to the high numbers of students and young professionals). A common emerging development across the districts is the rapid growth of the older population, and its increasing share of the total population over the next 20 years. The over 65s are forecast to grow by almost 80% between 2013 and 2036, within this the over 90s to grow by more than 250%, from 5,600 to 19,700.

The growth in the working age and children sectors is forecast to be less dramatic. This means the dependent population's share of the total population is growing whilst the working age population's proportion of the total is shrinking.

- The rise in the number of births in recent years is reflected in the higher numbers of under 5s.
- The bulge seen in 40-49 year olds is due to high births in the 1960's.
- The higher number of 60-69 year olds are the post war baby boomers.
- The county is seeing a significantly ageing population (the extent of this varies by district).
- The pyramid for Cambridge City is different to other districts. This is predominantly due to a high student and young professional population (20-24 years).

Population pyramids for the five districts within Cambridgeshire are available at http://www.cambridgeshireinsight.org.uk/poppyramids

1.1.2 Where is the growth happening?

Table 2: Number of New Houses from the District Council's Local Plans

Local Authority	Number of new dwellings	Local Plan Period	SMHA Requirement	Comments
Cambridge City	14,000	2011-2031	14,000	Greater Cambridge Area (City and South Cambs) total is 33,500
South Cambridgeshire	19,500	2011-2031	19,000	500 added following consultant's study
East Cambridgeshire	11,500	2011-2036	13,000	Shortfall addressed by Peterborough area
Huntingdonshire	17,000	N/A	17,000	Local Plan not yet submitted
Fenland	11,000	2011-2031	12,000	Shortfall addressed by Peterborough area
Cambridgeshire	73,000			

This growth is happening across the county, most of which is happening in the south of the county.

Table 3: Major Growth Sites across the county

District	Site Name	Number of Dwellings	Status
Cambridge City and South Cambridgeshire	Cambridge North West	up to 3,000	Primary school opened September 2015.
	Darwin Green 1 & 2	• DG1 - 1593 • DG2 - 1100	Darwin Green 1 granted outline permission and s.106 signed
	Southern Fringe	4,100	Building work started, and occupation started for Trumpington Meadows site Due for completion 2028
	WING	Up to 1,300	Awaiting viability assessment prior to Planning Committee
South Cambridgeshire	Northstowe	up to 10,000 (phase 1 - 1,500)	Phase 1 granted outline planning permission Work on infrastructure has started Phase two outline permission granted (subject to signing of s.106 agreement).
	Cambourne West	2,350	Application has been submitted
	Bourn Airfield	3,500	Site in proposed Local Plan Planning Application expected2016
	Waterbeach	Up to 9,000	Site in proposed Local Plan Early consultations started

Huntingdonshire	Alconbury Weald	Up to 5,000	First occupations due summer 2016
	Wintringham Park and Loves Farm 2	up to 2,800 and 1,020 at Loves Farm 2	Application approved subject to signing Sec 106 No timescales for Loves Farm 2
	Wyton	4,500	Application expected2016
	Bearscroft	753	
East Cambridgeshire	Ely North	up to 3,000 across two sites	First phase of 800 homes approved
Fenland	Hatchwood Park, March	1,450	
	Hallam Land, Chatteris	1,000	

1.1.3 House Prices and Affordability in Cambridgeshire

Affordability of housing is a key issue for Cambridgeshire, those people on lower incomes find it particularly hard to access the private housing market. This is due to a number of factors including changes to benefits, availability of homes that are in the right location and of the right type. This includes many households that form key staff for organisations providing health, social care and service industries.

The highest average house price in Cambridge of £483,000(1) is up by £50,629 compared to September 2014. South Cambridgeshire saw a slightly bigger increase, up by £50,790, and the average rise across England in the past year was more than £20,000, the East of England was more than £26K.

There is a pattern of higher prices in the south and the west of the Cambridge sub-Regional Housing Board (CRHB) and lower to the north and east.

The Cambridge sub-Regional Housing Board (CRHB) area consists of: Cambridge City, East Cambridgeshire, Fenland, Huntingdonshire, South Cambridgeshire, Forest Heath and St Edmundsbury.

The average prices used are based on sales and valuation data using prices averaged over the previous six months.

Average prices over time inCambridge and South Cambridgeshire are noticeably higherthan in other districts, and rising more quickly. The trendsfor England and the region are very similar.

Ratio of House Price to Income
This data is based on Hometrack's house price data (both salesand valuations) and CACI data on household incomes.

The ratios show, on average, how many "times" income the localhouse prices represent. One common rule of thumb is that houseprices of 3 to 3.5 times income are considered affordable. In general, homes are less affordable in thesouth and the north-west of the area. There is a wide variationacross the districts. This points out that district-wide figuresmask the

local variations at ward level. Allratios are well above the “rule of thumb” 3 to 3.5 times income,and in general are worsening.

Cambridge sees the highest ratios, where the median house price was 11.5 times the median income, there is not a linear relationship between income and house prices with the lower quartile house price was 17.1 times the lower quartile income, meaning that lower a households income the greater the ratio. Lowest ratios were seen in Fenland with median house price 6.0 times median income.

Table 4: Median house price to income ratio at September 2015

District	Number of times higher
Cambridge City	11.9
East Cambridgeshire	7.3
Fenland	6.2
Huntingdonshire	6.4
South Cambridgeshire	8.2

Source: Cambridge Sub-Region's Housing Market Bulletin, Issue 26 (Hometrack)

Affordable Housing Need

The overall net need for affordable homes per year

District	Affordable housing need 2011 to 2031 (based on 2011/12 data)
Cambridge City	14,418
East Cambridgeshire	3,517
Fenland	3,527
Huntingdonshire	7,212
South Cambridgeshire	9,011

Map 1: Average House Price by Ward

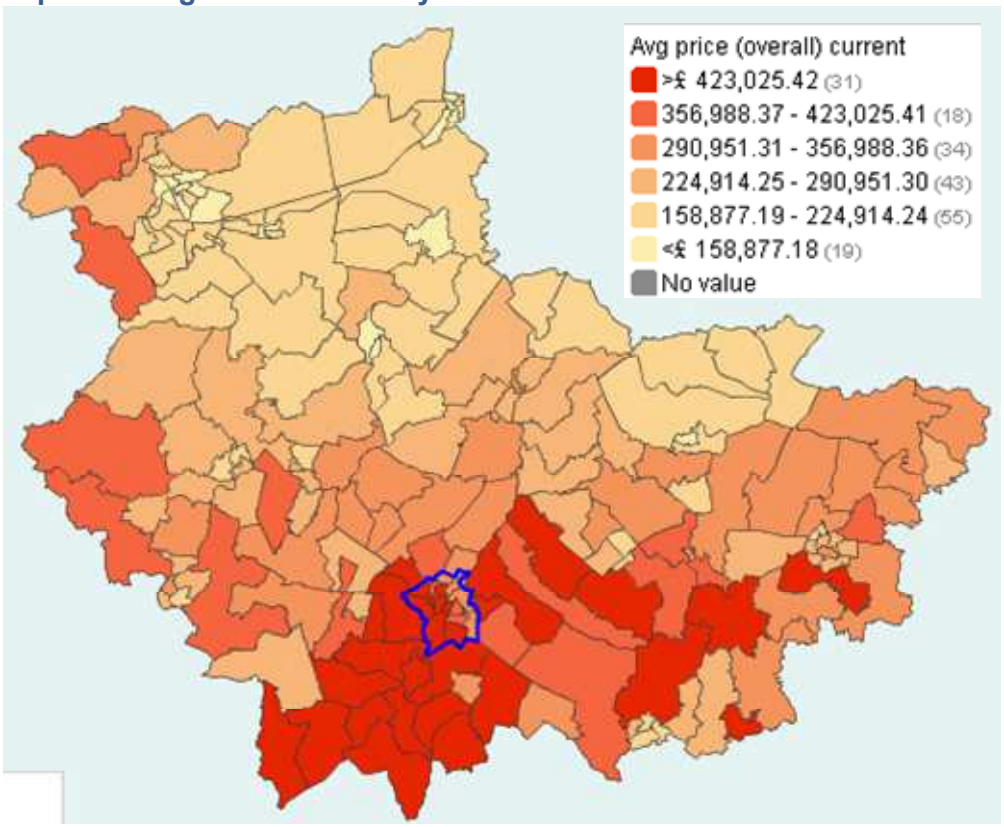
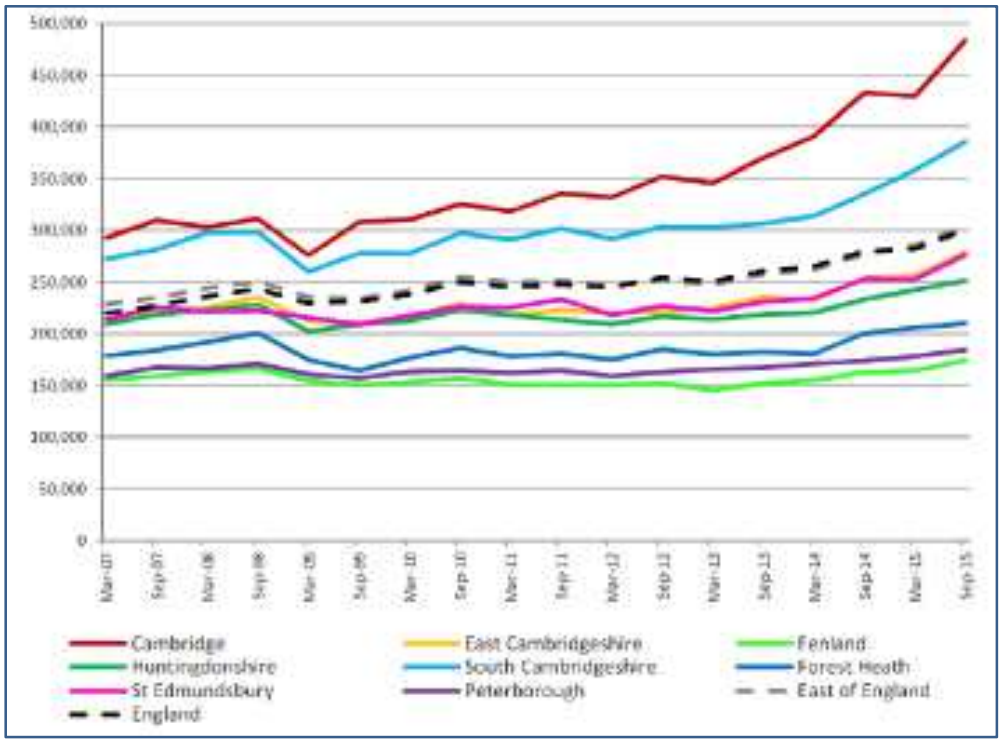


Figure 2: Trends in average house prices



The Cambridge housing sub-region is an area of economic success with a continued record of housing delivery and even during the recession homes continued to be delivered. Although this delivery tells a positive story, there are consequences when housing pressure in an area leads to problems with access and affordability, in urban, market town and rural communities.

More housing information can be found in the Housing & Health JSNA and on the Housing Pages on Cambridgeshire Insight:

http://www.cambridgeshireinsight.org.uk/housing-jsna-2013

http://www.cambridgeshireinsight.org.uk/housing

Some parts of the area feel other kinds of pressure, where land values are lower and new development is harder to get off the ground. The strategic housing market assessment and regular housing market bulletins track changes in the market and compare local areas to the regional and national picture.

The Cambridge functional economic area (which covers the housing sub-region) continues to thrive, both nationally and internationally. The labour market is fairly self-contained, with Cambridge acting as a regional centre of employment. It is a diverse economy with some significant strengths, but some weaknesses too. Housing is both a positive and a negative force within the local economy.

1.1.4 Do housing developments and the environment have an effect on the local health system?

There are two main effects on the local health system which could be attributed to new developments. The first being the pressures the increase in the population has on the Health system, typically new developments see an increased birth rate and demand for maternity services. The second is how the design of the build of a new development can affect the preventative health agenda by encouraging healthy lifestyles and enabling people to remain independent and remain in their own homes for longer.

Cambridgeshire and Peterborough health system was identified as one of the 11 most challenged health economies in England. NHS England, Monitor and NHS Trust Development Authority identified 11 health systems that are particularly challenged as a whole, and were most likely to benefit from intensive support in order to develop plans which would improve outcomes for patients, whilst developing a financially sustainable future for the local health economy.

A healthy well-designed environment can add to the prevention of ill health and aid in improving health and wellbeing, reduce demand on services through enabling healthier lifestyle choices.

1.1.5 What do we mean by “health and the built environment”?

The World Health Organisation (2) defines health as “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.” Implicit in the definition is the notion that there are both positive and negative elements of health.

Defra(3)also mentions the connection between positive and negative elements of health and wellbeing. Wellbeing is defined as “a positive physical, social and mental state; it is not just the absence of pain, discomfort and incapacity.”

Health and wellbeing are therefore related concepts. It has been observed (4) that “health” is generally used in a medical context where the presence or absence of physical and psychological symptoms is used to categorise an individual. “Wellbeing” tends to be used to describe a broader and more encompassing concept that takes into consideration the “whole person”. It aims to capture how a person is flourishing. The social rather than the medical context is relevant in defining “wellbeing”. Indicators that attempt to quantify “quality of life” generally attempt to measure wellbeing.

A “healthy community” would be one that prevented ill-health and promoted wellbeing. Building structures and transport systems that reduce or minimise air and noise pollution have demonstrable health benefits in terms of respiratory illness and stress related conditions. Providing adequate green space can promote physical activity with the subsequent benefits of reducing overweight and promoting mental health. The evidence base for ensuring healthy communities through design and planning is summarised in reports(5)such as “Future Health: sustainable places for health and wellbeing” by the Commission for Architecture and the Built Environment (CABE), and is explored further in Chapter 2 (Built Environment) of this JSNA.

Alongside the physical built environment, another aspect of a new community that is vital to its health is the social environment that has important benefits to physical and mental health, and is the context in which people can flourish. The social environment can be facilitated by the social amenities that are included in a new community such as community buildings but relies heavily on how people work together to achieve good governance and build cohesive and inclusive communities, social cohesion and community assets & services are explored further in Chapters 3 and 4 respectively.

1.2 AIM AND SCOPE – WHY A JSNA ON NEW HOUSING DEVELOPMENTS AND THE BUILT ENVIRONMENT?

The Cambridgeshire Health and Wellbeing Board selected New Communities as a topic for the JSNA programme of work for 2015-16 following feedback from district councils and other colleagues who emphasised the importance of assessing the health needs of new communities, given the scale of housing development in Cambridgeshire. Following a stakeholder event and discussions held at the JSNA steering group the topic was refined to focus on new housing developments and the built environment.

1.2.1 What are the aims of a JSNA for new housing developments and the built environment communities?

The first aim of the JSNA is to gather data and information on the health and wellbeing needs of populations in new developments with a view to informing service provision and commissioning for existing and future development sites within Cambridgeshire.

The second aim of the JSNA is to review the evidence on “designing and building in” opportunities for improving and maintaining health and wellbeing as part of the design of the new developments.

Unlike other JSNAs this JSNA focuses on communities and population groups that do not yet exist, although it does draw on the experience and evidence from existing new communities. While all JSNAs must rely on assumptions about the changes in size and needs of population groups to plan future health and wellbeing needs, these extrapolations are generally based on fairly stable estimates in existing populations.

Every new community is different and while lessons learnt from experiences in one community can inform planning for another there must necessarily be caution in transferring these lessons from one setting to another.

A particular challenge of this JSNA is that each new development poses very different challenges. The largest and most complex such as Northstowe will be built over relatively long periods of time (15+ years). This prolonged period will likely have unpredictable impacts on community identity and cohesion, and in turn on mental health and wellbeing, the "needs" of a new community in year one of occupation are likely to be different from the "needs" at the end of the construction many years later.

Smaller developments also have cumulative impacts on existing communities and infrastructure. It is not always possible to ensure that the relevant infrastructure and services will be available when needed. Health services and facilities must be commissioned at the optimal point. Too early and the facilities are underused and uneconomical; too late and health needs are not adequately met and waiting times increase. In addition, with the pressures on public sector finances there is a need to plan and provide services differently, the model of service provision now may not be "fit for purpose" in 20 years' time.

1.2.2 What is the focus of this JSNA?

Due to the complexity of the various impacts of new housing developments and the built environment on health this, Cambridgeshire New Housing Developments and The Built Environment, JSNA has restricted its focus to the following themes:

- Demography
- Environment
- Social Cohesion and Social connectivity
- Assets and services
- NHS Commissioning

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

A scoping paper was submitted and approved by the Health and Wellbeing Board on Thursday 17 September 2015, agreeing the focus on the five priority themes.

A stakeholder workshop was held on 28 July 2015 and was wellattended with approximately 40 representatives from Cambridgeshire County Council, District Councils, NHS organisations, academic groups, Third Sector organisations and Healthwatch. The aims of this workshop were to:

- Capture stakeholders' perspectives on the scope of this JSNA – priorities, questions to be answered and how to approach these.
- Increase awareness and understanding of the purpose of the JSNA.

- Identify stakeholder priorities and “place making” intentions (including commissioning and service delivery.

The workshop was organised into three sessions focusing on:

- Identifying the perceived and actual health and wellbeing needs of a new community in Cambridgeshire.
- Identifying what a successful and resilient community looks like, specifically:
    - What are the local assets – both physical and social
    - Are there any good examples we should be drawing from?
- What should the JSNA contain, specifically:
    - What evidence/intelligence do the stakeholders need in order to plan services in new communities
    - What evidence do stakeholders need to enable healthy design of new communities
    - What evidence do stakeholders need in order to support bids for money in new communities (including Section 106 and Community Infrastructure Levy (CIL) negotiations)

Feedback from this event significantly shaped the specific focus for each theme, and working groups were subsequently created for The Built Environment, Social Cohesion, Assets and Services, and NHS Commissioning. These working groups had significant input from Cambridgeshire County Council (Public Health and Children Families and Adults), District Councils, NHS, Third Sector organisations.

The JSNA, therefore, tries to address the following questions within these themes:

Demography and Health & Wellbeing Needs

- What are the demographic profiles and health and wellbeing needs of existing new developments and can they be applied to proposed new communities, and are these health and wellbeing needs likely to be different depending on the development?
- Where do people who move into new communities move from and how long do they stay?

Built Environment

- What factors contribute to “health and wellbeing” in new communities?
- What can we learn from other new developments in terms of communities that are healthy and resilient?
- How do we “design and build in” opportunities for improved health and wellbeing as part of the design of the new developments, e.g. access and active travel, mental wellbeing, nutrition, opportunities to be physically active etc.?

Social Cohesion and Social Connectivity

- What are the most effective models of community development for building healthy and resilient communities and when should they be deployed?
- How can a community development approach be sustained through the long periods required for communities to mature?
- What do existing new community residents value? – learning from other developments
- What type of Health and Social Care services (including non “health and social care services” which contribute to health and wellbeing e.g. Community Development) need to be provided in New Communities and what models of finance are available?

Assets and services

- What do we know about Health & Social Care utilisation in new communities, and can an analysis of the data show any patterns?
- What assets are currently available in new communities (a Needs and Assets Assessment), and how can we replicate good practice in new and developing communities?

Implications for NHS Commissioning

- What is the current NHS commissioning landscape, and how does this "fit in" with the Local Authority Planning system? To include but not limited to:
    - Pharmacy provision
    - Primary Care
    - Secondary care
    - Dentistry
    - Ophthalmology

The JSNA also contains case studies of new communities locally as illustrations.
Links are made to other relevant JSNAs e.g. Housing and Health, Transport and Health.

1.2.3 Ways of accessing information from this JSNA

This JSNA provides evidence and information on New Developments and the Built Environment and Health in Cambridgeshire and is available as a full report and in separate section reports on the CambridgeshireInsight website (www.cambridgeshireinsight.org.uk/jsna).

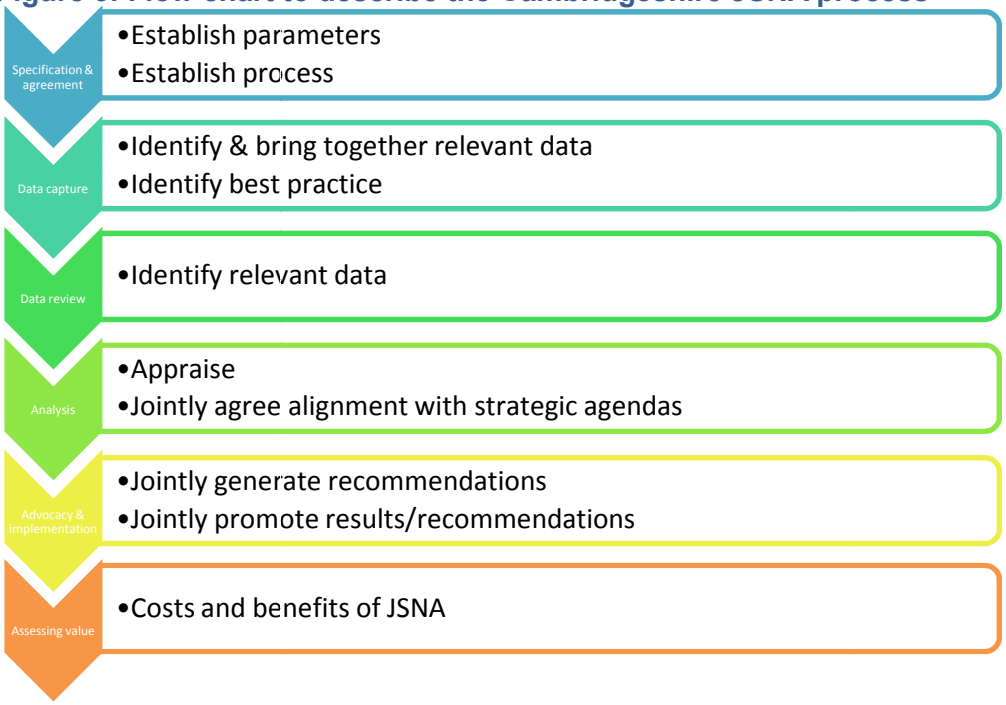
1.2.4 Who should use this JSNA?

This JSNA is intended as a resource of evidence to help developers design and build healthy developments, commissioners of NHS services understand how the "Planning System" operates, Local Authority planning officers in understanding how the NHS Commissioning system works, and how the built impacts health and wellbeing, and by all others with an interest in the built environment, community cohesion and health and wellbeing.

1.3. PROCESS – HOW HAS THIS JSNA BEEN PRODUCED?

There have been several stages in the development of this JSNA (Figure3).

Figure 3: Flow chart to describe the Cambridgeshire JSNA process



1.4. STRUCTURE – HOW IS THIS JSNA REPORT ORGANISED?

Following the agreed scope outlined in 1.2.2 above the JSNA consists of five chapters with case studies. The chapters can be read as standalone documents but are better taken in the context of the complete JSNA.

Chapter 1: **Demography** - provides an overview and context of the new growth in Cambridgeshire; it describes the policies that determine the pattern of housing development, for example, the housing need for the county contained in the Local Planning Authorities Local Plans. This chapter summarises the key demographics for the main growth areas that are being built now along with population forecasts for the new areas of development. The chapter also summarises the main demographics for each primary care practice(s)within these new housing developments.

Chapter 2: The Built Environment - provides a summary review of the evidence of the health implications of the built environment. The chapter outlines the national planning system and reviews the local plans of each planning authority within Cambridgeshire exploring where health related planning policies are contained in the local plans and identifying where they are not.

Chapter 3: Social Cohesion/Community Development - provides a review of the evidence on what the health implication of the social environment are on health, it emphasises some of the 'softer' outcomes for health and wellbeing such as community development and social cohesion. New communities do not develop in isolation from existing communities. The character of new communities is also determined by much more than their

physical infrastructure. Communities continue to develop for decades after building has stopped.

Chapter 4: Assets and Services – reviews the evidence on what are “assets & services” and what is the utilisation of services in New Developments? The chapter examines local referral rates of children and adults to social services in these new developments, and contains examples of good practice.

Chapter 5: NHS Commissioning–provides an overview of the commissioning landscape for the NHS, who are the main players and who commissions what services. The chapter also explores the links between contributions from developers and provision of primary care buildings in new communities, an explanation of which is the detail required under planning law in order to help secure developer contributions.

Chapter 6: Orchard Park Case Study – provides a case study of Orchard Park, on the outskirts of Cambridge, in the form of the results of the South Cambridgeshire District Council Scrutiny Task and Finish Group. This group reviewed the lessons learned from Orchard Park.

DEMOGRAPHY

1. KEY FINDINGS

Summary – key demographic and health data

- It is estimated that there are 627,000 people living in Cambridgeshire, with a bulge seen in 40-49 year olds which is due to high births in the 1960's and a higher number of 60-69 year olds are the post war baby boomers.

- Forecasts suggest that the population of Cambridgeshire is set to increase by 25% over the next 20 years, with the majority of the increase seen in Cambridge City and South Cambridgeshire. This is associated with a forecast increase in the number of new dwellings between up to 2036 of 73,000.

- Population trends in the GP Practice populations serving new developments show a steady increase each year from 2006 to 2015, except the Bar Hill Practice which has remained constant indicating that the population in Bar Hill has matured and is settled.

- The age profile breakdown for GP Practice populations serving new developments show the that majority have an age structure similar to the CCG area, except for Cambourne which shows a spike in the 0-14, and 25-44 age groups.

- The average household size in new developments ranges from 2.6 to 2.8.

2. INTRODUCTION

This JSNA seeks to compare Health and Social Care Data from new developments to the Cambridgeshire and Peterborough Clinical Commissioning Group (C&PCCG) area as a whole to explore any differences with a view to service delivery in new developments.

Six new developments, of different scales,have been compared to the C&PCCG area one of which, Bar Hill, is a settled new community and is a useful comparator to see how the development has matured and changed over time now having a profile similar to the C&PCCG profile.

The new developments are:

- Southern Fringe/Trumpington Meadows (Straddles Cambridge City and South Cambridgeshire).
- Loves Farm (St Neots, Huntingdonshire).
- Orchard Park (Straddles Cambridge City and South Cambridgeshire)
- Cambourne (South Cambridgeshire)
- Bar Hill (South Cambridgeshire)
- Hampton Heath (Peterborough City)

3. MAIN DATA

3.1 PRACTICE PROFILES

This section provides a snap shot of the demographic profiles of the Primary Care practices that serve the new developments of:Trumpington Meadows, Loves Farm, Orchard Park, Cambourne, Bar Hill and Hampton Heath. Where possible the practice profiles have been compared to the Cambridgeshire and Peterborough CCG profile.

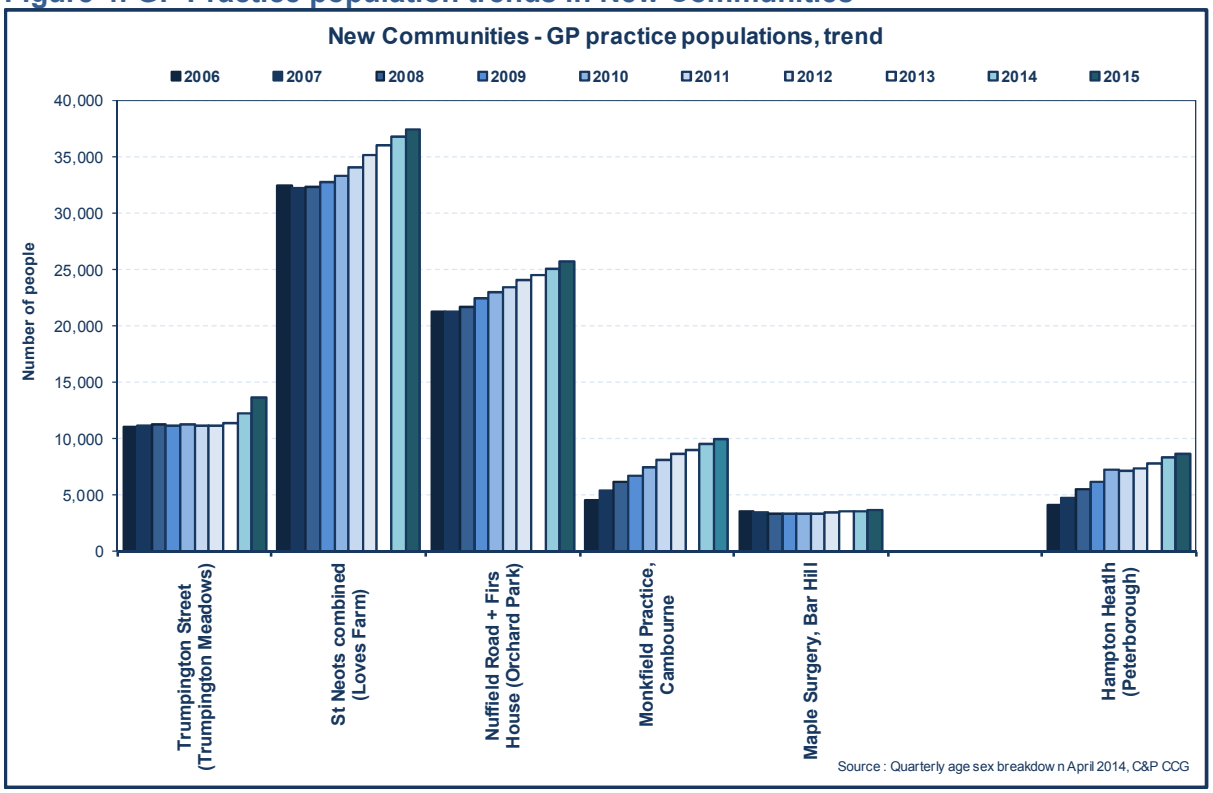
The analysis of the data includes for these practices:

- population trends,
- age breakdowns,
- population forecasts,
- Ethnicity profiles,
- births rates,
- Quality and Outcomes Framework data,
- patient satisfaction data,
- housing information.

3.1.1 Populations trends in the Primary Care Practices Serving New Developments

Population trends in the GP Practice populations serving new developments show a steady increase each year from 2006 to 2015, except the Bar Hill Practice, which has remained constant indicating that the population in Bar Hill has matured and is settled.

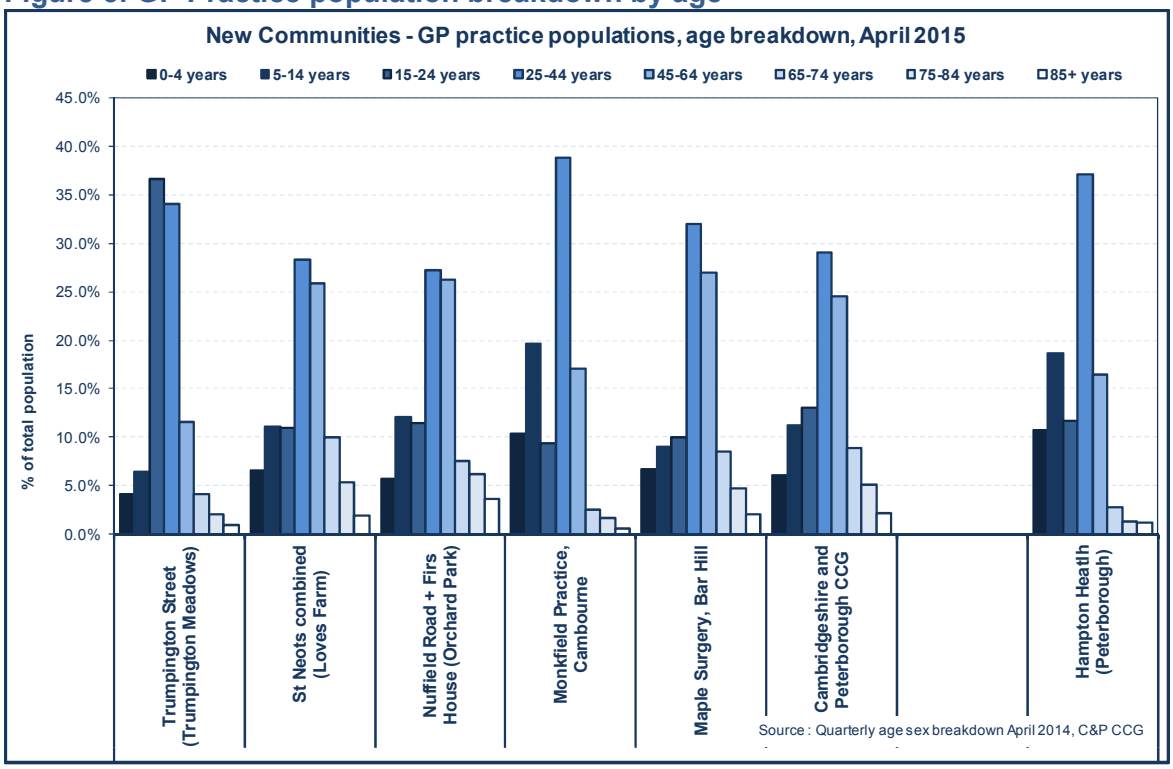
Figure 4: GP Practice population trends in New Communities



3.1.2 Age Profiles in the Primary Care Practices Serving New Developments

The age profile breakdown for GP Practice populations serving new developments show that the majority have an age structure similar to the CCG area, except for Cambourne which shows a spike in the 0-14, and 25-44 age groups.

Figure 5: GP Practice population breakdown by age



3.1.4 Patient Satisfaction

Table 5: Patient Satisfaction survey in new communities (1 of 3)

Development		Response rate	Overall experience	
			Good experience	Recommend GP surgery to someone who has just moved to the local area
Cambourne	Monkfield Medical Practice	30.9%	55.3%	45.4%
St Neots	Almond Road,	40.8%	82.3%	78.8%
	Cedar House	40.0%	76.9%	65.5%
	Eaton Socon	46.1%	74.0%	65.1%
	St Neots Health Centre	31.3%	89.6%	89.3%
Orchard Park	Nuffield Road, Cambridge	33.3%	93.2%	88.3%
	Firs House, Histon	44.9%	92.4%	89.5%
Southern Fringe	Trumpington St, Cambridge	25.2%	94.6%	96.5%
Bar Hill	Maple Surgery	41.0%	73.8%	63.2%
Hampton	Hampton Health	31.1%	74.4%	65.4%
Cambridgeshire and Peterborough CCG		37.5%	86.0%	80.6%
Statistically significantly worse compared to CCG				
Statistically significantly better compared to CCG				

Table 6: Patient Satisfaction survey in new communities (2 of 3)

Development		Accessing GP		Opening hours	
		% who have seen or spoken to a GP in the past 6 months	% who have seen or spoken to a nurse in the past 6 months	Satisfaction with opening hours	GP surgery currently open at times are convenient
Cambourne	Monkfield Medical Practice	57.4%	50.3%	42.3%	42.7%
St Neots	Almond Road,	65.2%	57.7%	75.6%	70.4%
	Cedar House	72.2%	60.4%	74.6%	76.3%
	Eaton Socon	58.4%	59.8%	62.0%	52.7%
	St Neots Health Centre	81.0%	72.4%	96.2%	93.7%
Orchard Park	Nuffield Road, Cambridge	75.3%	48.1%	77.1%	73.5%
	Firs House, Histon	76.8%	65.2%	78.0%	72.4%
Southern Fringe	Trumpington St, Cambridge	69.6%	50.8%	70.3%	71.8%
Bar Hill	Maple Surgery	72.3%	58.6%	82.3%	83.2%
Hampton	Hampton Health	63.1%	57.3%	64.5%	56.8%
Cambridgeshire and Peterborough CCG		69.0%	56.6%	75.9%	74.1%
Statistically significantly worse compared to CCG					
Statistically significantly better compared to CCG					

Table 7: Patient Satisfaction survey in new communities (3 of 3)

Development		Managing health			
		Long standing health condition	In last 6 months, had enough support from local services or organisations to help manage long-term health condition(s)	Confident in managing own health	Activities limited today due to recent illness or injury
Cambourne	Monkfield Medical Practice	47.2%	70.1%	93.6%	16.6%
St Neots	Almond Road,	54.2%	59.9%	98.7%	13.0%
	Cedar House	50.2%	64.7%	97.4%	15.2%
	Eaton Socon	47.9%	52.1%	95.9%	13.2%
	St Neots Health Centre	53.7%	70.9%	95.2%	15.8%
Orchard Park	Nuffield Road, Cambridge	58.4%	69.0%	90.0%	19.8%
	Firs House, Histon	53.9%	60.2%	94.6%	14.1%
Southern Fringe	Trumpington St, Cambridge	39.8%	71.5%	92.6%	12.6%
Bar Hill	Maple Surgery	58.8%	60.5%	94.1%	19.3%
Hampton	Hampton Health	41.0%	48.1%	90.6%	12.3%
Cambridgeshire and Peterborough CCG		52.3%	63.7%	93.6%	15.7%
Statistically significantly worse compared to CCG					
Statistically significantly better compared to CCG					

A number of practices in the new development areas have significantly worse overall experience ratings compared to the CCG. Bar Hill is one of these practices and it is considered a “settled” community indicating that the picture of satisfaction is more complicated than just a reflection of serving a new development area. Cambourne Practice has a considerably worse score possibly reflecting local anecdotal evidence from the Cambourne community on the difficulty of getting appointments at the practice, which is a reflection of the inability of the practice to recruit to vacant GP posts. The other finding is that the St Neots Health Centre performs better than the CCG area on opening hours,probably a reflection of the drop in nature of the practice.

3.1.5 Quality and Outcomes Framework Data

Table 8: Quality and Outcomes Framework 2014/15: Summary for New Communities (1 of 3)

Quality and Outcomes Framework 2014/15:
Summary for New Communities

						Cardiovascular						
		Total Population (Jan 16)	Population 0-17 years	Population 18-64 years	Population 65+ years	Atrial fibrillation	Coronary heart disease	Cardiovascular disease – primary prevention (30-74 years)	Heart failure	Hypertension	Peripheral arterial disease	Stroke and transient ischaemic attack
Cambourne	Monkfield	10,486	34%	62%	5%	0.54	1.10	0.62	0.17	5.77	0.14	0.55
St Neots	Almond Road	7,189	21%	63%	16%	1.62	3.37	0.65	0.51	12.51	0.44	1.19
	Cedar House	13,948	22%	60%	18%	1.72	3.23	0.80	0.58	13.98	0.61	1.44
	Eaton Socon	11,466	20%	58%	22%	2.13	4.02	0.78	0.59	15.21	0.51	1.58
	St Neots Health Centre	5,100	22%	72%	6%	0.46	1.22	1.27	0.19	6.72	0.19	0.71
Orchard Park	Nuffield Road	14,004	20%	64%	15%	1.91	3.14	0.46	0.93	12.60	0.68	1.87
	Firs House, Histon	12,300	21%	60%	19%	2.08	3.03	0.92	0.63	13.49	0.48	1.81
Southern Fringe	Trumpington St	14,901	14%	79%	7%	0.68	0.96	0.60	0.19	4.71	0.17	0.59
Bar Hill	Maple Surgery	3,689	19%	66%	15%	1.29	2.91	0.98	0.49	13.18	0.33	1.18
Hampton	Hampton Health	8,834	33%	61%	5%	0.67	1.09	0.63	0.27	5.83	0.26	0.72
C&P CCG		929,926	20%	64%	16%	1.52	2.88	0.90	0.61	12.72	0.55	1.45
England		57,539,930	21%	62%	17%	1.63	3.25	1.07	0.72	13.79	0.63	1.73

Key: Compared to the England average / comparison to relevant threshold

	Values are not statistically significant		Values are statistically significantly lower/better
	Values are statistically significantly higher/worse		

Table 9: Quality and Outcomes Framework 2014/15: Summary for New Communities (2 of 3)

		Respiratory system		High dependency and long term conditions				Musculoskeletal	
		Asthma	Chronic Obstructive Pulmonary Disease	Cancer	Chronic kidney disease (18+ years)	Diabetes mellitus (17+ years)	Palliative care	Osteoporosis (50+ years)	Rheumatoid Arthritis (16+ years)
Cambourne	Monkfield	6.46	0.33	1.26	1.15	2.52	0.07	0.07	0.47
St Neots	Almond Road	4.75	2.32	2.27	0.77	5.52	0.21	0.04	0.71
	Cedar House	6.64	1.76	2.36	3.96	5.92	0.23	0.14	0.93
	Eaton Socon	5.67	1.99	3.28	5.74	5.97	0.23	0.13	0.86
	St Neots Health Centre	6.25	1.34	1.09	1.22	3.09	0.02	0.00	0.55
Orchard Park	Nuffield Road	7.32	1.87	2.06	4.10	5.47	1.55	0.20	0.68
	Firs House, Histon	6.23	1.18	2.49	2.34	4.48	0.15	0.15	0.93
Southern Fringe	Trumpington St	5.16	0.71	1.06	0.48	1.57	0.13	0.15	0.28
Bar Hill	Maple Surgery	7.53	1.29	2.53	2.79	4.75	0.16	0.15	0.69
Hampton	Hampton Health	5.60	0.53	1.06	1.87	3.69	0.80	0.00	0.29
C&P CCG		6.26	1.65	2.31	3.26	5.68	0.43		0.74
England		5.99	1.82	2.26	4.13	6.37	0.31	0.17	0.73

Table 10: Quality and Outcomes Framework 2014/15: Summary for New Communities (3 of 3)

		Mental health and neurology					Lifestyle
		Dementia	Depression (18+ years)	Epilepsy (18+ years)	Learning Disabilities	Mental Health	Obesity (16+ years)
Cambourne	Monkfield Medical Practice	0.18	11.04	0.37	0.17	0.55	6.88
St Neots	Almond Road,	0.38	12.45	0.84	0.84	0.90	3.79
	Cedar House	0.65	6.68	0.77	0.35	0.76	8.87
	Eaton Socon	0.75	4.46	0.74	0.42	0.38	9.21
	St Neots Health Centre	0.27	8.70	0.47	0.36	0.71	10.32
Orchard Park	Nuffield Road, Cambridge	2.17	8.85	0.84	0.58	1.34	9.37
	Firs House, Histon	1.06	5.35	0.59	0.26	0.69	5.25
Southern Fringe	Trumpington St, Cambridge	0.25	3.35	0.26	0.12	0.78	3.41
Bar Hill	Maple Surgery	0.44	5.34	0.94	0.33	0.60	10.81
Hampton	Hampton Health	0.80	14.90	0.57	0.35	0.60	9.05
Cambridgeshire and Peterborough CCG		0.67	6.97	0.70	0.41	0.77	8.48
England		0.74	7.33	0.79	0.44	0.88	9.03

3.1.6 Birth Data

Birth rates per 1,000 female population aged 15-44 in all but one of the growth areas are higher than the CCG area. The rate in Loves Farm is twice the CCG area rate and the rate in the southern fringe area is lower. There is no obvious explanation for this but it might be related to the socio-demographic profile of females moving into Trumpington Meadows.

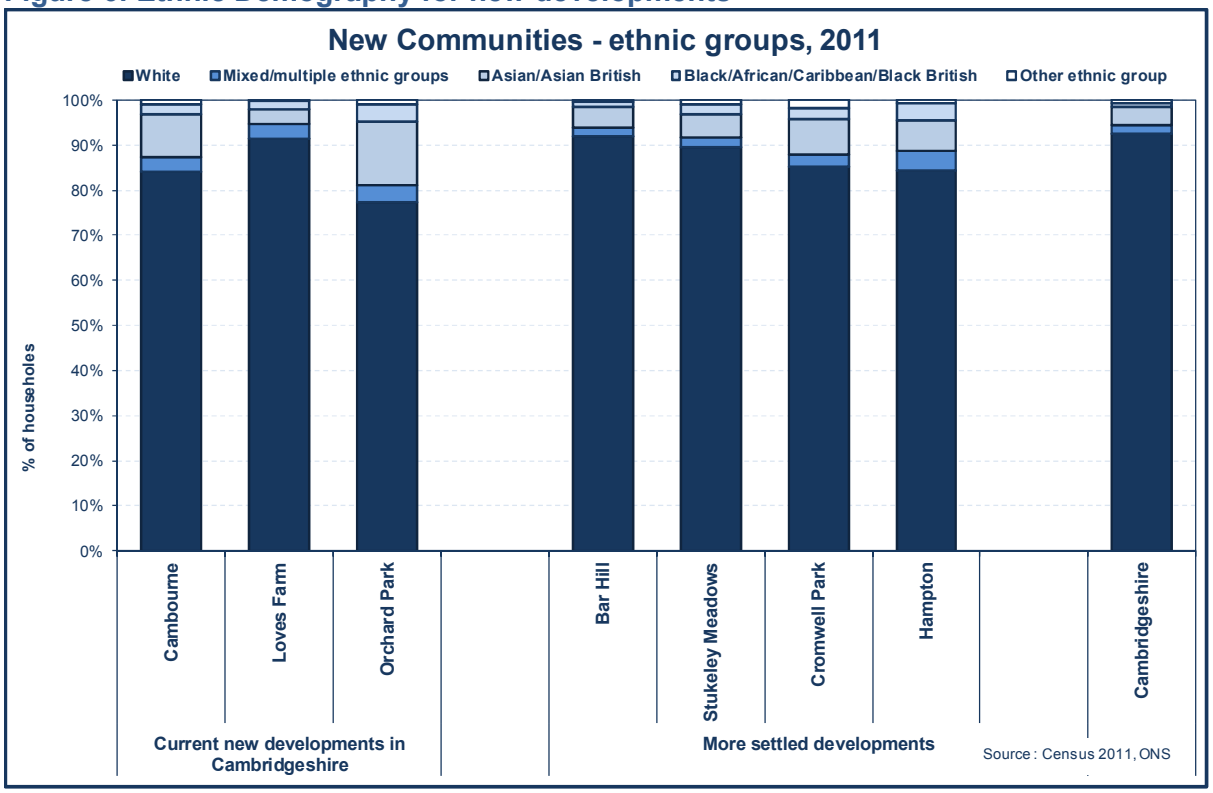
Table 11: Birth rates per 1000 females in new developments

Development	Births		
	Number	Rate per 1,000 female population aged 15-44 years	95% CI
Cambourne	180	65.9	(59.4 - 79.9)
LovesFarm	95	104.2	(80.4 - 121.5)
Orchard Park	61	72.9	(34.6 - 58.0)
SouthernFringe	42	55.7	(41.6 - 78.0)
Cambridgeshire County	7,268	58.4	(57.4 - 60.1)

3.1.7 Ethnicity

All the developments show a predominance of “white” as the main ethnic classification, mirroring the Cambridgeshire ethnic profile, there are small differences between the growth sites with Orchard Park and Cambourne both showing increased percentage of Asian/Asian British households. Both of which are also higher than Cambridgeshire as a whole.

Figure 6: Ethnic Demography for new developments



3.2 HOUSING

3.2.1 Average Household Size in New Developments

Average household size in the new developments tend to be larger than the standard multiplier used of 2.5, with Cambourne, Cromwell Park and Orchard Park seeing average household sizes of 2.8. This has implications for not only the service delivery in new developments (ie coping with an increase in population compared to predicted populations) but also for design on these development sites in the longer term (eg households with a household size of 2.8 is likely to need more space and more car parking facilities).

Table 12: Average household size in new developments

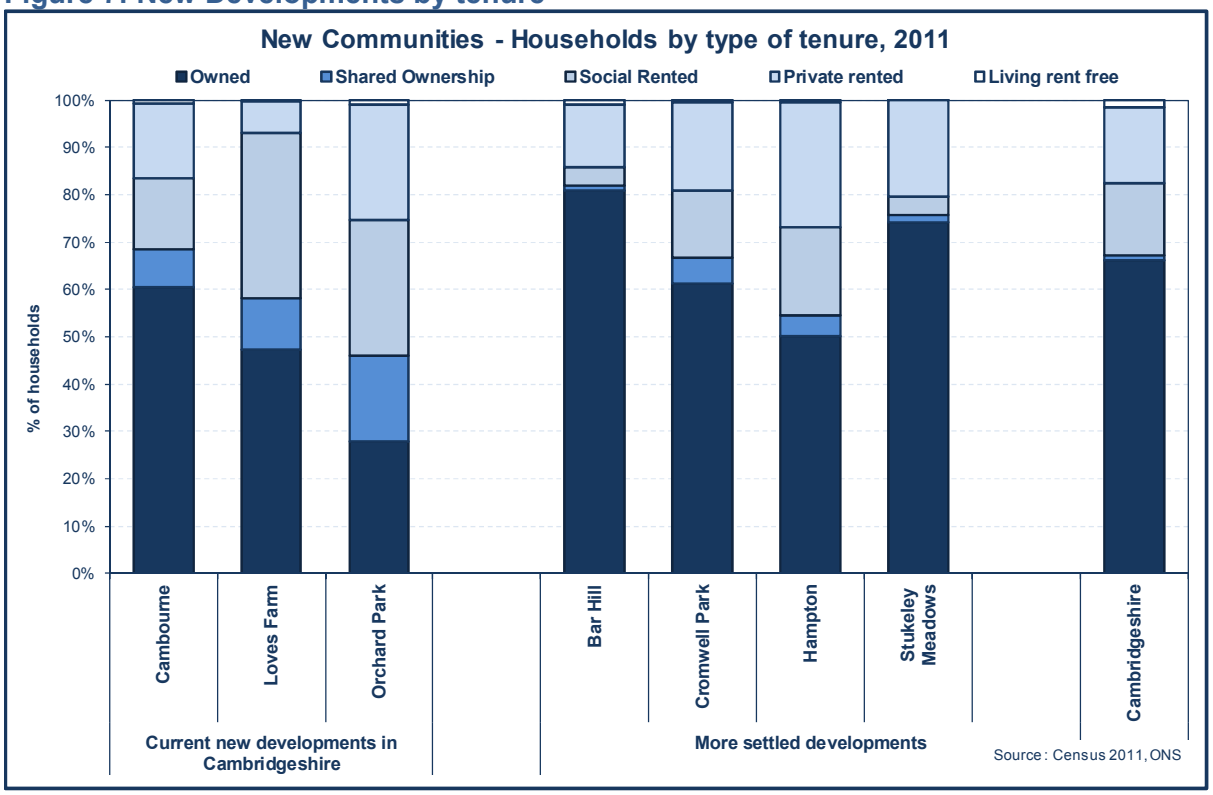
Development	Residents in households	Households	Average Household Size
Bar Hill	4,026	1,725	2.3
Cambourne	8,186	2,964	2.8
Cromwell Park	1,817	646	2.8
Hampton	10,398	3,903	2.7
Loves Farm	1,602	619	2.6
Orchard Park	1,885	670	2.8
Stukeley Meadows	3,320	1,259	2.6

Source: Cambridgeshire Research Group and ONS Population Census 2011

3.2.2 Tenure

There is a marked difference in tenure across the new developments, with Bar Hill showing over 80% of properties privately owned compared to 70% across Cambridgeshire. Orchard Park shows less than 30% of properties are in private ownership with a high percentage in both the private rented and social rented sector.

Figure 7: New Developments by tenure



3.2.3 Strategic Housing Market Assessment (SMHA) Summary.

The SMHA summary shows the need for affordable housing compared to the dwellings contained in the Local Plan, Cambridge City's affordable housing need is greater than the total housing (market and affordable) proposed. The majority of the affordable housing need (62%) is in Cambridge City and South Cambridgeshire.

Table 13: Dwelling change (all tenures), net affordable housing need and jobs increase 2011 to 2031

	Dwelling change 2011 to 2031	Affordable housing need 2011 to 2031 Based on 2011/12 data	Jobs increase 2011 to 2031
Cambridge	14,000	14,418	22,000
East Cambridgeshire	13,000	3,517	7,000
Fenland	12,000	3,527	5,000
Huntingdonshire	17,000	7,212	15,000
South Cambridgeshire	19,000	9,011	22,000
Cambridgeshire to 2031	75,000	37,684	71,000
Forest Heath	7,000	3,742	3,000
St Edmundsbury	11,000	3,437	7,000
Housing sub-region	93,000	44,863	81,000

3.3 POPULATION FORECASTS

The population forecasts for the new developments all show a similar pattern with a steep increase in the population aged 20-64 in the first 10-20 years of the development with a slow decline then onwards. The 0-19 aged population has a steady increase during this time but not so steep, reflecting that not all residents moving into a new development have or will have children. The 65+ age group shows a steady increase year on year but starts from a low base, suggesting that the increase is mainly due to a naturally ageing population rather than a large influx of older people moving into new developments. There are population forecasts for:

- North West Cambridge – University Site
- North West Cambridge – Darwin Green/NIAB site
- Southern Fringe/Trumpington Meadows
- Ely North
- St Neots
- Hatchford Farm, March
- Alconbury
- Northstowe

Figure 8: Population forecast: University Site

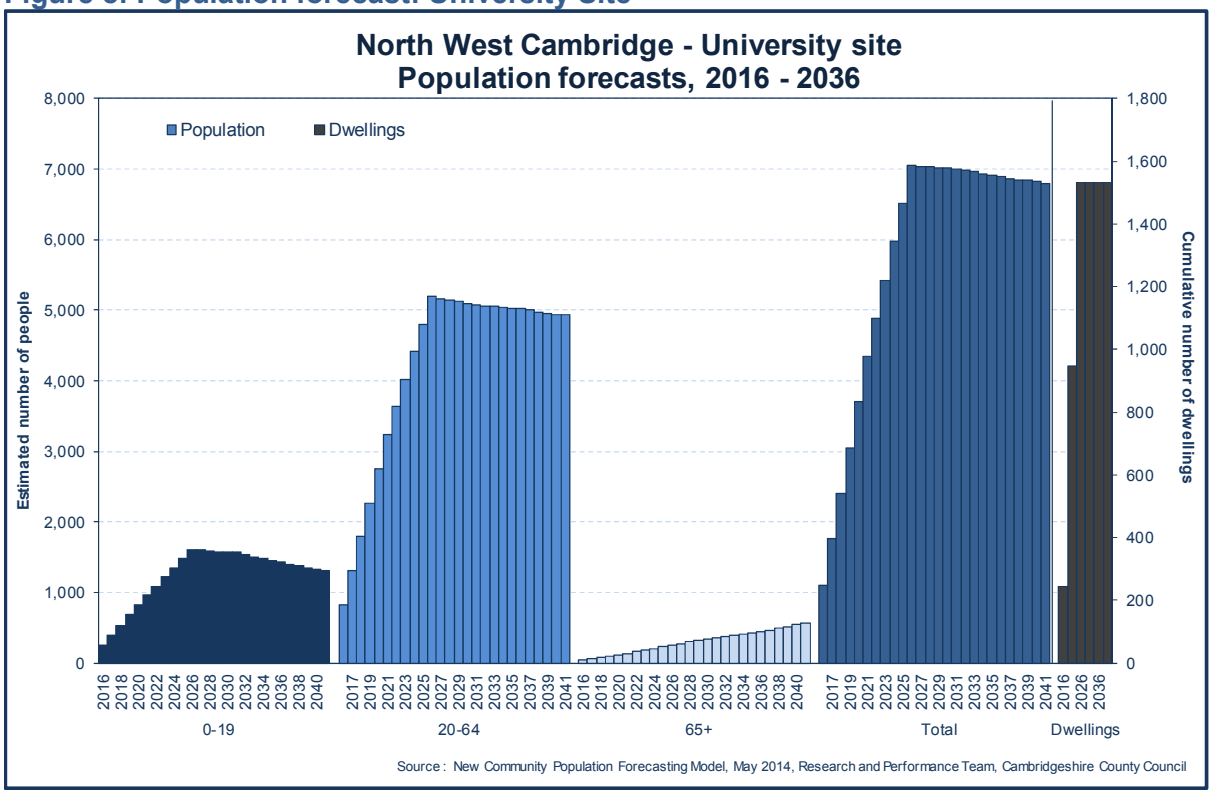


Figure 9: Population forecast: NIAB Site

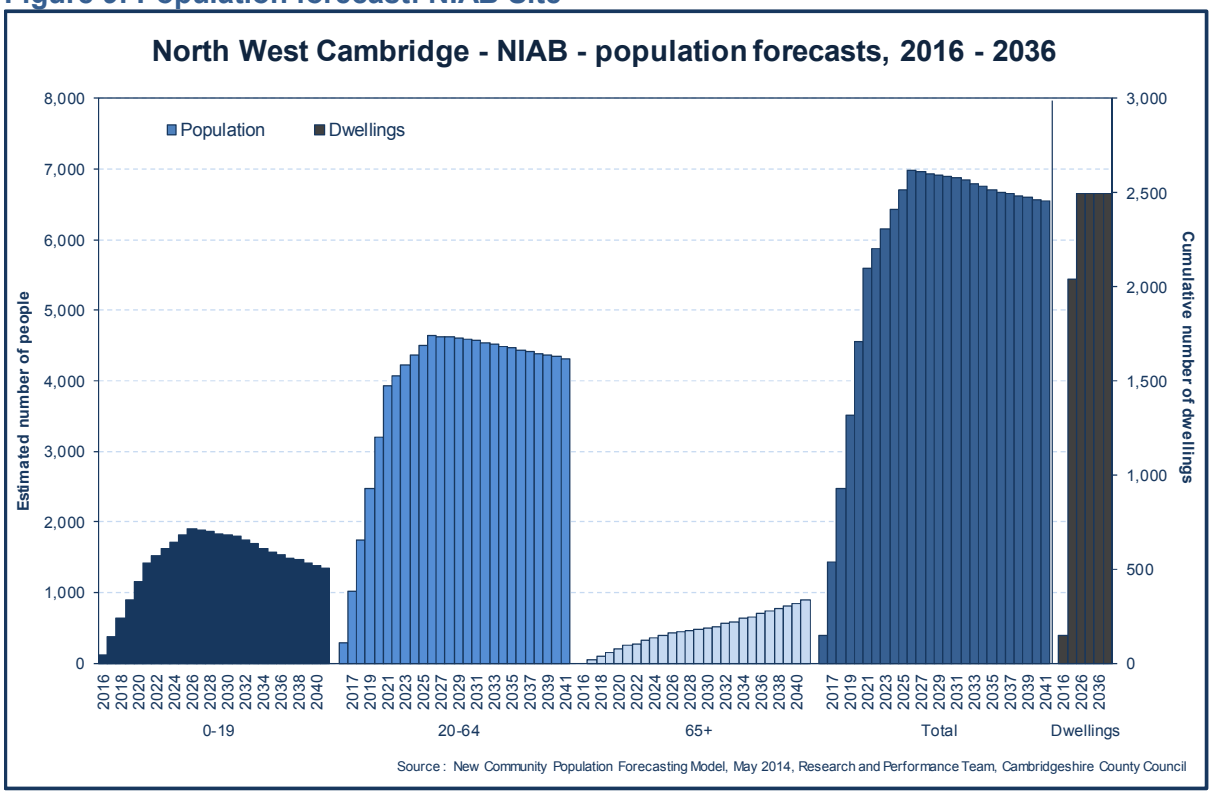


Figure 10: Population forecast: Trumpington Meadows Site

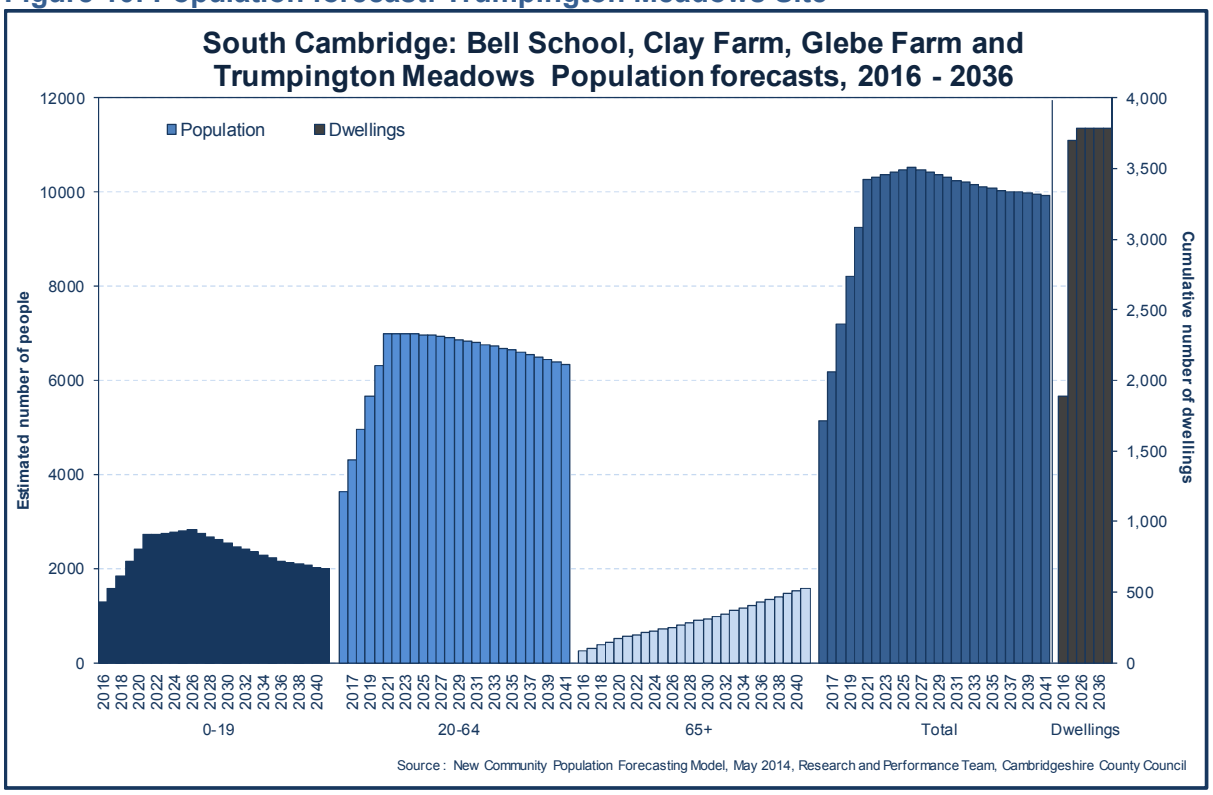


Figure 11: Population forecast: Ely North Site

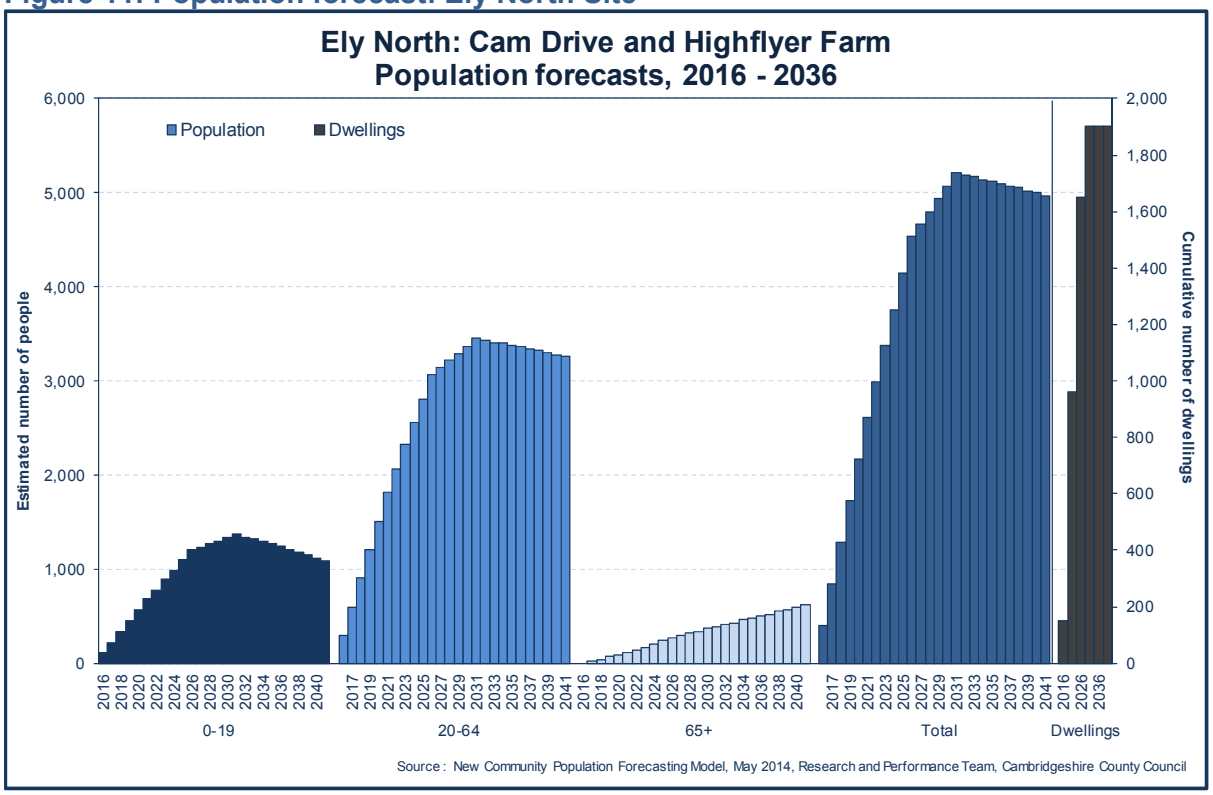


Figure 12: Population forecast: Loves Farm Site

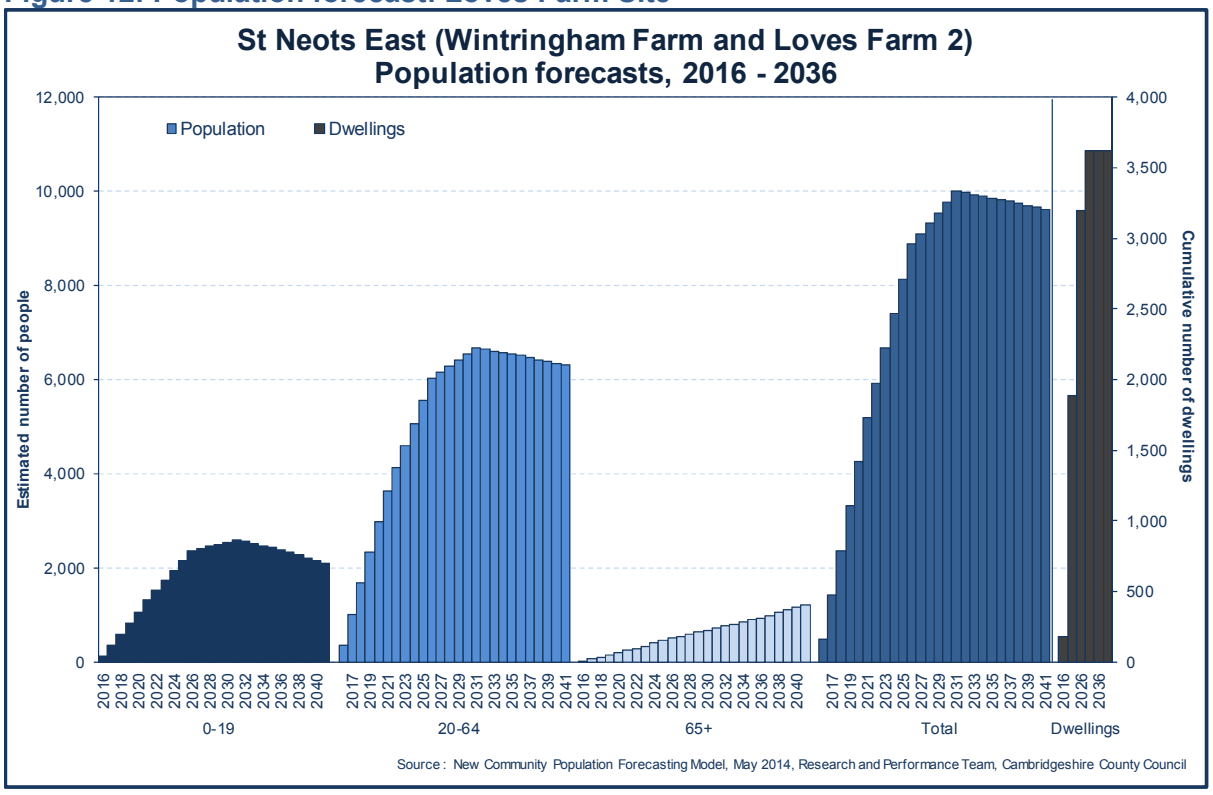


Figure 13: Population forecast: Hatchford Farm Site

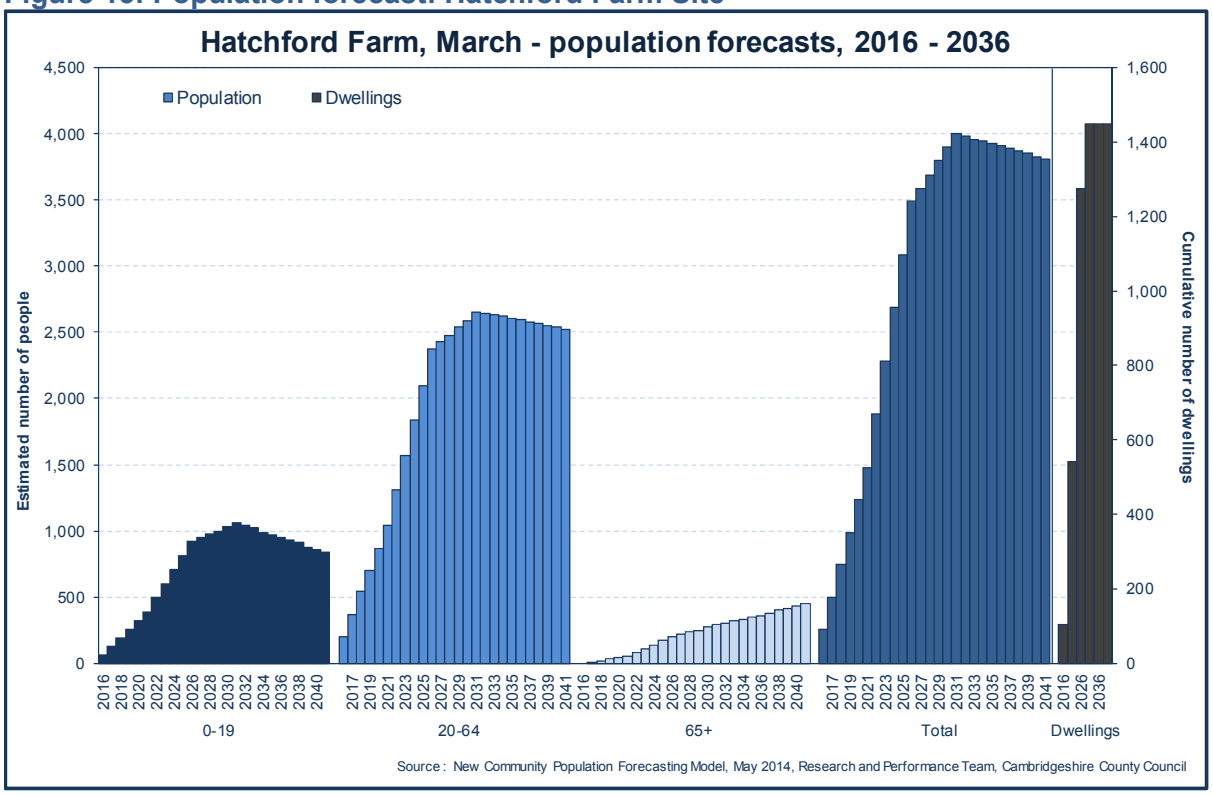


Figure 14: Population forecast: Alconbury Site

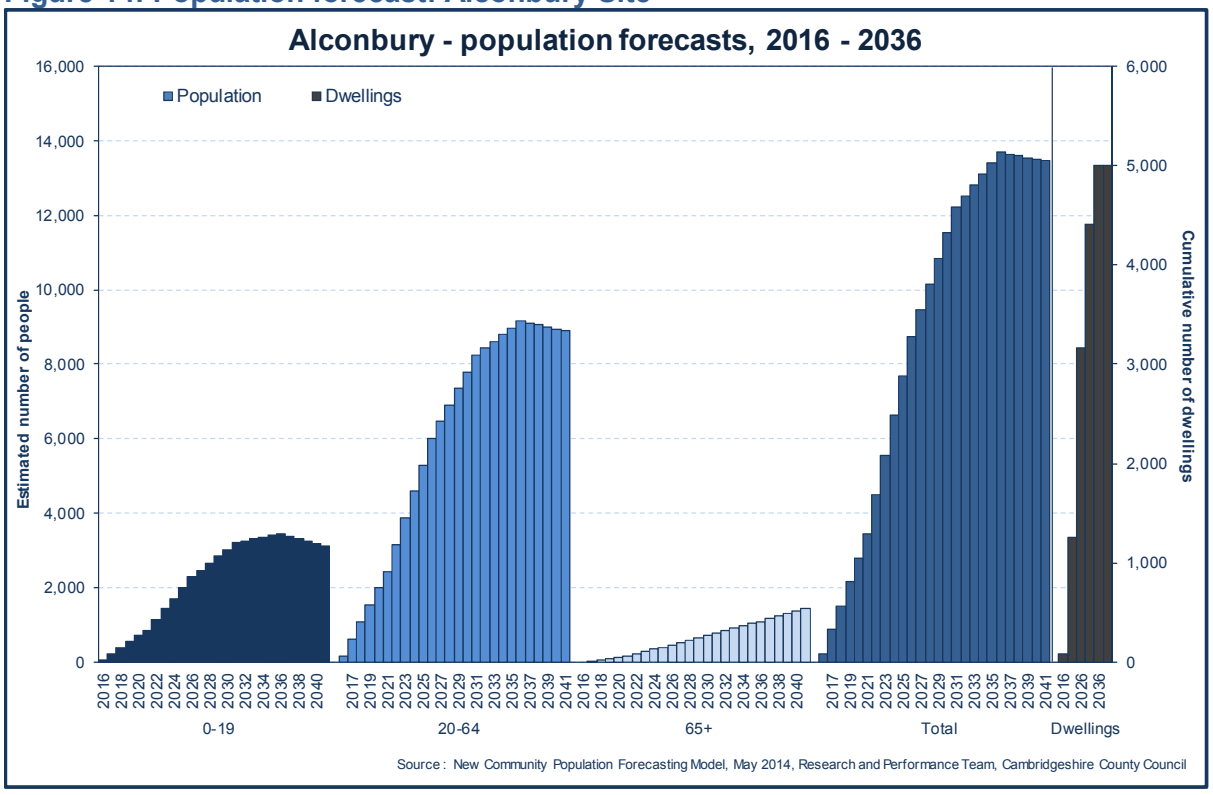
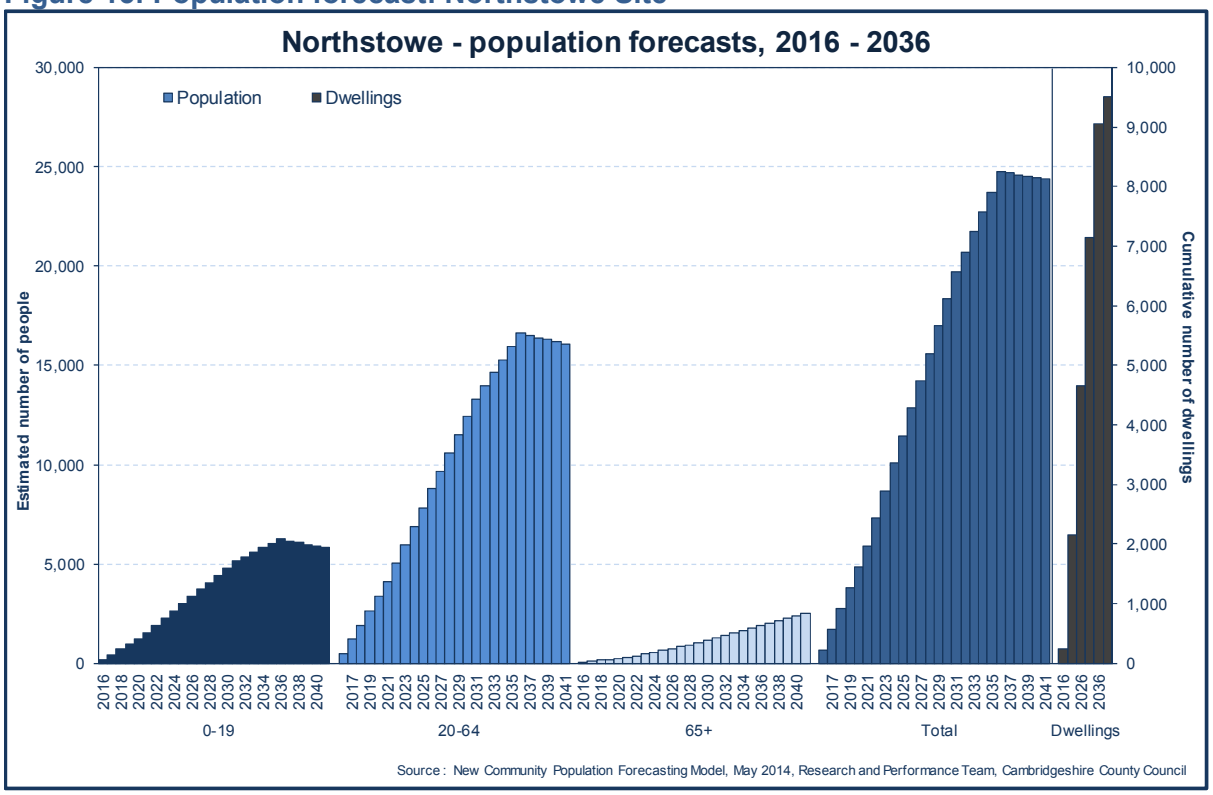
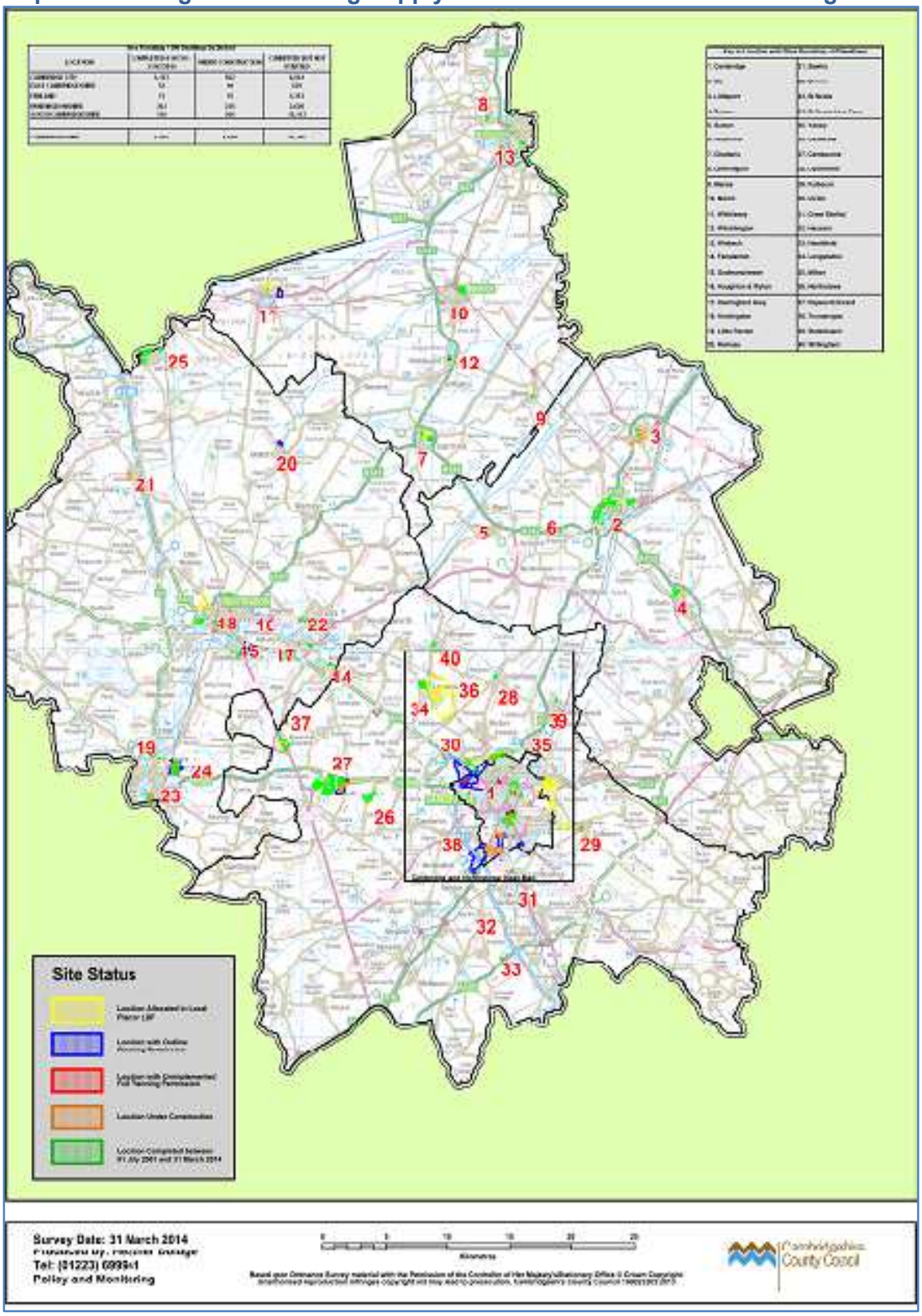


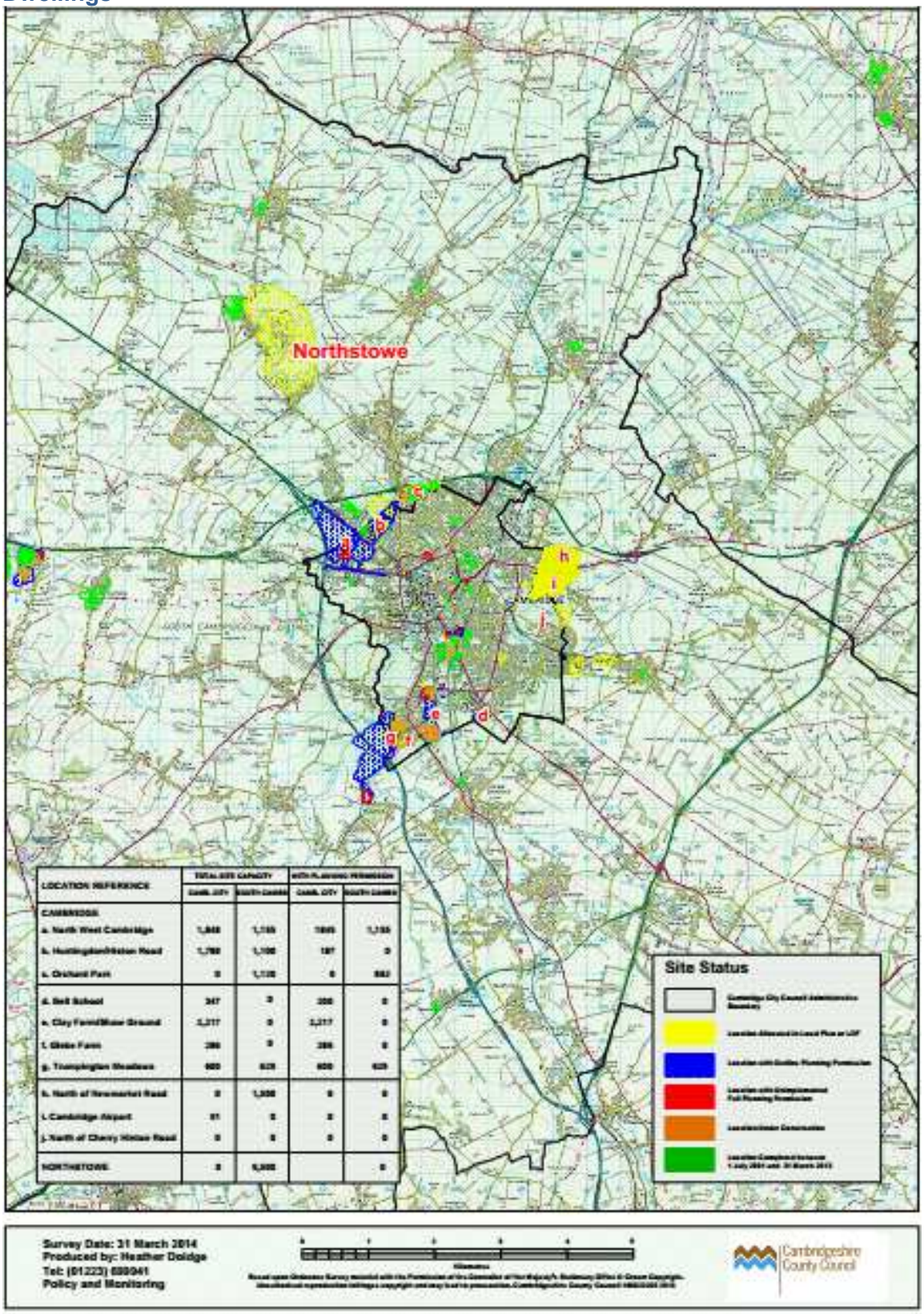
Figure 15: Population forecast: Northstowe Site



Map 2: Cambridgeshire Housing Supply on Sites Greater than 100 Dwellings



Map 3: Cambridge City and Northstowe Housing Supply on Sites Greater than 100 Dwellings



BUILT ENVIRONMENT

1. KEY FINDINGS

- There is a lack of consistency across the Local Authority Local Plans with regard to the inclusion of policies to improve health. The main policies to include in future plans need to focus on green infrastructure, active travel, suicide prevention, Health Impact Assessment requirements.

- There is a lack of consistency and understanding on the funding of Primary Care facilities and securing Community Infrastructure Levy/Section 106 funding.

- Importance of accessible green space and parks, which need to be designed to maximise potential use. There is a need for an open spaces specific design codeto complement the policies on open space within Local Plans, design code should cover provision of paths, cycleways and unstructured routes through and to the green space, provision of toilets and other facilities.

- The importance of providing infrastructure to enable people to make more active travel choices.

- Securing what can be perceived as “nice to have” infrastructure as part of the overall design of new development to support healthy ageing, e.g. street furniture, public toilets.

- The need to consider suicide prevention and public mental health as part of the design of highrise private and public buildings to limit their access and opportunities for suicide.

- The NHS Local Estates Plan should be reflected in the District/City Councils local plans and Infrastructure Delivery Plans.

2. INTRODUCTION

2.1 HOW DOES THE PLANNING SYSTEM WORK?

2.1.1 The role and purpose of Spatial Planning

“The planning system helps us to decide who can build what, where and how. It makes sure that buildings and structures that the country needs (including homes, offices, schools, hospitals, roads, train lines, power stations, water pipes, reservoirs and more) get built in the right place to the right standards. A good planning system is essential for the economy, environment and society.”(6)

Good planning should ensure that the right development is built in the right place at the right time.

2.1.2 An introduction to the national planning system

The planning law requires that applications for planning permission must be determined in accordance with the Councils' development plan, which includes the Local Councils' Local Plan (See section 2.1.3 below) and neighbourhood plans (See section 2.1.5 below).

The National Planning Policy Framework (NPPF) must be taken into account in the preparation of these local and neighbourhood plans, and is a material consideration in planning decisions. Planning policies and decisions must reflect, and where appropriate, promote relevant EU obligations and statutory requirements. There is also guidance to complement the NPPF in the National Planning Policy Guidance (NPPG) document.

What is it?
The National Planning Policy Framework *- sets out the Government's planning policies for England and how these are expected to be applied. It provides a framework within which local people and their accountable councils can produce their own distinctive local and neighbourhood plans, which reflect the needs and priorities of their communities.*

The National Planning Policy Guidance (NPPG) states that local planning authorities should aim to involve all sections of the community in the development of Local Plans and in planning decisions, and should facilitate neighbourhood planning.

The NPPG further outlines that planning policies and decisions should aim to achieve places which promote:

- opportunities for meetings between members of the community who might not otherwise come into contact with each other, including through mixed-use developments, strong neighbourhood centres and active street frontages which bring together those who work, live and play in the vicinity;
- safe and accessible environments where crime and disorder, and the fear of crime, do not undermine quality of life or community cohesion;
- safe and accessible developments, containing clear and legible pedestrian routes, and high quality public space, which encourage the active and continual use of public areas.

What is it?
The National Planning Policy Guidance *- adds further context to the NPPF and the two documents should be read together. It replaced over 7,000 pages of planning guidance that was previously published in separate documents.*

In order to deliver the social, recreational and cultural facilities and services the community needs the NPPG, recommends planning policies and decisions should:

- plan positively for the provision and use of shared space, community facilities (such as local shops, meeting places, sports venues, cultural buildings, public houses and places of worship) and other local services to enhance the sustainability of communities and residential environments;
- guard against the unnecessary loss of valued facilities and services, particularly where this would reduce the community's ability to meet its day-to-day needs;
- ensure that established shops, facilities and services are able to develop and modernise in a way that is sustainable, and retained for the benefit of the community;
- ensure an integrated approach to considering the location of housing, economic uses and community facilities and services.

2.1.3 What is a Local Plan?

Planning involves making decisions about the future of cities, towns and countryside. This is vital to balance the desire to develop the areas where we live and work with ensuring the surrounding environment isn't negatively affected. It includes considering the sustainable needs of future communities.

In order to ensure health impacts are assessed and successful outcomes are achieved opportunities to include health related policies in local planning policy documents and local planning guidance should be sought. Health impacts may already be assessed in a range of assessments that are submitted with large scale planning applications, these may include assessments of air quality, noise and transport for example as well as Health Impact Assessments.

The consideration of health impact assessment (HIA) in the Government's impact assessment process is mandatory. As part of the White Paper 'Choosing Health' 2004, the Government gave a commitment to building health into all future legislation by including health as a component in regulatory impact assessment (RIA). The Cabinet Office has revised RIA to become impact assessment (IA) and HIA is one of the specific impact tests. This means that health and wellbeing are designed into national policy.

In order to ensure that a new development makes a positive contribution to the health and wellbeing a specific policy requirement must be contained in the Local Plan, for example at its simplest level if the Local Plan does not have a policy requiring the provision of open green space, then the developer is under no obligation to provide open green space. There may be opportunities to require open green space if the Local Plan has a general policy requiring that development proposals should contribute to creating a healthy, living environment. An overview of the Local Plans in Cambridgeshire is given in section 3.1

What is it?
***The Local Plan** - is a plan for the future development of the local area, it is drawn up by the Local Planning Authority. It guides decisions on whether or not planning applications can be granted.*

The Local Plan should plan positively for the development and infrastructure communities need, setting out the strategic priorities for the area in the Local Plan. This should include policies to deliver:

- housing, including affordable homes;
- retail, leisure and other commercial development;
- infrastructure for transport, minerals, waste, energy, telecoms, water supply and sewage treatment;
- education, health, police and community facilities;
- energy, including from renewable sources;
- protection and enhancement of the natural and historic environment, including landscape, wildlife, open space, listed buildings and archaeology;
- protection of homes and property from flooding from rivers and the sea.

Local Plans should be aspirational but realistic. They should address the spatial and land use implications of economic, social and environmental change. The Local Plan is normally in two sections, the first contains the vision for the plan area and the policies to achieve this, and the second is a set of maps of the area indicating where development will normally be permitted.

2.1.4 Other plans

In addition to the local plan there are other Community Planning Tools & Options that can be used to improve health and wellbeing at a local level, the most relevant are "Community led/Parish Plans", "Neighbourhood Plans", "Neighbourhood Development Orders", "Community Right to Build Orders", and "Village Design Statements".

Community led/Parish Plans – create a vision for how a community wants to develop and identifies the actions needed to achieve it. It explores key services and facilities needed by a parish and demonstrates how the character of the parish might be protected. It also identifies challenges and opportunities. A good Parish Plan will address issues the whole community feels are important and, which it intends to address itself. It must contain an action plan.

Advantages	Challenges
• Very high community participation rates. • Focuses on the things people in a community care about. • Good collaboration between different interests. • Led by members of the community. • An established process: over 4,000 plans produced nationwide. • Track record of deploying a range of engagement techniques. • Fosters and capitalises on local social capital. • Can help to secure funding for projects identified in them by providing evidence of robust community consultation. • Potential formal adoption by Parish Council. • Provides detailed knowledge and insight not otherwise available to the Local Planning Authority (LPA). • Effective identification of locally perceived problems/assets. • Must include an action plan so they are practical.	• Cannot make specific land use proposals. • No legal power. • If dependent on external pots of money or a "community's wealth", there is a risk that resource and finance won't be available to deliver the actions. • Uncertain power to implement proposals.

Neighbourhood Plans – identify a shared vision and common goals for a designated "neighbourhood area". They define where new homes, shops, offices and other development should be built; identifying and protecting local green space; and influencing what new buildings should look like.

Neighbourhood Plans can only be initiated by parish councils in parished areas (or Neighbourhood Forums where there is no parish council). A Neighbourhood Plan must broadly conform to the strategic policies set out in the local planning authorities Local Plan. It can be used to promote more development than is set out in the Local Plan (in both numbers and/or detail) but *cannot be used to promote less or prevent development*. It must

also comply with national planning policy and other national and EU requirements. Independent examination and endorsement via a local referendum are statutory requirements.

Advantages	Challenges
• The plan has a statutory status, and will become part of the Local Plan for that district council. • Planning applications in an area with a neighbourhood plan will be determined by using the policies in that neighbourhood plan. • Whilst a Neighbourhood Plan must conform to the strategic policies in the Local Plan, Planning decisions are made in favour of the Neighbourhood Plan where non-strategic policies conflict, unless material considerations indicate otherwise. • Enables strong community influence over land use and development, including through a democratic process (referendum). • The Local Planning Authority has a duty to assist with producing a Neighbourhood Plan. • Builds on local knowledge and insight • Is the responsibility of a formal part of representative democracy, i.e. Parish Council. • Could respond practically to local housing need by allocating development sites. • Should stimulate greater ownership of planning decisions among local communities. • Areas with a Neighbourhood Plan benefit from a 10% uplift in the Community Infrastructure Levy (CIL) from 15% to 25% on any development in the area, not only that proposed in the Neighbourhood Plan.	• Must follow government regulations in preparing them. Requires various stages of formal consultation, independent examination and referendum before being 'made' or adopted. • Need to scope the policies in the plan to see if full sustainability appraisal is needed which can be a complex task. • Needs to have a strong evidence base to withstand potential legal challenge. Must be able to justify policies in the plan. • Could become a vehicle for conflict within the community or between community and developers in disputes over development land. • Current arrangements can be bureaucratic and time-consuming. • Non-land use related issues that a community might wish to address are better addressed through a separate document, e.g. a parish plan. They will not be looked at by the independent examiner. • Cannot be used to alter Green Belt boundary. • CIL benefits are limited where small-scale developments are proposed .

Neighbourhood Development Orders – grant planning permissions for certain types of development in a designated 'neighbourhood area'. They can apply to a specific site, sites or a wider geographical area. They can grant planning permission outright or subject to conditions and can exclude certain areas from Neighbourhood Development Order projects. They must meet the same minimum requirements as the Neighbourhood Plan with regard to compliance, examination and referendum. Only a parish council can prepare one.

Advantages	Challenges
• Removes the need for planning permission for the types of development permitted by the order. • Minor changes could avoid a formal planning application or be delegated to a local body. • Might help stimulate local democracy. • Promotes projects with locally distinctive design. • Local community formally involved in planning decisions.	• Limited range of permitted development proposals. • Long and complex process to establish the Order. • Where the Order creates exemptions from planning consent, there is less guarantee of locally appropriate design. • Without the framework of a Local Plan, Neighbourhood Plan or Design Statement development might be uncoordinated and potentially unattractive. • There are continuing liabilities for whoever manages them.

Community Right to Build Orders – is a specific type of Neighbourhood Development Orders that allows development without a lengthy and difficultplanning process. They can be created as part of a Neighbourhood Plan or separately. They aim to give communities certain powers to decide what is built in their area. They allow small-scale developments where they have the agreement of the local community. Communities can build family homes to sell on the open market, affordable housing for rent or to convert disused farm buildings into affordable homes, supported housing for older local residents, low cost starter homes for young local families, or facilities such as a new community centre or a children's playground.

Advantages	Challenges
• Follows a streamlined version of the Neighbourhood Planning process. • Subject to lighter consultation requirements and examination levels than Neighbourhood Plans – the examiner's report is binding on the Local Planning Authority. • Has to go through a referendum. Where 50%+1 of those voting approves the Order, the Local Planning Authority has a duty to implement it. • Allows communities to take forward small-scale development even where the Local Planning Authority is opposed. • Benefits (such as profits generated) are kept and managed by a community organisation on behalf of the whole community, regardless of ownership of the development. • Groups can ensure affordable housing remains affordable in perpetuity. • Development can be located in the Green Belt as long as National Planning Policy Framework Green Belt criteria are met.	• Can be used in conjunction with Community Right to Bid. Simultaneous use of the Community Rights could be advantageous but as timescales for each Community Right are different, this would be difficult to achieve. • Little to be gained by Community Right to Build if there is little chance of development being delivered – to make it happen community may have to acquire the land/engage with a willing developer. • Community must find funding to cover costs of the process. • Only for use by community organisations in which local people (based on electoral register) have majority voting rights and directorships and include different people from at least 10 different addresses within the area (preventing developers gaining easy planning permission against a community's wishes). • Proposals requiring an Environmental Impact Assessment (EIA) or having a significant impact in terms of Habitats Regulations are not eligible.

• Particularly beneficial in rural areas with a need for small-scale development and/or economic regeneration. • If built by a developer, the Community Infrastructure Levy and New Homes Bonus apply.	• Proposals must not be at odds with conservation and listed building legislation, or be at odds with the strategic policies in the Local Plan or Neighbourhood Plan, (if there is one). • Community Right to Bid only gives the community the right to bypass normal planning consents. (land acquisition, financial processes (including raising finance) and building regulations apply).

Village Design Statements – aim to record, celebrate and enhance what a community feels are the distinctive features that make a village unique. It uses those characteristics to frame guidelines on how future development might look (not whether or where development might take place). The aim is to ensure a close relationship with the statutory planning system to maximise effectiveness.

Advantages	Challenges
• Very clear focus on design and local distinctiveness. • Can be adopted as material planning considerations by the Council and taken into account when planning applications are being considered. • Provides local insight and information not otherwise available to local planning departments. • Clear parameters – how, not whether or where, development should take place. • Can draw developers into the process. • 20 year+ track record.	• Might attract only 'design-aware' residents and not the whole community. • Can be initiated to prevent development, which is not their purpose. • Emphasis is on conservation and replication and can, therefore, be limited. • Can require management of different opinions about design-related matters. • Can be dependent on motivated individuals with the right skills. • The Council may not be willing to adopt it. • Not straight forward to turn into a Supplementary Planning Document (SPD). There are strict regulations for producing SPD and it would have to bementioned in the Council's Local Plan.

2.1.4 What is a Health Impact Assessment (HIA)

HIA is commonly defined as "*a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population*." (7)It is a tool to appraise both positive (e.g. creation of new jobs) and negative (e.g. generation of pollution) impacts on the different affected subgroups of the population that might result from the development. Public participation is considered a major component of the process.

It usually assesses a policy or proposal that does not have health improvement as a primary objective. The implementation of the development may result in intended objectives being met but may also result in consequences that are unintended and unanticipated. These unintended effects may be beneficial or adverse for people's health and wellbeing.

The Health Impact Assessment aims to identify all these impacts on health in order to enhance the benefits for health and minimise any risks to health. It includes specifically a

consideration of the differential impacts on different groups in the population, because certain groups are potentially more vulnerable to negative impacts from development such as those on a low income, people involved in the criminal justice system, minority ethnic groups, young, disabled (physically and learning) older people.

A HIA is usually forward looking (prospective) and done at a time when it is possible to change the proposed development if necessary, e.g.during or prior to the masterplanning stage. It may be necessary to submit two HIAs, one at the outline stage of a planning application and one the reserved matters stage. This will be dependent on how detailed the outline application is.

A Health Impact Assessment should:

- Appraise the potential positive and negative health and wellbeing impacts of the proposed development on planned new communities and the adjacent existing communities in the development area.
- Highlight any potential differential distribution effects of these impacts among groups within the population by asking ‘who is affected?
- Suggest actions and/or mitigations that aim to minimise any potential negative health impacts and maximise potential positive health impacts, referencing where possible the most affected vulnerable group(s).

Table 14: Common features of HIA and other Assessments

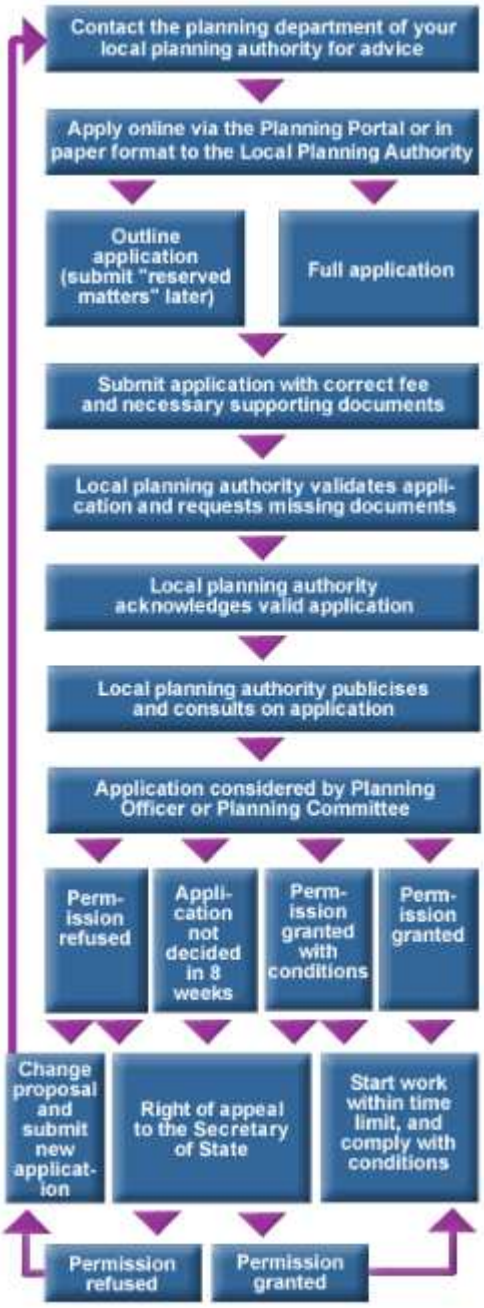
	Health Needs Assessment	Health Impact Assessment	Integrated Impact Assessment	Health Equity Audit	Equality Impact Assessment	Environmental Impact Assessment
Starting point	Population	Proposal	Proposal	Services and resources	Proposed policyor organisational function	Proposal requiring planning permission
Primary output	Informs decisions about strategies, service priorities, commissioning and local delivery plans, and informs future HIAs and IIAs	Recommends how to maximize benefits and minimise negatives of a proposal to inform decision making and improve joined-up working	Recommends how to maximise benefits and minimise negatives of a proposal to inform decision making and improve joined-up working	Agreed and acted upon interventions that equitably distribute services and resources	Ability of organisation to demonstrate it is meeting legal requirements to promote equality in its policies and functions	Agreed and acted upon interventions that reduce any negative impact on the environment arising from a proposal
Aims to take account of inequalities	Describes health needs and health assets of different groups in local population. Helps improve health and reduce health inequalities	Compares impact of proposals on most vulnerable groups in the population. Helps improve health and reduce health inequalities	Compares impact of proposals on most vulnerable groups in the population. Helps improve health and reduce health inequalities	Compares health needs and outcomes in the local population with use and access to services and resources. Helps improve health and reduce inequalities	Assesses how far a policy or function may promote equality and good race relations. Helps reduce organisational and racial inequity	Describes environmental impact of a proposal and should identify groups that are particularly vulnerable to associated health issues.
Involvement of stakeholders	Always	Always	Always	Always	Always	Always
Involvement of community	Always	Ideally (dependent on resources)	Ideally (dependent on resources)	No	Always	Ideally (dependent on resources)
Involvement from many sectors	Sometimes	Usually	Always	Always	Sometimes	Sometimes
Based on determinants of health	Usually	Ideally	Always	Usually	No	No
Best available evidence used	Always	Always	Always	Always	Always	Always
Uses data from other approaches; informs other approaches	Always	Always	Always	Always	Always	Always

2.1.5 What is the process for determining a planning application?

In order for a new development to start, the developer/landowner must obtain planning permission from the local planning authority (LPA).

The **local planning authority** (LPA) – usually the district or borough council (in Cambridgeshire the five District/City Councils are the LPAs (the County Council is the planning authority for Highways and Waste infrastructure) is responsible for deciding whether a proposed development should be allowed to go ahead and planning permission granted. The application is assessed against compliance with that LPA's Local Plan.

Figure 16: The Planning Process



Validation
All applications are checked to make sure all documents and the required fee(s) have been submitted.

Consultation and publicity
Consultations are sent to various statutory and non-statutory bodies to obtain their expert view. Advertisements, where required, are placed in the appropriate local paper and on site.

Consideration
The site is inspected and the application assessed by the planning case officer, taking into account planning policies, consultation responses and public representations.

Recommendation
The planning officer will make a recommendation, via the officers' report to the relevant committee of the council or individual who has delegated powers to make the decision.

Decision
A decision is taken on the application by the appropriate body.

Local planning authorities are expected to determine planning applications within a time period of 8, 13 or 16 weeks (depending on the type of development).

2.1.6 Who are the Statutory and Non-Statutory Consultees for planning applications?

Planning law prescribes where consultation must take place between a local planning authority and certain organisations (dependant on the type of planning application), prior to a decision being made on an application. The consultees in question are under a duty to respond to the local planning authority within a set deadline and must provide a substantive response to the application in question. Where statutory consultation is required, statutory consultees are under a duty to respond within 21 days.

Table 15: List of Statutory Consultees (Planning Practice Guidance (Paragraph: 009 Reference ID: 15-009-20140306))

Statutory Consultees	
Adjoining landowners	Canal and River Trust
Coal Authority	Control of major-accident hazards competent authority (COMAH)
County Planning Authorities	Crown Estates Commissioners
Department of Energy and Climate Change	Environment Agency
Forestry Commission	Garden History Society
Greater London Authority	Health and Safety Executive
Highways Authority	Highways England
Historic England	Local Highway Authority
Local Planning Authorities	National Parks Authorities
Natural England	Parish Councils
Rail Infrastructure Managers	Rail Network Operators
Sport England	
Non-statutory Consultees	
Emergency Services and Multi-Agency Emergency Planning	Forestry Commission
Health and Safety Executive	Ministry of Defence
Office of Nuclear Regulation	Police and Crime Commissioners
Rail Network Operators	
Business Improvement Districts	

It is important to note that the NHS is not a consultee for planning applications in any capacity.

2.1.7 What are the main types of planning applications?

There are two main types of planning applications: applications for full planning permission; and applications for outline planning permission.

Full Planning Permission – allows for a decision on all aspects of the proposed development, although it would generally be subject to various conditions.

Outline Planning Permission – allows for a decision on the general principles of how a site can be developed. Outline planning permission is granted subject to conditions requiring the subsequent approval of one or more 'reserved matters'.

Reserved matters – are the aspects of a proposed development which an applicant chose not to submit details of with an outline planning application, (ie they can be 'reserved' for later determination). These are defined in article 2 of the Town and Country Planning (Development Management Procedure) (England) Order 2015 as:

- 'Access' – the accessibility to and within the site, for vehicles, cycles and pedestrians in terms of

Applications can also be made for:

- *approval of reserved matters;*
- *discharge of conditions;*
- *amending proposals that have planning permission;*
- *amending planning obligations;*
- *lawful development certificates;*
- *prior approval for some permitted development rights;*
- *non-planning consents (such as advertisement consent, consent required under a Tree Preservation Order and hazardous substances consent).*

the positioning and treatment of access and circulation routes and how these fit into the surrounding access network.

- 'Appearance' – the aspects of a building or place within the development which determine the visual impression the building or place makes, including the external built form of the development, its architecture, materials, decoration, lighting, colour and texture.
- 'Landscaping' – the treatment of land (other than buildings) for the purpose of enhancing or protecting the amenities of the site and the area in which it is situated and includes: (a) screening by fences, walls or other means; (b) the planting of trees, hedges, shrubs or grass; (c) the formation of banks, terraces or other earthworks; (d) the laying out or provision of gardens, courts, squares, water features, sculpture or public art; and (e) the provision of other amenity features;
- 'Layout' – the way in which buildings, routes and open spaces within the development are provided, situated and orientated in relation to each other and to buildings and spaces outside the development.
- 'Scale' – the height, width and length of each building proposed within the development in relation to its surroundings.

Planning Conditions

A planning condition is a condition placed on the grant of planning permission. These conditions permit development to go ahead only if certain circumstances are satisfied. Conditions can include time limits on development, undertakings regarding environmental and noise issues and limits on the size and external appearance of a new development.

Planning permissions are usually granted subject to a planning condition which requires the development to be commenced within a set number of years. Some of these conditions will need to be complied with before any work starts on site; others will take effect once the development is commenced, or later.

Developer Contributions

Developers may be asked to provide monetary contributions for infrastructure in several ways. Either through the Community Infrastructure Levy (CIL) and/or through planning obligations in the form of Section 106 agreements.

The CIL is intended to provide infrastructure to support the development of an area, rather than making individual planning applications acceptable in planning terms. As a result, some site specific impact mitigation may still be necessary in order for a development to be granted planning permission. Some of these needs may be provided for through the CIL but others may not, particularly if they are very local in their impact. Therefore, there is still a role for development specific planning obligations to enable a local planning authority to be confident that the specific consequences of a particular development can be mitigated.

A planning obligation needs to meets all of the following tests:

- *necessary to make the development acceptable in planning terms;*
- *directly related to the development; and*
- *fairly and reasonably related in scale and kind to the development.*

However, in order to ensure that planning obligations and the CIL can operate in a complementary way, the CIL Regulations 122 and 123 place limits on the use of planning obligations in three respects:

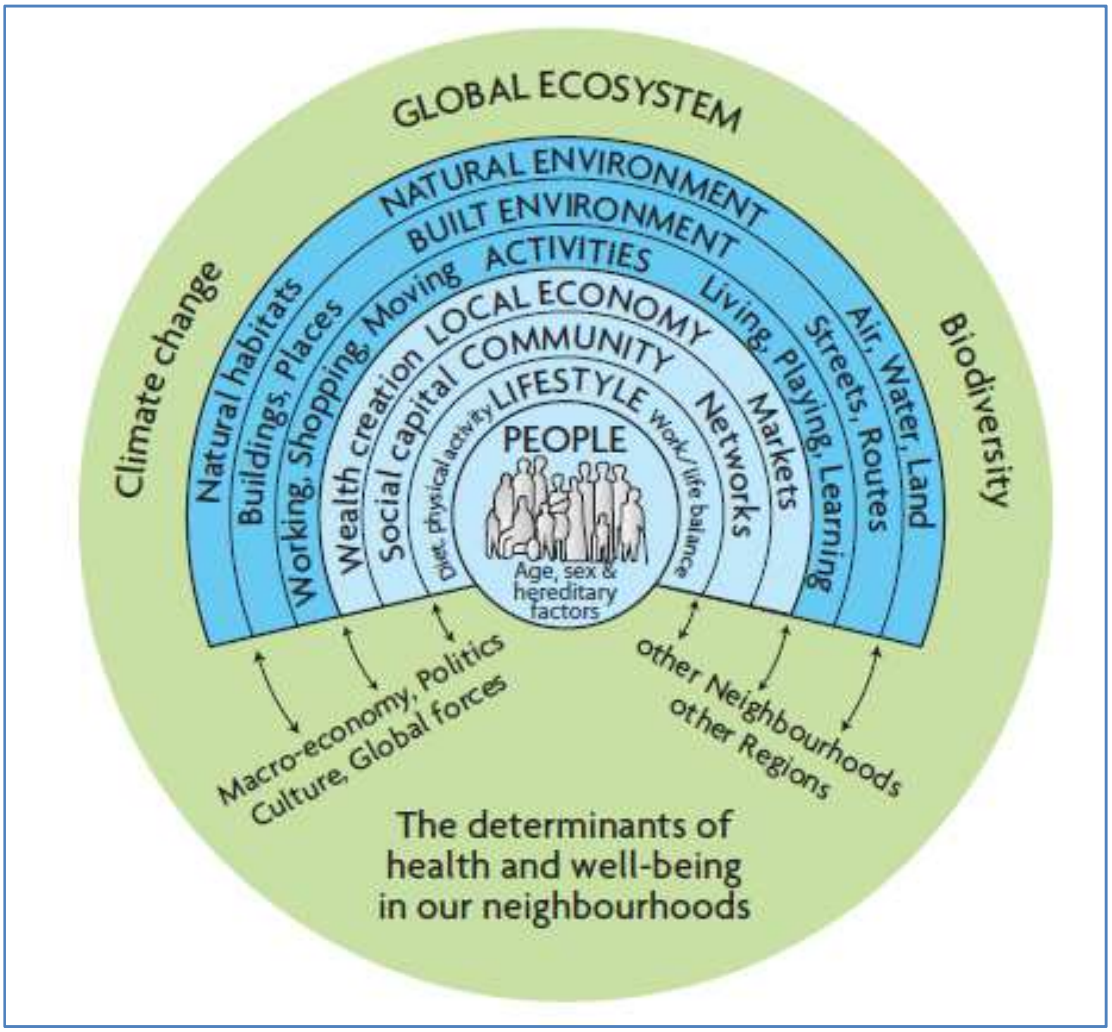
- they put the Government's policy tests on the use of planning obligations on a statutory basis, for developments that are capable of being charged the CIL
- they ensure the local use of the CIL and planning obligations does not overlap; and
- they impose a limit on pooled contributions from planning obligations towards infrastructure that may be funded by the CIL.

Therefore, it is possible to require both a CIL contribution and a Section 106 Planning Obligation contribution from the developer for the same application.

2.2 WHAT FEATURES OF THE BUILT ENVIRONMENT AFFECT HEALTH AND WELLBEING?

Place and space have an impact on health andwellbeing and individual actions to improve lifestyle or health and wellbeing status are likely to beinfluenced by the environmental and socioeconomic context in which they take place. Theterm “built environment”includes open space, networks and connectivity between areas as well as the physical structures. This includes the places where people work, live, play and socialise. The connections between these spaces, both manmade and natural features are also important. The built environment includes several material determinants of health,including housing, neighbourhood conditions and transport routes, all of which shape thesocial, economic and environmental conditions for which good health and wellbeing is dependent, these determinants of health are depicted in Figure 17.

Figure 17: The determinants of health and wellbeing in our neighbourhoods. Diagram by Barton, H & Grant, M, 2006, derived from Whitehead, M & Dahlgren, G, The determinants of health and well-being, 1991.



Due to the scale of the topic of the built environment and health a pragmatic approach of grouping the evidence by the broad themes which emerged from the literature has been taken.The evidence is, therefore, presented in the following themes:

- Generic evidence supporting the built impact on health
- Green space
- Developing sustainable communities
- Community design (to prevent injuries, crime, and to accommodate people with disabilities)
- Connectivity and land use mix
- Communities that support healthy ageing
- House design and space
- Access to unhealthy/"Fast Food"
- Health inequality and the built environment

2.2.1 Generic evidence supporting the built environment's impact on health

There is a clear association between the built environment and physical activity(1), where the physical characteristics of neighbourhoods are identified as having a positive impact on health, wellbeing, physical activity and walkability, these characteristics are: choice and diversity; well-kept environments; affordable and efficient public transport; safe and sociable play areas; the presence of greenspace; well-lit and pedestrian-friendly footpaths; and street patterns that provide opportunities for informal contact among residents(2). In addition, the Cambridge quality charter(3) sets out a series of basic principles for achievinghigher quality developments under four broad themes; Community, Connectivity, Climate, and Character ie building a sense of **community** through providing a greater choice of housing along with the active participation of people in the way their neighbourhoods are run. New developments should be located where people can benefit from high **connectivity** to jobs and services, and the infrastructure upgraded to match the pace of development. **Climate change** should be tackled through imaginative landscaping that treats water as a friend not an enemy, and through innovative approaches to transport, energy and waste. Finally, places of **character** should be created, with distinctive neighbourhoods and a first class public realm.

2.2.2 Green space

Provision of green space and infrastructure supports health through bringing with it the co-benefits that occur when accessing it eg physical activity and social interaction. (4)Contact with nature has a positive impact on blood pressure, cholesterol, outlook on life and stress reduction. (5)

The term Green Spaceincludes parks, forests, playing fields, river corridors, play areas and cemeteries.

The NICE physical activity and environment guidance conclude that people are more like to walk or cycle if there is an attractive streetscape with well-maintained and unobstructed pavements, although there does not seem to be a clear association between the amount and availability of green space and physical activity. (6)

There is anecdotal evidence from community members and local organisations that note the positive health benefits including increased physical activity, improved sense of security and increased social capital with community gardens.(7)

Dutch data on the self-reported health of over 10,000 people combined with land-use data on the amount of greenspace in their living environment concluded that living in a green environment was positively related to *Self-reported health indicators* (iethe number of

symptoms experienced in the last 14 days, perceived general health, and scores on the Dutch version of the General Health Questionnaire (GHQ) which indicate a person's propensity to psychiatric morbidity). Analyses on subgroups showed that the relationship between greenspace and one of the health indicators was somewhat stronger for "housewives" and the elderly, two groups that are assumed to be more dependent on, and therefore exposed to, the local environment. Furthermore, for all three health indicators the relationship with greenspace was somewhat stronger for lower educated people.(8) The study also concluded that having 10% more green space in the living environment is associated with a decrease in age related symptoms (in the last 14 days) that is comparable with a decrease in age by five years.

Green space and mental health
Garden users in a children's hospital found that they felt more relaxed and less stressed after visiting the garden.(9)

A study from MIND comparing groups taking part in two walks in contrasting environments, a country park compared to a shopping centre found that the group in the country park reported significant improvement in self-esteem, depression, anger, tension, confusion, fatigue compared to the group walking in the shopping centre.(10)

Green spaces and social ties
Evidence indicates that natural features within urban environments can encourage greater use and facilitate higher levels of social contact/integration.(11) A study in the US reported that the presence of trees and grass is related to social activity that takes place within them and the proportion of social to non-social activities they support.(12)

Green space and the elderly
Walkable green spaces near the residences of older people aged 75+ significantly and positively influences five-year survival.(13) The probability of five year survival increased in accordance with the space for taking a stroll near the residence ($p<0.01$), parks and tree lined streets near the residence ($p<0.05$), and their preference to continue to live in their current community ($p<0.01$). Two environment related factors emerged, the factor of walkable green streets and spaces near the residence and the factor of a positive attitude to a person's own community. The factor of walkable green streets and spaces near the residence showed significant predictive value for the survival of the urban senior citizens over the following five years ($p<0.01$). The study concluded that living in areas with walkable green spaces positively influenced the longevity of urban senior citizens independent of their age, sex, marital status, baseline functional status, and socioeconomic status.

Characteristics of green space
There are differences in the use of parks by ethnicity, a study found that Caucasian users of a large attractive urban park, lived locally and walked daily, while non-Caucasian users lived further away, visited the park infrequently as a family, and for passive recreational pursuits.(14)

Qualitative and quantitative surveys suggest that factors influencing use of Public Open Space include perceived proximity and accessibility (i.e. the absence of major roads); aesthetic features of the park such as the presence of trees, water (e.g., a lake) and birdlife, park maintenance (e.g., irrigated lawns), park size (which, in turn provides variety and opportunities to "lose oneself"), and the availability of amenities such as walking paths. Larger parks tend to have more attributes that provide more satisfying experiences for the user.(15)

Several studies have shown that parks with paved trails, unpaved trails, or wooded areasare more than seven times as likely to be used for physical activity compared to parks without these facilities. The presence of paved trails (OR=32.41; 95% CI=3.27, 320.36; P=.01), unpaved trails (OR=7.11; 95% CI=1.40, 36.12; P=.02), and wooded areas (OR=6.75; 95% CI=1.40, 31.90; P=.02) were significantly related to park-based physical activity when examined independently. In the unadjusted analyses, a greater number of both facilities (OR=1.85; 95% CI=1.18, 2.90; P=.01) and amenities (OR=1.49; 95% CI=1.04, 2.14; P=.03) was significantly associated with increased odds of at least some physical activity occurring in the park. (16)(17)

A systematic review of qualitative evidence on characteristics of park use and physical activity: showed both adults and children report multiple attributes within parks that encourage use, including those that support active and passive pursuits. Toilet facilities, water fountains, barbeques, picnic areas, seating, signage, and shade were all identified as important amenities within parks.(18)Similar attributes associated with park use are reported among quantitative research (Cronan et al., 2008; Reed et al., 2008; Kaczynski et al., 2008; Giles-Corti et al., 2005a; Floyd et al., 2008; Gobster, 2002; Shores and West, 2008). The review also found that features of parks that facilitated both structured (i.e., sports fields, courts) and unstructured (i.e., paths, trails) physical activity were important for encouraging park visits, and recent quantitative research suggests that parks with walking paths and trails were visited more often than parks containing sports-related facilities. Parks that support passive activities such as sitting may contribute to incidental physical activity if individuals seeking these activities use an active mode of transport to travel to or through the park. Moreover, the provision of amenities such as water fountains and toilets may allow parks to be used for longer periods, which in turn may encourage increased levels of physical activity.

Distance to public open space
Public open spaces closer to a person's home is associated with higher levels of use. Families that live further away visited parks less frequently. Overall use of Public Open Spaceis positively associated with accessibility.

Accounting for attractiveness as well as distance does not produce a stronger trend with level of access. However, when size was also taken into account, the odds ratio (OR) increases for those with very good access. Compared with those with very poor access, those with very good access to large attractive public open spaces are twice as likely to use it. These results suggest that after distance to public open spaces is taken into account, size was more important than attractiveness in encouraging use.(15)

Those parks with good access to attractive and large public open spaces were 50% more likely to achieve high levels of walking (six walking sessions a week totalling >180mins (15).

Natural England(19) has developed an Accessible Natural Greenspace Standard (ANGSt) which provides local authorities with a detailed guide as to what constitutes accessible green space. The Accessible Natural Greenspace Standard not only recommends the distance people should live from certain types of green spaces but also recommends the size of the green spaces in conjunction with distance to homes. All people should have accessible natural green space:

- of at least two hectares in size, no more than 300m (five minutes' walk) from home;
- at least one accessible 20 hectare site within 2km of home;
- one accessible 100 hectare site within 5km of home;
- one accessible 500 hectare site within 10km of home.

In 2008, Bristol City Council developed an accessible green space standard(20), known as the distance standard, which sits alongside both quality and quantity standards. The aim of the distance standard is to safeguard and encourage an accessible network of green spaces.

The standard is based on local research which identified the distance Bristol residents felt they could reasonably walk to access green space which coincided with the layout of Bristol's green spaces to ensure the standards were credible.

The distances proposed include:

- distance to the nearest green space – 400m/nine minutes' walk;
- children's play space – 450m/10 minutes' walk;
- formal green space – 600m/15 minutes' walk;
- informal green space – 550m/13 minutes' walk;
- natural green space – 700m/18 minutes' walk.

Allotments

Allotment gardeners report higher levels of physical activity in summer than a control group of neighbours significantly or marginally better than the control group on several measures of health and well-being. Allotment gardeners of 62 years and older reported better scores on all measures of health and wellbeing than neighbours, whereas younger allotment gardeners did not differ in health and wellbeing from younger neighbours.(21)This is supported by other reports outlining the importance of allotment gardens in achieving physical activity(22), (23), (24), in addition other studies have highlighted these benefits for the older people (25), (26).

Farmers Markets

Farmers markets are a crucial place for social interaction in the lives of older people as well as families and children, when market shopping is a time "to bump into friends and chat at leisure". In addition, market stalls take on the important role of including low income groups, who may be excluded from other shopping sites.(27)

Studies have also shown proximity of local food produce rather than fast food outlets to be associated with a lower rate of obesity amongst the population.(28), (29), (30)

2.2.3 Developing sustainable communities:

Design principles that have shown to produce health and occupational benefit (31), which in turn has been shown to reduce work place stress and absenteeism, reduce energy expenditure and building maintenance, these design principles include:

- Maximising natural daylight
- Solar collectors
- Passive cooling
- Non-toxic materials
- Harvesting rain water
- Creating pedestrian and bike greenways
- Filling buildings with plants, art, natural air
- Social cohesion and connectivity

2.2.4 Community design to prevent road trafficinjuries, crime, and to accommodate people with disabilities.

Environments designed to encourage walking and cycling contribute to lower pedestrian and cyclist injury rates in Holland and Germany than in the United States. Traffic-calming measures and other improved road and trail designs that take into account potential conflicts

between pedestrians, bicyclists, and motorists may lead to reductions in motor vehicle collisions and injuries.(32)

Rates of crime and fear of crime are associated with features of the physical environment within neighbourhoods, such features range from housing configurations that facilitate “eyes on the street” to abandoned buildings that suggest vulnerability to crime. The Crime Prevention Through Environmental Design (CPTED), which include design recommendations for housing layout, land use, territoriality, and physical maintenance, was developed to improve public safety, the UK version is called “secure by design”.

Communities that have user-friendly transportation systems and are compact and walkable are more accessible for persons with disabilities, allowing them to participate more fully in the community by working, shopping, and living within the integrated setting. Wheelchair users generally benefit whenever a community is made more walkable, as long as appropriate accommodations (such as curb cuts) are included in such community improvements. Older people without disabilities may receive similar benefits in improved quality of life from community designs that aid people with disabilities.(33)

2.2.5 Pavements

Urban developments contribute towards increasing the risk ofsurface water flooding as a result of continued development on floodplains and the increased use of impervious materials which increase surface water runoff. As runoff increases, so too does the risk of flooding and contamination from microbial and chemical agents. Exposure to contaminated floodwater increases the risk of respiratory illness, gastrointestinal illness and high blood pressure, and many of the chemical contaminants found in floodwater are carcinogenic.

2.2.6 Connectivity and land use mix

Well-connected and attractive public places and streets can encourage more people to exercise and make active travel choices. Having access to local services and resources (shops, sports centre, financial services) is associated with positive health outcomes. Places which enable people to carry out daily routines (eg shopping, banking, exercising, meeting people) within walking distance of their homes are likely to have higher levels of walking and cycling.

The availability and accessibility of parks, recreation and sports facilities strongly influence physical activity levels, and areas of socioeconomic disadvantage often suffer due to the poor quality or unequal distribution of such resources. Having access to local services and resources (shops, sports centre, financial services) is associated with positive health outcomes (The location and accessibility of some local services may influence the ‘obesogenic’ environment in terms of encouraging or discouraging physical activity and providing for a healthy diet). Local schoolscater for young families but also acts as centres for other social activities.

2.2.7 Communities that support healthy aging

The design of the environment must consider the declining visual, auditory, and kinaesthetic senses to maintain mobility, autonomy, independence, and well-being. Impaired hearing and vision need to be compensated for by louder signals and increased lighting. Changes in gait and balance mean that hazards such as steps, uneven pavements, and obstacles may lead to falls and subsequent health problems. Loss of cognitive functioning may inhibit way finding and orientation, so clear signage is required. More resting places may also be required for older adults who have low stamina.

Traffic has an impact on how older people navigate their surroundings, improvements can be made through the designing out of high speed through traffic, designing in traffic calming designs (narrower roads, more curves, street parking, slower speed limits), locating shop and amenities in locations which are accessible without having to cross busy streets.(34)

2.2.8 House design and space

Quantitative analysis noted the importance of adequate space in providing personal privacy, reducing depression, anxiety and stress, giving children room to play and a good nights sleep.(35) The cramming of different activities (studying, socialising, and relaxing) into limited space may adversely affect family life, creating a difficult dynamic which may play a part in the breakdown of relationships

Poor housing encompassing a lack of private study space for children is associated with underachievement. There is strong evidence that children with better quality homes gain a greater number of GCSEs, "A" levels and degrees and therefore have greater earning power(36), (37), (38)

Studies have linked this with an increase in anti-social behaviour. Children especially, teenagers deprived of adequate space at home may be disruptive and aggressive. In addition, low space standards contribute to poor health and low educational attainment that can express itself in incidences of antisocial behaviour.(39), (40)

The case for space(37) concludes that adequate space enables:

- Socialisation both with other family members and with guests (and having the privacy to do so).
- Having more storage space.
- Having more space for solitary activities and good circulation spaces which can also act as storage.
- Spaces for outdoor items such as prams, umbrellas and shoes.
- Relaxation, engaging in private study within bedrooms.
- Reorganisation of rooms internally, if need be, by making openings or converting pitched roofs.
- Working from home (e.g. to improve life-work balance).(41)
- Having more space in the kitchen so that children can play under the supervision of their parents; more space for waste and recycling bins.
- Improves day light and ventilation.

Large floor spaces allows long term utility of a house, creating the so called life time home. Çavusoglu et al (2008) argue that such adaptability delivers long-term accessibility as well as long-term sustainability as adequate space in dwellings will allow residents to adapt space to their changing needs over the life course: homes will become future proof.(37), (41)

It is important to create minimal space standards, similar to the London housing minimal space standards, which is based upon the Park Morris standard.(39)

Housing that is of a reasonable size and is affordable to heat is associated with positive health outcomes. Improved warmth and energy efficiency measures, which are often part of wider rehousing and retrofitting programmes, can lead to improvements in health. Reports indicate that increased usable indoor space as a result of improvements in thermal comfort and affordable warmth can have many benefits for householders, which may lead to improved physical and mental health.(42)

Qualitative studies have found that homes with improved thermal comfort reported: increase in usable indoor space; improvements in diet, privacy and household/family relationships. Although no clear evidence on health improvement, respondents made links to improvement in physical and mental health.(43), (44), (45)

2.2.9 Health inequality and the built environment

Individuals from lower income groups, older people and those with disabilities are less likely to have access to personal transport (Lavin et al., 2006). These groups may find that access to services such as shops and health care is reduced. Consequently, they may spend a higher proportion of their income on transport (Lavin et al., 2006). (46)

Access to transport that enables residents to move outside of their own community has been shown to positively correlate with a reduced fear of social isolation and positive mental health (Whitley et al, 2005). For those on higher incomes, this is by car or taxi. However, for those on lower incomes, access to public transport is important (Whitely et al, 2005). (46)

Lack of facilities such as public toilets (Greed, 2006) impacts on vulnerable groups, for example young children, older people and those with illnesses or chronic diseases. Lack of suitable areas for resting, for example benches and seating may also limit the ability for certain groups to explore or walk longer distances. For older people this impacts negatively linking to social isolation. (46)

Moreover, lack of availability and accessibility of municipal services such as libraries, health facilities, doctors' surgeries, schools and social support can have a negative social impact on communities and affect both physical and mental health (Horowitz et al, 2005; Lavin et al, 2006). Places which lack facilities often become ghettoised fostering a risk of further criminal activities (Horowitz et al, 2005) (46)

Inequitable distribution of physical activity facilities in communities is significantly associated with disparities in health related behaviours and obesity. Availability of resources to allow for physical activity decreases the relative odds of an overweight status, Particularly there is reduced equity amongst ethnic minorities and those of a lower socio-economic status. (47)

2.2.10 Obesity and access to unhealthy/fast food establishments in developments.

Children living close to fast food outlets more likely to be overweightChildren living in areas surrounded by fast food outlets are more likely to be overweight or obese. Centre for Diet and Activity Research (CEDAR) research looked at weight data from more than a million children and compared it with the availability of unhealthy food from outlets including fish and chip shops, burger bars, pizza places, and sweet shops. The results show that older children living in more deprived areas, which have higher density of unhealthy food outlets, are more likely to be obese. In particular, they are more likely to be overweight when living in close proximity to a high density of unhealthy eating outlets. For older children, unhealthy food outlets partly explained the association between deprivation and obesity but only by a small amount. The prevalence of fast food and other unhealthy food outlets explained only a small proportion of the observed associations between weight status and socioeconomic deprivation. Children's weight status may be influenced by their local environment, particularly older children, but associations between obesity and deprivation do not appear strongly due to local food environment characteristics.(48)

There is little evidence that food retailing around schools may influence student body mass index (BMI). A CEDAR study examined associations between food retailing and BMI among

a large sample of primary school students in Berkshire. By controlling for individual, school and home characteristics and stratifying results across the primary school years, it aimed to identify if the food environment around schools had an effect on BMI, independent of socio-economic variables. The results showed that there were no significant associations between retailing near schools and student BMI, but significant positive associations between fast food outlets in home neighbourhood and BMI z-scores. Year 6 students living in areas with the highest density of fast food outlets had an average BMI z-score that was 0.12 (95% CI: 0.04, 0.20) higher than those living in areas with none.(49)

Socio-ecological models of behaviour suggest that dietary behaviours are potentially shaped by exposure to the food environment ('foodscape'). Research on associations between the foodscape and diet and health has largely focussed on foodscapes around the home, despite recognition that non-home environments are likely to be important in a more complete assessment of foodscape exposure. CEDAR research characterises and describes foodscape exposure of different types, at home, at work, and along commuting routes for a sample of working adults in Cambridgeshire.

Home and work locations, and transport habits for 2,696 adults aged 29–60 were drawn from the Fenland Study. Density of and proximity to food outlets was characterised at home and work. Commuting routes were modelled based on the shortest street network distance between home and work, with exposure (counts of food outlets) that accounted for travel mode and frequency. For all types of food outlet, the research found very different foodscapes around homes and workplaces (with overall outlet exposure at work 125% higher), as well as a potentially substantial exposure contribution from commuting routes. On average, work and commuting environments each contributed to foodscape exposure at least equally to residential neighbourhoods, which only accounted for roughly 30% of total exposure. Furthermore, for participants with highest overall exposure to takeaway food outlets, workplaces accounted for most of the exposure. Levels of relative exposure between home, work and commuting environments were poorly correlated.(50)

Exposure to takeaway food outlets is positively associated with consumption of takeaway food. Among domains at home, at work, and along commuting routes, associations are strongest in work environments, with evidence of a dose-response effect. Exposure to takeaway food outlets in home, work, and commuting environments combined is associated with marginally higher consumption of takeaway food, greater body mass index, and greater odds of obesity. Government strategies to promote healthier diets through planning restrictions for takeaway food could be most effective if focused around the workplace.(51)

2.2.11 Suicide and new developments

Suicide is a major issue for society and a leading cause of years of life lost.
The Government's "Preventing Suicide in England" (59)report identified a number of objectives and areas for action, one of which is directly related to the built environment:

Reduce access to the means of suicide, as reducing access to high-lethality means of suicide i.e.jumping from a height is one of the most effective ways to prevent suicide. This is because people sometimes attempt suicide on impulse, and if the means are not easily available, or if they attempt suicide and survive, the suicidal impulse may pass. Suicide in high-risk locations and those on the rail and underground networks are most amenable to intervention.

Jumping from a high place is an important method of suicide to address. Suicides by jumping almost inevitably occur in public places, have a very high fatality rate and are

extremely traumatic for witnesses and people living and working in the surrounding area. Jumps also tend to attract media attention, which can lead to copycat suicides. All the world's most notorious suicide locations are jumping sites.

Locations that offer easily accessible means of suicide include vehicle and pedestrian bridges, viaducts, high-rise hotels, multi-storey car parks and other high buildings, and cliffs. Most new development sites will have structures that lend themselves to suicide attempts.

The risk of suicide can be reduced by limiting access to these sites and making them safer.

Evidence suggests that loss of life can be prevented when local agencies work together to discourage suicides at high-risk locations, including sites that temporarily become suicide hot-spots following a suicide death.

Effective approaches to reducing suicides at high-risk locations or from jumping includepreventative measures – for example barriers or nets on bridges, including motorway bridges, from which suicidal jumps have been made, and providing emergency telephone numbers, e.g. Samaritans.

Local authority planning departments and developers can include suicide in health and safety considerations when designing structures such as multi-storey car parks, bridges and high-rise buildings which may offer suicide opportunities.

Suicide by jumping or lying in front of trains and other moving vehicles is similarly an important method to address. While suicide rates have been falling generally, suicide deaths on the railway network have increased slightly, to about 210 people a year in England, Scotland and Wales. Most (about 80%) are men and most are in the 15–44 age range. The Rail Safety and Standards Board (RSSB) and the British Transport Police collect extensive information on railway deaths and incidents, including suicides and attempted suicides.

3. LOCAL DATA

3.0 WHAT IS IN THIS SECTION?

This section is split into two parts: the first gives a short overview of the five Local Plans in Cambridgeshire, their status and indication of the policy focus for each plan and the second part compares polices in each plan against the evidence themesthatemerged in section 2.2 above.

3.1 THE LOCAL PLANS OF CAMBRIDGESHIRE

Although each Council in Cambridgeshire has its own local plan "the statutory duty to cooperate" requires the authorities to work together to address strategic planning issues, including the additional homes and jobs needed in the area. Recognising both the need to work together and the statutory duty, the authorities in Cambridgeshire and Peterborough work closely with each other, and with neighbouring authorities.

The authorities set up the Cambridgeshire & Peterborough Joint Strategic Planning Unit (JSPU) in 2012, in response to the removal of statutory strategic planning functions. The JSPU works with the Cambridgeshire & Peterborough local authorities, and with relevant strategic bodies, to help develop a coherent approach to planning across the area.

3.2 THE FENLAND DISTRICT COUNCIL LOCAL PLAN

3.2.1 Overview of the local plan

The Fenland Local plan was adopted in May 2014 and the plan period is for 20 years
The main introduction to the plan contains a health summary highlighting that poor health is a key issue for Fenland and that the following health indicators are significantly worse in Fenland compared to the England average:

- Life expectancy for men.
- Levels of obesity amongst children.
- Levels of adult smoking.
- Levels of physical activity amongst adults.
- Levels of people diagnosed with diabetes.
- Rates of road injuries and deaths.
- Numbers of hospital stays for alcohol related harm.

Fenland remains relatively sparsely populated, but has experienced considerable housing and population growth in recent years, in line with growth across Cambridgeshire. In the decade up to 2001, the district's population grew at four times the national average and has continued to grow rapidly since. The 2011 Census suggests Fenland has a population of approximately 95,300, compared to 83,700 in 2001 and 75,500 in 1991. Chatteris and March in particular have accommodated significant new house building, as have Doddington, Wimblington and Manea.

Growth in employment in Fenland has not matched workforce expansion and out-commuting is increasing. Currently, almost 40% of Fenland's working population commute out of the district for work.

Fenland is Cambridgeshire's most deprived district (ranking as 94th most deprived authority out of 326 nationally). Deprivation levels in Fenland are generally more severe to the north of the district, and this is evident in Wisbech in particular.

Fenland's local plan has specific objectives to improve the quality, range and accessibility of services and facilities (eg health, transport, education, training, leisure opportunities and community activities); and ensure all groups thrive in safe environments and decent, affordable homes, and to create and enhance open space that is accessibleand improves opportunities for people to access and appreciate wildlife and wild places. There are also objectives to redress inequalities related to age, gender, disability, race, faith, location and income.

The Plan recognizes the need to address:

- appropriate housing;
- improved access to quality local services;
- healthy transport choices such as cycling and walking;
- access to green infrastructure and active recreation;
- good place making (including creating new, and connecting with existing, vibrant and successful communities);
- promoting renewable energy and energy efficiency to help address fuel poverty;
- improve the health and wellbeing of its residents including mental health;
- the promotion of community cohesion;
- reduction of crime, the fear of crime and anti-social behaviour;
- promote access to healthy and local food.

3.2.2 Developer Contributions Requirements

Developers will either make direct provision or will contribute towards the provision of local and strategic infrastructure required by the development either alone or cumulatively with other developments. Fenland do not operate the Community Infrastructure Levy system at the present time and is unlikely in the short term up to 2018, relying on developer contributions through the Section 106 process.

Fenland require developer contributions for the following infrastructure:

- Transport
- Community Facilities
- Education Facilities
- **Healthcare Facilities**
- Open Space and Play Areas
- Water, Drainage, Flood Protection and Energy Provision
- Culture, Leisure and Heritage
- Waste Collection and Disposal

Case Study 1: Health Facilities Policy - Fenland

Case Study – Fenlands policy on Health Care facilities:
When a new development is proposed, a common public comment is along the lines of 'but the doctor's/ dentist's surgery is too full – we will need a new one/or expanded one'. However, in simple terms, such surgeries are in effect a private business with complicated funding mechanisms linked, amongst other matters, to the number of patients. It could be said that, like a shop, doctor/ dentist surgeries are 'market-led'.

However, for very large strategic sites, which in themselves would generate demand for a new doctor's or dentist's surgery, we would expect a broad concept plan to make space available for such facilities. To determine whether a site should provide such a space, it will require the developer to research local capacity/ demand, and provide such evidence with a planning application or broad concept plan.

It is, therefore, likely that most planning proposals will not require a developer contribution towards healthcare facilities. The exception could be very large sites, which provide a space for such facilities with an appropriate agreement in place to secure the site.

3.3 Huntingdonshire District Council Local Plan(s)

3.3.1 Overview of the local plan(s), current and proposed

Huntingdonshire is in the process of adopting its new local plan, the current Huntingdonshire Local Plan Part One was adopted in December 1995.

The 1995 Local Plan
The plan doesnot mention health and wellbeing and the environment and the policies which have a positive impact of health do not mention these benefits.
The plan recognizes the need to address:

- Open space, community recreational facilities, children's play areas.
- Infrastructure, services and amenities.
- Environmental pollution which would be detrimental to housing.

- Noise pollution and housing sites.
- Specialist communal housing.
- Economic and employment growth to reduce commuting.
- Traffic management, pedestrian routes, and segregated cycleway routes.
- Bus travel.
- Recreation and leisure provision.
- Basic provision of a meeting place for each village.
- Retain existing allotment provision.
- Access for the disabled.
- Crime prevention.
- Health and social services.
- Need for nursing homes, residential homes, sheltered accommodation and small hostels.
- Library services.
- Public conveniences.

Huntingdonshire's Draft Local Plan to 2036
The introduction to the plan contains a summary of the demography highlighting that Huntingdonshire's residents are generally healthierthan the national average with 6% of residents having long-term health or disability issues which limit theirday to day activities a lot compared to 8% for England as a whole. Car ownership in Huntingdonshire is significantly higher than the national average reflecting the relatively rural nature of most of the district with consequent dependence on private cars for personal transport. Only 19.3% of employed residents travelled to work by public transport, cycling or walking.

There are 22 General Practices operating within the district with some having satellite surgeries in villages to provide more local facilities to patients. Hinchingbrooke Hospital provides medical services for residents of Huntingdonshire and some surrounding areas, the hospital has a major treatment centre which has allowed a significant increase in day case patients.

The spatial vision and objectives for Huntingdonshire include an objective that Huntingdonshire will be a destination of choice as a place to live, work and invest. It will offer attractive homes, jobs and a high quality of life providing opportunities for all residents and workers to achieve their maximum potential and enjoy healthy and sustainable lifestyles.

The plan recognises the need to address:

- High quality, well designed, locally distinctive sustainable development that is adaptable to climate change and resilient to extreme weather.
- Better job opportunities and more affordable homes.
- Opportunities for people to pursue a healthy lifestyle and to actively participate in their community and to have a high quality of life.
- Maintain an up-to-date Infrastructure Business Plan to identify the infrastructure needs of proposed developments.
- Sustainable modes of travel and minimise the needs for unnecessary travel priority is to be given to use of public transport, cycling or walking.
- Adequate infrastructure to meet the needs of new growth and facilitate active, cohesive communities and sustainable lifestyles.
- Inclusive and accessible provision for community needs including education, health, social care, policing, sports, play and open space and integrated community facilities.
- Range of market and affordable homes that enables choice between types, sizes and tenures as well as over lifetimes and within individual communities.

- Opportunities for vulnerable people to live independent lives with support to meet their needs.
- Attractive, safe and distinctive residential neighbourhoods in which people can meet their day-to-day social, health, educational, recreational and convenience shopping requirements.
- Opportunities for minimising energy and water use and securing carbon emission reductions.
- Waste management and pollution control practices which minimise contributions to climate change and do not incur unacceptable impacts on the local environment or endanger human health.

3.2.2 Developer Contributions Requirements

Community Infrastructure Levy

Applicable developments will be liable to pay the Community Infrastructure Levy (CIL) as set out in the Huntingdonshire Community Infrastructure Levy Charging Schedule or successor documents.

Planning Obligations (Section 106)

Contributions in addition to the CIL may be necessary to make the proposals acceptable in planning terms.

Case Study 2: Health Facilities Policy - Huntingdonshire

Case Study – Huntingdonshire's policy on Health Care facilities:

The District Council will continue to seek to secure appropriate health service facilities related todevelopment sites. In considering whether contributions will be sought towards the provision of healthservice facilities, the Council will liaise with their local National Health Service (NHS) Primary Care Trust(PCT), or successor bodies, and other relevant agencies. Consideration will be given to relevant healthdocuments such as the Strategic Plan Document 2010 - 2015, the Corporate Strategy and the StrategicServices Delivery Plan (currently under development 2011). Health needs are informed by the JointStrategic Needs Assessment (JSNA) which is a suite of documents that include an overall summary plusclient group or themed areas including a JSNA for New Communities.

In addition, the Government White Paper "Our Health, Our Care, Our Say", the Lord Darzi Interim Reviewof the NHS, the latest White Paper "Equity & Excellence; Liberating the NHS" and the NHS Future Forumrecommendations seek to shift more health and social care into community settings, closer to people'shomes and continue the ongoing modernisation of service delivery. The impact of development thereforegoes far beyond the need for GP facilities and services which have often been the only element of healthservices considered in the past.

The District Council will continue to seek to secure appropriate health service facilities to meet the needsof communities from new development sites in accordance with the Adopted Core Strategy, the DevelopmentManagement DPD: Proposed Submission 2010, or successor documents as appropriate.

Specifically, Core Strategy Policy CS10 sets out the contributions that for infrastructure may be requiredand will be applied to all development proposals across the administrative area of Huntingdonshire.

Huntingdonshire's Sustainable Community Strategy 2008 – 2028 shows how HDC with its partners willbuild a better future for Huntingdonshire. It reflects key strategies, specifically the Local DevelopmentFramework, which will be the delivery mechanism for the spatial elements of the strategy.

Types of facilities/services for which provision may be required:
On site provision of land for space within development to accommodate identified health needs. In certaincircumstances it may be more appropriate to have the facility at an alternative location off site. In suchcircumstances, where more than 50% of need for infrastructure is generated by the proposal, a proportionatefinancial contribution to purchase the land or provision of the land as an in-kind payment will be required. Contributions will also be needed in all cases for the construction or funding of these health servicefacilities. The range of services that this could include is:

3.3 EAST CAMBRIDGESHIRE DISTRICT COUNCIL LOCAL PLAN

3.3.1 Overview of the local plan

The East Cambridgeshire Local plan was adopted in April 2015 and the plan period is for 20 years. The main introduction to the plan contains a health summary highlighting thatAccording to a 2012 survey(52), East Cambridgeshire's residents have the best quality of life of any rural area in Great Britain. In particular, health and life expectancy are amongst the highest of rural areas. However, there are variations across the district and pockets of deprivation exist.

The plan also makes reference to the needs of older people. There is an identified need in the district to provide care accommodation for various groups of people for rehabilitation and out of hospital care, including the elderly, people with disabilities and vulnerable people.

The forecast change in population by broad age groups for the period 2011-2031 predicts significant growth in the over 60 age group. The proportion of people aged 75+ years will rise by 93% and those aged 85+ years will grow by 144%.

Accommodation for the elderly and others in need of care is moving towards more flexible forms of living and support which seek to maintain their independence and control of their lives. There are several options where residents can enjoy their own self-contained home within a site offering extra facilities. These include retirement homes/villages, and 'extra care' housing, where varying levels of care and support are provided in the home. These models often include a restaurant or dining room, health & fitness facilities and hobby rooms on site. Other forms of accommodation include care or nursing homes, which comprise single rooms within a residential setting where residents receive varying levels of care. Care can range from primarily personal care to nursing care for those who are bedridden, very frail or have a medical condition or illness.

The plan outlines the key issues and challenges as:

- **Infrastructure provision** – Recent high levels of growth have placed pressure on local services and facilities including health, education and leisure. The provision of a good broadband service is also critical to support business growth, especially in the rural areas where the current service can be poor. The challenge is to ensure that services and facilities are delivered alongside growth.
- **Sustainable travel** – The district is predominantly rural with a dispersed population, which creates challenges in providing a comprehensive public transport network. Many local communities are reliant on the car as their only transport option. This impacts on carbon dioxide emissions, air quality, noise, public safety and the quality of the environment in towns and villages. The challenge is to ensure that development is directed to sustainable locations and that sustainable modes of transport are encouraged to reduce reliance on the car.
- **Rural services** – The retention of local services is a key issue, particularly for rural communities. The challenge is to resist the loss of important facilities and support the delivery of new ones. This will be especially important in the context of the district's ageing population, and the dispersed rural nature of the district.

The spatial vision for East Cambridgeshire includes improved social, recreational, health and educational facilities. The needs of elderly, young and lower-paid people will receive special attention. Existing vital community services will be retainedand new infrastructure and services required to support growth will be delivered on time to meet the needs of new residents. The levels of crime and the fear of crime will have been further reduced.

Transport deficiencies will be tackled and accessibility improved. Public bus services between market towns and villages will be improved (including to settlements in neighbouring areas). Better cycling and pedestrian facilities and links will be provided, including segregated cycle routes along key routes linking towns and villages.

The Strategic objectives include:

- Ensure that new development is of high quality and sustainable design which reflects local character and distinctiveness, provides attractive and safe environments, and is supported by appropriate facilities and services.
- Provide greater opportunities to reduce car use, by locating most development where there is good access to jobs, services and facilities, and supporting improvements in public transport and walking/cycling networks.
- Ensure a high quality of life by maintaining and delivering strategic and local infrastructure and facilities needed to support local communities.

3.3.2 Developer Contributions and CIL

East Cambridgeshire District Council has adopted the Community Infrastructure Levy (CIL), and most residential and retail development is required to pay a CIL charge. In some cases, it will also be necessary for development to make provision for site-specific infrastructure needed in relation to a particular scheme. This may be provided on-site, or through financial contributions from developers secured through Section 106 agreements. Section 106 agreements will need to meet tests set out in Regulations, and may be sought for a variety of infrastructure and benefits, including:

- Community facilities including library and public health services.
- Education facilities including primary, secondary and special schools.
- Sport, leisure, open space and recreation facilities.

- Transport infrastructure.
- Flood mitigation and improvement measures
- Environmental improvements.

East Cambridgeshire requires contributions for the following infrastructure:

Table 16: CIL and Section 106 Requirements, East Cambridgeshire District Council

Type of infrastructure	**Section 106 infrastructure/mitigation**	**CIL funded infrastructure**
Affordable housing	Affordable housing	
Education	Development specific schools and educational facilities on large strategic housing sites	School and educational places/facilities not on large strategic housing sites
Community facilities	Development specific community meeting space(s) and library/lifelong provision on large housing sites	Improvement of existing library services and community buildings not on large strategic housing sites Art facilities and museums
Health	**Development specific new healthcare facilities on large housing sites**	**Other healthcare provision**
Transport	Local site-related road/transport requirements	Other road and transport infrastructure projects
Economic development	Development specific economic initiatives on large strategic sites	Other economic development measures not on large strategic sites
Environment	Local site-related habitat/nature/heritage requirements	Other environmental/heritage provisions and infrastructure
Open Space	Provision of on site or site related informal open space, land, play facilities and recreational equipment	Development of district wide infrastructure network (where off site and unrelated to specific developments)
Sport Facilities	Development specific formal sports land & facilities on large housing sites	Formal sports land and facilities not on large strategic sites or related to a large strategic site
Emergency Services	Development specific police service provision	District wide Police service infrastructure requirements
Flood defence/drainage	Site-related flood defence/drainage infrastructure	Other flood defence/drainage infrastructure

Case Study 3: Health Facilities Policy - East Cambridgeshire

Case Study – East Cambridgeshire's policy on Health Care facilities:
Context
Cambridgeshire Primary Care Trust (PCT) is currently responsible for the planning and securing of health services and improving the health of the local population. This section looks at the need for primary healthcare infrastructure (which includes GP and dentist provision) within the district.

What is required?
New residential development will be required to contribute to the improvement or expansion of existing healthcare facilities unless there would be sufficient capacity in available health infrastructure within the locality to cater for the needs arising from the new development. CIL funds will generally be used to address the cumulative impacts of developments on healthcare facilities. Where the expansion of existing healthcare facilities is required this will be considered for inclusion on the Regulation 123 list.

Planning obligations will be used to secure new healthcare facilities associated with specific development schemes, e.g. large strategic housing sites which generate the need for new facilities, and where the PCT (or successor bodies) have identified the site as a preferred location for a new facility. The need for new facilities will be dependent upon the capacity of existing healthcare facilities and the proximity of facilities to new residential developments, and will take account of the following national provision guidelines: one GP per 1,800 population, and one dentist per 2,000 population. Applicants will be required to make on-site provision of land which is required to accommodate the identified healthcare facilities. They will also be required to make a financial contribution to the delivery of new healthcare facilities required on-site – as detailed in the section below.

In certain situations, planning obligations may also be used to deliver a new healthcare facility required by a small number of medium/large scale developments – with the facility provided on a nearby site. This can include situations where a site for healthcare facilities has been identified by the Cambridgeshire PCT (or successor bodies) for this purpose. The Council will ensure that these facilities will not be funded through CIL receipts, that the obligations meet the statutory tests, and that no more than five separate planning obligations are secured for the same facility.

Financial contributions
Contributions will be sought towards the cost of constructing and fitting out facilities, in addition to land provision. The following tables provides indicative costs for new community facilities (excluding land purchase costs). The figures are intended to be used as a guide by applicants and will vary depending upon the proposed location, development specifics and the timing of the development.

Type of community facility	Cost per m^2	Source
Healthcare facilities	£2200	**NHS Cambridgeshire**

Facility	Expected cost of building
Healthcare Facility (375m2)	£825,000

3.4 SOUTH CAMBRIDGESHIRE DISTRICT COUNCIL LOCAL PLAN(S)

3.4.1 Overview of the local plan(s), current and proposed

South Cambridgeshire is in the process of adopting its new local plan, the current South Cambridgeshire Local Plan was adopted in January 2007.

The 2007 Local Plan

The introduction to the plan gives an overview of the location and surrounding environment but does not give an indication as to the health status of the district.

The Plan recognizes the need to address:

- Locate development where access to day-to-day needs foremployment, shopping, education, recreation, and otherservices is available by public transport, walking and cyclingthus reducing the need to travel, particularly by private car.
- Ensure the provision of appropriate community facilities tomeet the needs of new developments, working in partnershipwith other service providers and voluntary organisations.
- Ensure that major new developments create distinctive,sustainable and healthy environments that meet the needs ofresidents and users, and contribute towards the creation ofvibrant socially inclusive communities.
- Achieve a permeable development for all sectors of the community and all modes of transport, including links to existing footways, cycleways, bridleways, rights of way, green spaces and roads.
- Provide high quality public spaces.
- Provide an inclusive environment that is created for people, that is and feels safe, and that has a strong community focus.
- Safe and secure cycle parking.
- Outdoor play space.
- Safe and convenient access for all to public buildings and spaces, and to public transport, including those with limited mobility or those with other impairment such as of sight or hearing.
- A design and layout that minimises opportunities for crime.
- Encourage the provision of public art in new development.
- To meet the formal and informal sport and recreation needs of the district, including provision of high quality indoor and outdoor facilities.
- Protect and enhance important areas of local and strategic open space for their recreation and amenity value, and create connectivity with existing public rights of way and the wider countryside.
- The provision of adequate health facilities, including mental health provision, in appropriate accommodation and locations to cater for the existing andproposed population of Cambridgeshire.
- Natural environment (noise environment, light pollution, re-use of land, air quality).

The 2007 plan does have a requirement for a Health Impact Assessment to be submitted for major developmentsie

- Residential development: the erection of 20 or more dwellings, or, ifthis is not known, where the site area is 0.5 hectares or more; or
- Other development: where the floor area to be created is 1,000 m_2 ormore, or the site area is 1 hectare or more.

South Cambridgeshire's Draft Local Plan to 2031
South Cambridgeshire is a prosperous area with high levels of economic activityand low levels of unemployment. Its 350 square miles of countryside provides a highquality setting for its 105 settlements. In recent decades the district has experiencedsignificant growth, reflecting the success of the local economy and the need for newhomes. These high levels of growth have managed to balance development withmaintaining a high quality social, built and natural environment which is valuedlocally and has ensured that South Cambridgeshire regularly performs well innational quality of life surveys.

The vision for South Cambridgeshire is that South Cambridgeshire will continue to be the best place to live, work and study in the country. The district will demonstrate impressive and sustainable economic growth. The residents will have a superb quality of life in an exceptionally beautiful, rural and green environment.

Two of the six key objectives of the Local Plan are:

- To ensure that all new development provides or has access to a range of services and facilities that support healthy lifestyles and wellbeing for everyone, including shops, schools, doctors, community buildings, cultural facilities, local open space, and green infrastructure.
- To maximise potential for journeys to be undertaken by sustainable modes of transport including walking, cycling, bus and train.

The 'health' of people living in the district is generally better than the average for England. Good health leads to an aging population with the highest growth expected to occur in the 65+ age group. In national indices of multiple deprivation (2010), out of 326 English local authorities where a rank of 1 is the most deprived authority in England, and a rank of 326 the least deprived authority, our score was 322 (meaning South Cambridgeshire is one of the most successful areas in England).

The indices take account of income, employment, health and disability, education skills and training, barriers to housing and other services, crime, and the environment.

Age structure is a key factor for planners and service providers as it affects requirements for services such as education, health, leisure, arts and sports facilities. It influences household composition and therefore the overall size of a new development's population.

People who move into new developments can have very different population characteristics to the surrounding area. Initial populations tend to have a young age structure, with many young couples and young children, and very few older people.

Population age structures change markedly over time as developments mature, with children and adults ageing and the age structure gradually becoming older and more similar to the surrounding population. This process may take as long as 30 years.

Rural shops and services are vital for maintaining communities and supporting access for the less mobile members of society.

Sport and play space is important for supporting healthy lifestyles.

There are high levels of demand for new allotments, which provide opportunities to support healthy lifestyles.

Areas around the A14 north of Cambridge, and the centre of Cambridge, are designated as Air Quality Management Areas.

National Noise Action Plans First Priority Locations have been identified within the district in areas close to the M11, A14 and A10, and other busy roads.

The Plan recognizes the need to address:

- Design Principles, which includes: permeable development; safe and convenient access for all users and abilities; cycleparking and storage; mix of use; landscaping and public spaces; health and amenity of occupiers; crime.
- Public Art.
- Green Infrastructure, including Local Green Space.
- Residential Space Standards for Market Housing.
- Shared Social Spaces in Employment Areas.
- Health Impact Assessment.
- Protection of Village Services and Facilities.
- Meeting Community Needs.
- Hospice Provision.
- Outdoor Play Space, Informal Open Space and NewDevelopments.
- Lighting.
- Noise Pollution.
- Contaminated Land.
- Air Quality, including Odour and Other Fugitive Emissions to Air.
- Sustainable Travel.

3.4.2 Developer contributions requirements

South Cambridgeshire is currently consulting on the adoption of the Community Infrastructure Levy (CIL), so is reliant on Section 106 contributions

Case Study 4: Health Facilities Policy - South Cambridgeshire

Case Study – South Cambridgeshire Policy on Section 106 and CIL Contributions
The sites allocated in the Local Plan identify where new communities will be developed over the plan period. Experience from developing Cambourne, and the ongoing work to deliver Northstowe and the urban extensions to Cambridge, have informed the content of this policy. New large scale major developments will need to include a wide range of services and facilities to become successful communities. Smaller village developments will not usually need to include new services and facilities on-site but may need to contribute to the expansion of existing facilities and sometimes provide land for that expansion. The provision of facilities and services will be secured via a planning obligation when mitigating a site specific impact or more generally through a Community Infrastructure Levy contribution (CIL).

The Proposed CIL Regulation 123 infrastructure list:

- Pre-school education
- Secondary school education
- Libraries and lifelong learning
- Public and community transport
- Strategic green infrastructure
- Village halls and community centres

The Proposed CIL Regulation 123 infrastructure list (Continued):

- Household recycling centres
- **Primary health care**
- Major transport schemes identified in the Transport Strategy for Cambridge and South Cambridgeshire

The Policy within the proposed local plan is:
1. Planning permission will only be granted for proposals that have madesuitable arrangements for the improvement or provision of infrastructurenecessary to make the scheme acceptable in planning terms. The nature,scale and phasing of any planning obligations and/or CommunityInfrastructure Levy (CIL) contributions sought will be related to the formof the development and its potential impact upon the surrounding area.

2. Contributions may also be required towards the future maintenance andupkeep of facilities either in the form of initial support or in perpetuity inaccordance with Government guidance.

Contributions may be necessary for some or all of the following:

- Affordable housing, including for Key Workers.
- Education (including nursery and pre-school care).
- Health care.
- Public open space, sport and recreation facilities (including Strategic OpenSpace);
- Improvements (including infrastructure) for pedestrians, cyclists, equestrians,highways and public and community transport.
- Other community facilities (eg community centres, youth facilities, libraryservices social care, and the provision of emergency services).
- Landscaping and biodiversity.
- Drainage/flood prevention.
- Waste management (pursuant to the Cambridgeshire & Peterborough Minerals and Waste Development Plan).
- Arts and cultural provision.
- Community development workers and youth workers.
- Other utilities and telecommunications.
- Preservation or enhancement of the historic landscape or townscape.

Depending on the nature of the services and facilities, contributions may also berequired to meet maintenance and/or operating costs either as pump priming or inperpetuity, provided through an obligation.

Development can create additional demands for physical infrastructure and socialfacilities, as well as having impacts on the environment. In such cases planningobligations will be required, in accordance with government guidance, to make thenecessary improvements, provide new facilities, or secure compensatory provisionfor any loss or damage created. Such obligations will take account of the widerneeds of the Cambridge Sub-Region, in order to achieve wider planning objectives,with contributions pooled where appropriate to meet strategic requirements. In suchcases, the nature and scale of contributions sought will be related to the size of thescheme and the extent to which it places additional demands upon the area.

3.5 CAMBRIDGE CITY COUNCIL LOCAL PLAN

3.5.1 Overview of the local plan(s), current and proposed

Cambridge City Council is in the process of adopting its new local plan, the current Local Plan was adopted in 2006.

The 2006 Local Plan

The introduction to the plan gives an overview of the location and surrounding environment but doesnot give an indication as to the health status of the district. The Local Plan sets the context for economic growth, identifying that Cambridge is an important centre for employment, services, government, healthcare and shopping, and is nationally and internationally important for its higher education, knowledge-based industries and tourism.

Cambridgeshire has one of the fastest growing economies and populations in Britain. In the past much of this growth was directed to the villages beyond the Green Belt, resulting in a growth of commuting by car to Cambridge, and congestion and pollution in the cramped road network of the city. A lack of local housing that people can afford has reinforced these trends and forced people to live further away from Cambridge, a city which has almost twice as many jobs as residents in work.

The Plan recognizes the need to address:

- Creating Successful Places
- Open Space and Recreation Provision Through New Development
- The Design of External Spaces
- Protection of Open Space
- Pollution and Amenity
- Air Quality Management Areas
- Lighting
- Protection of Existing and provision of new Community Facilities
- Protection of, and provisionof new Leisure Facilities
- Food and Drink Outlets, including cumulative impacts
- Connectivity including: transport Impacts; Walking and Cycling Accessibility; Pedestrian and Cycle Network; Cycle Parking; Public Transport Accessibility
- Outdoor Sports Facilities: including Grass Pitches; Artificial Turf Pitches (ATPs)
- Indoor Sports
- Provision for Children and Teenagers
- Allotments

Cambridge City's Draft Local Plan to 2031

The vision for Cambridge's new development will be to secure innovative and will promote the use of sustainable modes of transport,helping to support the transition to a more environmentally sustainable andsuccessful low carbon economy. There are 15 strategic objectives for the implementation of the local plan, the most relevant ones to health and wellbeing are to requireall new development in Cambridge to:

- Assist the creation and maintenance of inclusive, environmentallysustainable communities.
- Promote social cohesion and sustainability and a high quality of life bymaintaining and enhancing provision for open space, sports andrecreation, community and

leisure facilities, including arts and culturalvenues that serve Cambridge and the sub-region.
- Be located to help minimise the distance people need to travel, and bedesigned to make it easy for everyone to move around the city and accessjobs and services by sustainable modes of transport.
- Ensure appropriate and timely provision of environmentally sustainableforms of infrastructure to support the demands of the city, includingdigital and cultural infrastructure.
- Promote a safe and healthy environment, minimising the impacts ofdevelopment and ensuring quality of life and place.

The Plan recognizes the need to address:
- Strategic transport infrastructure
- Contaminated land
- Light pollution
- Protection of human health from noise and vibration, poor air quality, odour and dust
- Housing in multiple occupation
- Residential space standards, inside and out
- Lifetime Homes and Lifetime Neighbourhoods
- Creating successful places
- Protection of open space
- Open space and recreation provision through newdevelopment
- Community, sports and leisure facilitiesNew facilities
- Loss of facilities
- Healthcare facilities
- Supporting sustainable access to development
- Mitigating the transport impact of development

Developer Contributions and CIL Requirements

Planning obligations and/or a future CIL could be required for the following:
- transport infrastructure
- public transport
- drainage and flood protection
- waste recycling facilities
- education
- **healthcare**
- leisure and recreation facilities
- community and social facilities
- cultural facilities, including public art
- emergency services
- green infrastructure
- open space
- affordable housing

This infrastructure is required if development is to be achieved in a timelyand sustainable manner. Infrastructure in this category is unlikely to preventphysical development in the short term, however, failure to invest could leadto delays in the medium term. The most common type of necessaryinfrastructure is social and community infrastructure such as schools, healthfacilities and children's play space. The category has the potential to allowinfrastructure prioritisation if funding shortfalls occur.

Case Study 5: Health Facilities Policy - Cambridge City

Case Study – Cambridge City's Policy on Health Care facilities
New or enhanced healthcare facilities will be permitted if:

- the scale, range, quality and accessibility of healthcare facilities would beimproved;
- they are located in the area they are expected to serve; and
- where possible and appropriate they are co-located with complementaryservices.

The Council will work with Local Commissioning Groups to provide highquality and convenient local health services in all parts of Cambridge, butparticularly in areas of population growth.

Planning permission will be granted for new primary healthcare facilities inlocations accessible by road, by walking, by cycling and by public transport,where this will meet an existing deficiency, or support regeneration or newdevelopment.

It is essential that the planning process supports the provision of good localhealthcare facilities of the right type and in the right locations. The provisionand location of community-based, out-of hospital, health-care should aim tomeet the needs of existing and new residents. The impact of household andstudent growth should not worsen healthcare provision for existingresidents. Healthcare facilities, for the purposes of this policy, do not includeteaching hospitals, which are covered by Policy 43, on university facultydevelopment.

Clinical Commissioning Groups (CCGs) are statutory bodies representinggroups of GPs responsible for designing local health services in England.Every GP practice will need to be a member of a CCG. Local CommissioningGroups (LCGs) are smaller groups of GP practices with a focus on more localissues than the CCG. The Cambridgeshire and Peterborough CCG includestwo LCGs responsible for patients in Cambridge and South Cambridgeshire.

Over recent years, there has been considerable change in the way healthcare services are delivered, with an ongoing shift away from hospital settingsinto community- based settings, delivering services as close to home aspossible. Advancements in medicine and technology have also had considerable impact on the way services are delivered and what can now bedelivered outside of hospitals.

The shift in location and delivery of services also requires more flexibility inplanning agreements and the detailed planning and procurement of healthfacilities. One key principle that should be considered is the co-location ofnon-NHS community, voluntary sector and commercial spaces alongsideprimary and community care services if their addition accords with thephilosophy of care and can improve affordability/accessibility.

Co-locating services may provide benefits including: a focal point for thecommunity, promotion of healthy lifestyles as part of an integrated healthand community care approach, better connectivity with other services andopening up new possibilities for residents, increased building/site usage, thecreation of a critical mass of linked services, increased convenience for users,improved funding; and more sustainable transport links. Examples of collocated facilities include those already built in Cambourne and in theplanning for Northstowe, Cambridge Southern Fringe and North WestCambridge.

3.6 COMPARISON OF THE LOCAL PLANS AGAINST THE THEMES FROM THE EVIDENCE REVIEW

Using the themes from the evidence review, each District's local plan has been reviewed against these themes to see if there are specific policies to address the impact the built environment can have on health, the themes identified were:

- Generic evidence supporting the built environment's impact on health
- Green space
- Developing sustainable communities
- Community design (to prevent injuries, crime, and to accommodate people with disabilities)
- Connectivity and land use mix
- Communities that support healthy ageing
- House design and space
- Access to unhealthy/"Fast Food"
- Health inequality and the built environment

Table 17: Comparison of the Local Plans Against the Themes from The Evidence Review

Key	Specific Policy in Local Plan	Not a specific policy, but policy/aim is relevant	No Policy in local Plan	No Policy but theme is contained in supporting text		
Policy		**South**	**City**	**Hunts**	**East**	**Fenland**
		Policy Ref:	Policy Ref:	Policy Ref:	Policy Ref:	Policy Ref:
	General HWB					LP2
	Health Impact Assessment	SC/2	Only relating to aviation (83)			LP2
Green Space	General policy on requiring Green Space	S/7 NH12	68	LP30	Policy Growth 3	LP16, Appendix B
	GS Near older peoples housing	SC/1 SC/7	Appendix I			
	Design to include paths etc.					Appendix B
	Distance to open space		Appendix I			Appendix B
	Size of open space	SC/8	Appendix I	Section B Developer contributions SPD		Appendix B
	LAP/NEAP/MUGA etc.	SC/8	Appendix I	Section B Developer		Appendix B

				contributions SPD		
	Allotments	SC/8	Appendix I	Section B Developer contributions SPD		Appendix B
	Farmers Markets					LP2
Developing Sustainable Communities	Max natural daylight	HQ/1	60	LP15		
	Solar/renewables	CC/3	29	LP5	ENV6	LP14
	cooling	HQ/1		Supporting text for policy LP5		
	harvesting rain water					LP14
	creating pedestrian and cycleways	TI/2	80	LP17	COM7	LP15, LP17
	public art	HQ/2	56		ENV2	
	social cohesion		Supporting text for policy 56	LP24		Introduction
Community Design	traffic calming		Supporting text for policy 80		Site Specific	
	secure by design	HQ/1	56	LP15	ENV2	LP16, LP17
	wheelchair friendly design		Supporting text for policy 80		Site Specific	LP17
Connectivity & Land Use Mix	walking and cycling	Site specific & HQ/1	80	LP17, LP18	COM7	LP15
	location of facilities/shopping	E/22	10	Site Specific	COM2	LP6
	concept of neighbourhoods	Site specific	Site specific	Objective 13	Site Specific	LP7
Healthy Ageing	signage		56	LP13		
	distinctive design		56	LP13		LP16
	street furniture		56	LP13		
and space Standards	minimum room size	H/11	50			
	Mix	H/8	Site specific	LP24	HOU1	LP17

	Lifetime Homes	H/8	51	LP13		LP5
	Fuel Poverty		30	LP14		LP14
Access to fast food	Location near sensitive receptors eg schools, workplaces etc.		Supporting text for policy 72			No Policy, but narrative in section 3.3.8
	Density		Supporting text for policy 72			
Health Inequality	Access to transport		75, 74, 50	LP17	COM7	LP15
	Provision of public toilets				Site Specific	Appendix B
	Street furniture eg benches				Site Specific	LP15
	municipal services	SC/4		Supporting text for policy LP20	Supporting Text for Developer Contributions	
	Libraries	SC/4		Supporting text for policy LP20	Supporting Text for Developer Contributions	Infrastructure Delivery Plan
	Health facilities	SC/4	75	Supporting text for policy LP20	Supporting Text for Developer Contributions	Infrastructure Delivery Plan, LP2
	Schools	SC/4	74	Site Specific	Supporting Text for Developer Contributions	Infrastructure Delivery Plan, LP7
	Community facilities	SC/4	Site Specific	Supporting text for policy LP20	COM4	Infrastructure Delivery Plan

From Table 8 above there are gaps across all the local plans relating to control of unhealthy/fast food outlets, the areas for further attention include healthy ageing, design of open space to include footpaths, facilities etc.

SOCIAL COHESION/COMMUNITY DEVELOPMENT

1. KEY FINDINGS

The evidence on the need for community development in the early stages of new developments is strong.

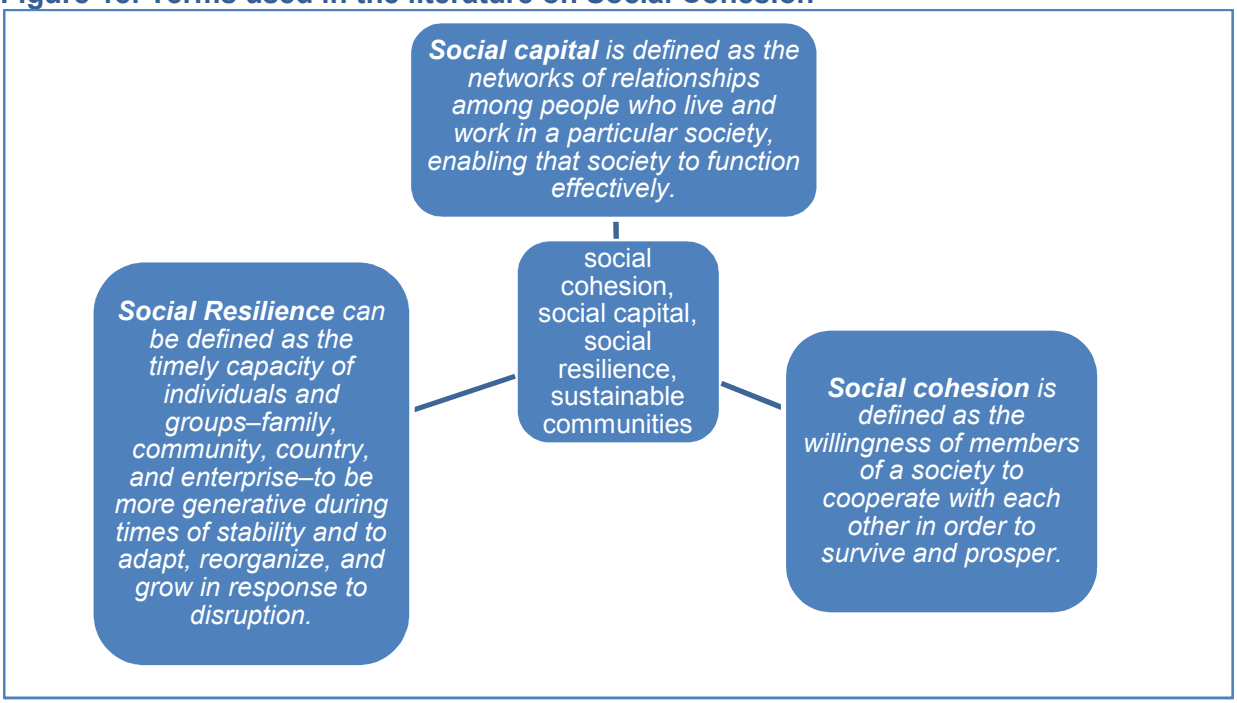
More research is needed locally into the measure of and approaches taken to improve social cohesion and community resilience in new developments, and the funding opportunities available to secure this.

Community development work needs to continue to focus on building resilient empowered communities rather than dependent communities. This should be carried out with other key agencies. Responsibility lies with all stakeholders and that all statutory agencies can benefit from active participation in building resilient empowered communities.

2. INTRODUCTION: HOW DOES THE BUILT ENVIRONMENT AFFECT SOCIAL COHESION AND HEALTH & WELLBEING?

The evidence around what makes communities strong and healthy varies in quality and definitions.The terms, social cohesion, social capital, social resilience, sustainable communities are all very similar and are often interchangeable in the literature. Therefore, a broad inclusive approach has been taken to the terms used in this chapter.

Figure 18: Terms used in the literature on Social Cohesion



The Cambridgeshire County Council: Strategy for supporting new communitiesencourages building a self-supporting community rather than imposing an intervention. One conclusion from the strategy suggests this can be helped by providing ‘anchor’ spaces such as libraries and community hubs, at home library serviceswhich visits the most vulnerable in society. This allows a community to support itself and aids social cohesion. People with greater social capital tend to have greater wellbeing and a greater sense of belonging.

Examples of projects promoting self-supporting communities include:

- **Mums networks** where new mothers are given email addresses of other new mothers living in the same area, to help build new networks of support.
- **Stepping stone project** which works with young people who have learning disabilities and/or physical disabilities. The project allows staff to assess a person's sporting needs and helps them to engage with sport.
- **Time credits** are incentives given to people who volunteer to beinvolved in community projects, which in turn they can "cash in" for work for themselves.
- **Family by Family**which offers training and resourcing to families that have overcome tough times (sharing families) and putting them in contact with families who would like things to change.

2.1 Delivering mixed, balanced communities

In order to achieve physical interaction between people "pepper potting" is often usedwhich provides a "graduated range of different house types within the same street" from affordable units to more executive market housing. This is proposed to aid social cohesion. In addition, it is suggested to target population mixes near significant potential areas of interaction e.g. nurseries and primary schools, community centres, shops, pubs and parking areas, paths and communal areas.(54)A cohesive community requires a balanced age profile. So it's important to have a mix of housing stock i.e. for rent or to buy etc.(53)

The Young Foundation examined citizen engagement and concluded that activities that encourage interaction between individuals from diverse backgrounds can increase trust and understanding. For example, contact with the elderly, children with disabilities and those with mental health problems.(55), (56)

Sustainable communities are places where people want to live and work, now and in the future. The Egan Review (57) examined the factors that go to make a sustainable community and presented them as a set of eight vital components (Active, inclusive and safe; Well run; Environmentally sensitive; Well designed and built; Well connected; Thriving; Well served; and Fair for everyone). These components make up the Egan Wheel.

Active, inclusive and safe, means being fair, tolerant and cohesive with a strong local culture and other shared community activities. It suggests a diverse, vibrant and creative local culture encouraging pride in the community and cohesion within it. It also suggests an active voluntary and community sector.

Well run, involves sound governance with effective and inclusive participation, representation and leadership. Strong leadership is essential if a community is to respond positively to change. Effective engagement and participation by local people, groups and businesses is vital especially in the planning, design and long-term stewardship of their community.
Environmentally sensitive, means providing places for people to live that are considerate of the environment. It requires a safe and healthy local environment with well-designed public and green space.

Well designed and built, means providing or retaining a high quality built and natural environment. A community must be of sufficient size, scale and density and have an effective layout to support basic amenities in the neighbourhood and minimise use of resources (including land). Buildings both individually and collectively must meet different needs over time, and minimise the use of resources. A sustainable community requires a well-integrated mix of decent homes of different types and tenures to support a range of household sizes, ages and incomes. The community should have a 'sense of place'.

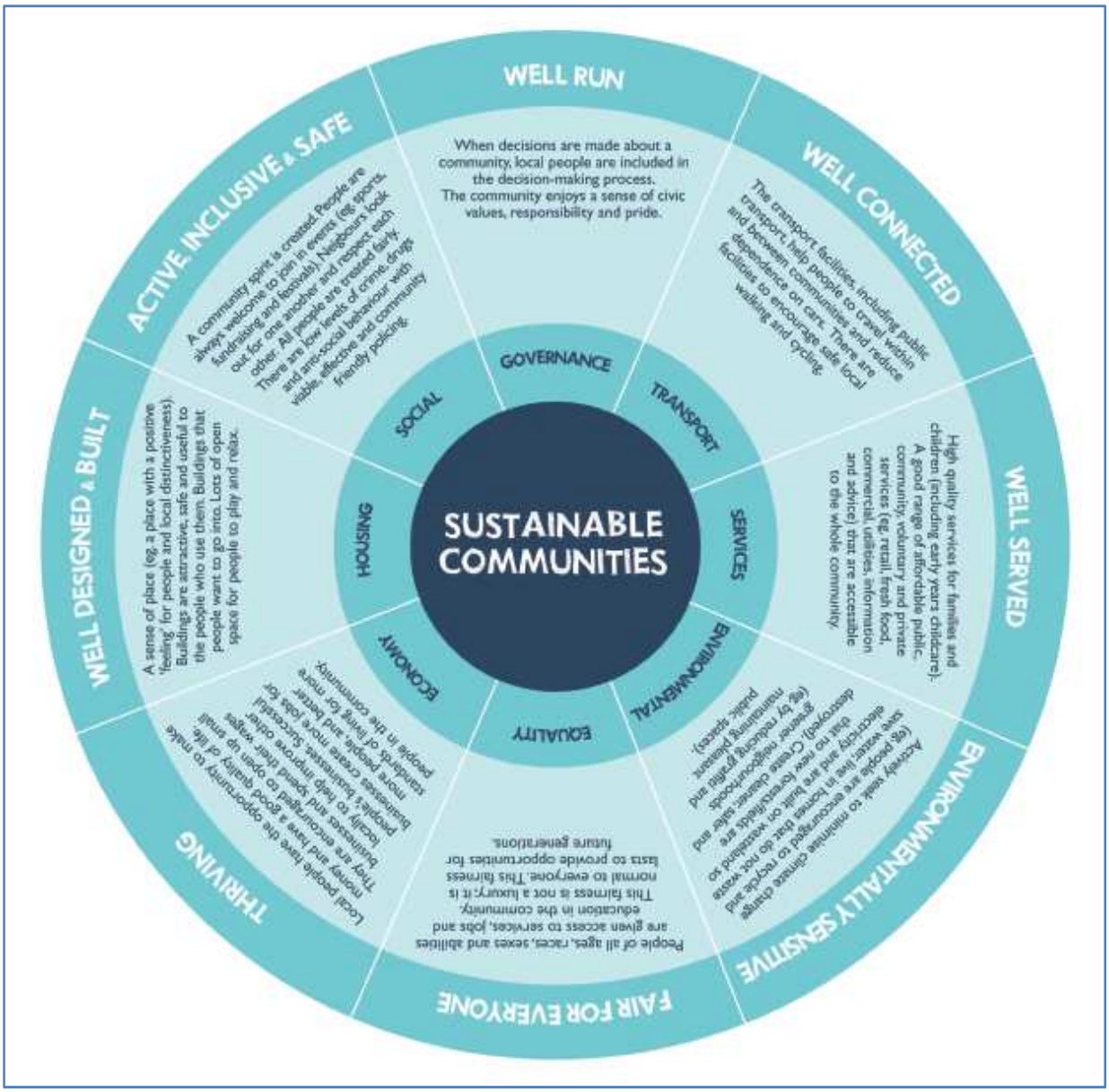
Well connected, means providing good transport services and communication linking people to jobs, health and other services. Good public transport and other transport infrastructure is needed both within the community and linking it to urban, rural and regional centres, as well as with the wider national and international community.

Thriving, involves a flourishing and diverse local economy to provide jobs and wealth.

Well served, involves providing public, private, community and voluntary services that are appropriate to people's needs and accessible to all. Good quality, local public services should be available including education and training opportunities, health care, community and leisure facilities.

Fair for everyone, involves consideration of the needs of those living in other communities both now and the future. All our individual and communal choices may impact adversely on others especially in terms of the overall need for sustainable development.

Figure 19: The Egan Wheel



2.1 Empowerment

Community participation is a key objective of community development which in turn can empower community citizens. "Highly participative voice mechanisms such as deliberative forums, citizens' juries, citizens' summits are likely to provide citizens with subjective empowerment.(58)

The "Pathways to participation project" (59) showed that being involved with the provision of community services, providing support for vulnerable members of the community etc. provides a range of cultural activities to enrich the lives of community members. Participation can help strengthen citizenship skills. The benefits given byparticipating interviewees included:

- **instrumental benefits;**
  - skills;
  - connections;
  - networks;
  - self-help;
  - improved access to job opportunities;
- **transformative benefits;**
  - sense of community,
  - confidence,
  - self-worth,
  - wellbeing.

Studies have showed that increased participation in local projects and community life or 'associational life' develops skills and confidence which can then be used in future. A study from South Africa showed citizens had learnedcampaigning and advocacy during the anti-apartheid movement and were using the same skills in the fight against HIV/AIDs through the treatment access campaign.(60) Another study in Brazil showed those involved in protests were more likely to be involved in participatory budgeting processes locally.

2.3 Community cohesion and mental health

The evidence shows that cohesive communities foster better mental health through the creation of neighbourhoods and communities that are in control and that pull together to shape the world around them. Evidence also shows that fostering and supporting social action, social inclusion and volunteering can improve wellbeing.

Local community groups such as local voluntary groups; peer support services, user led self-help groups, mentoring and befriending enables service users to be both providers and recipients of support. This allows members of a community to play an active role in their own wellbeing and that of their community(61).

2.4 Loneliness

Loneliness is a growing problem amongst older people. It is associated with poor health outcomes, specifically higher blood pressure, depression and higher rates of mortality comparable to those associated with smoking and alcohol(62).

Solutions include creating age friendly communities, which in turn makes the locality more socially inclusive(63), such communities should include:

- Availability of public meeting places and public seating
  - Improving street safety
  - Street lighting

- Ward assemblies to encouraging local decision making, encouraging intergenerational contact
- Local bus services and community transport alternatives
- Improving parking for those with restricted mobility
- Providing accessible clean public toilets
- Ensuring local shops and services are within easy reach

In addition to the above, the national planning policy framework suggests(64):

- Assurances that shops, facilities and services are able to develop and modernize in a way that is sustainable and retained for the benefits of the community, and
- Existing open spaces, sport and recreational buildings and land should not be built on unless the land is shown to be surplus to requirements or there is an adequate replacement or the development is for alternative sports/recreational provision which is of greater benefit.

3. LOCAL DATA

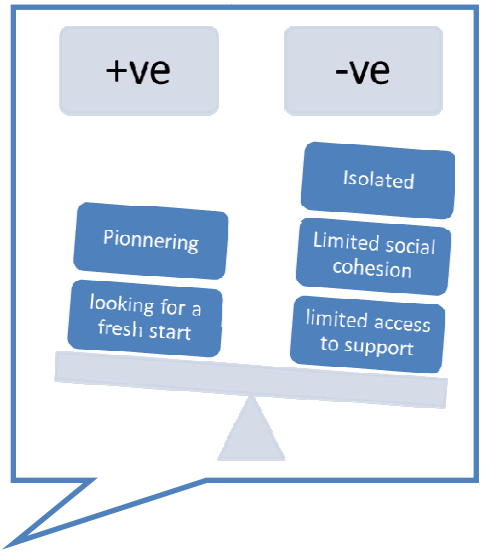
3.1 WHAT LESSONS CAN WE LEARN FROM PAST DEVELOPMENTS?

3.1.1 Lessons from Cambourne

One of the findings from the learning from Cambourne report is to provide and incorporate community buildings early in the stages of the development. (65)One of the downfalls in a new community is not having community halls/meeting places built early on i.e. Community halls, pubs, youth clubs, sport provisions. There also needs to be provision for younger children such as play areas, skate parks etc. It was noted that the small skate park built was not particularly well lit, which discouraged children from using it.

Loneliness and mental health problems were issues coming out of Cambourne partly due to the initial lack of community buildings. It is important to recognise that that people moving into communities may be moving away from their traditional support systems i.e. family and established communities with provisions to meet people and friends. Further information on the learning from Cambourne report can be found in the 2010 New Communities JSNA (http://www.cambridgeshireinsight.org.uk/cambridgeshire-jsna/new-communities).

In order to explain these patternsa shift in focus is needed away from buildings to people. Planning concentrates on buildings and landi.e.creating a pleasant built environment, it tends not to look beyond the houses being built and can focus on community development not building communities. This can result in the early residents feel displaced & isolated with the social networks taking time to form. Service providers are often underprepared and support can be difficult to find.



3.2 New housing development surveys

Research to find out more about who moves into new housing developments and reactions to the developmentsof residents across new developments in the Cambridgeshire housing sub-region was carried out between 2006 and 2012 by the Cambridgeshire County Council Research Group. In total 9,287 postal surveys were sent out during that period and 2,784 were returned (a response rate slightly under 30%) giving an overall confidence rating of +/-3%at the 95% confidence interval which is normal for this type of survey.

The developments surveyed were split into three categories:

- New town (where the numbers of dwellings doubled).
- Substantial extension (where the numbers of dwellings increased by >20%).
- Infill(where the numbers of dwellings increased by <20%).

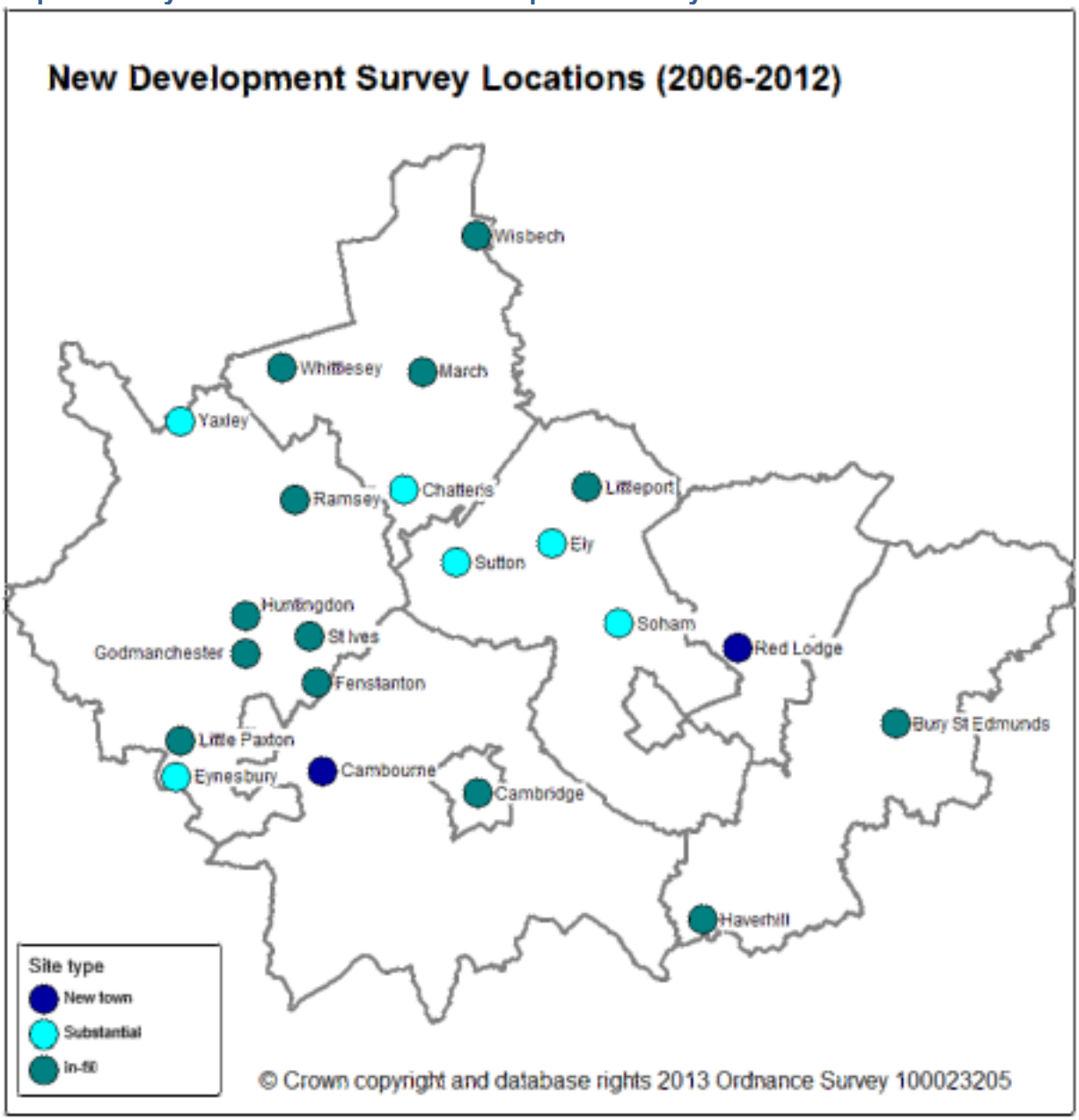
People were asked:

- Where they were moving from & reasons for leaving.
- Household structure on the new development - to help assess change to population, additional demand for school spaces, size and types of homes needed.
- Where they work, study and shop and how they travel to these locations.
- Opinions about the area, positive and negative.

When were the surveys undertaken?

Cambourne	*2006*
Huntingdonshire	*2007*
East Cambridgeshire	*2009/10*
Fenland	*2010*
Cambridge City	*2012*
Red Lodge in Forest Heath	*2011*
St Edmundsbury	*2011*

Map 4: Survey location for the New Development Surveys



3.2.1 Findings

Why do people move to new developments?

The main "push factors" for people moving are:

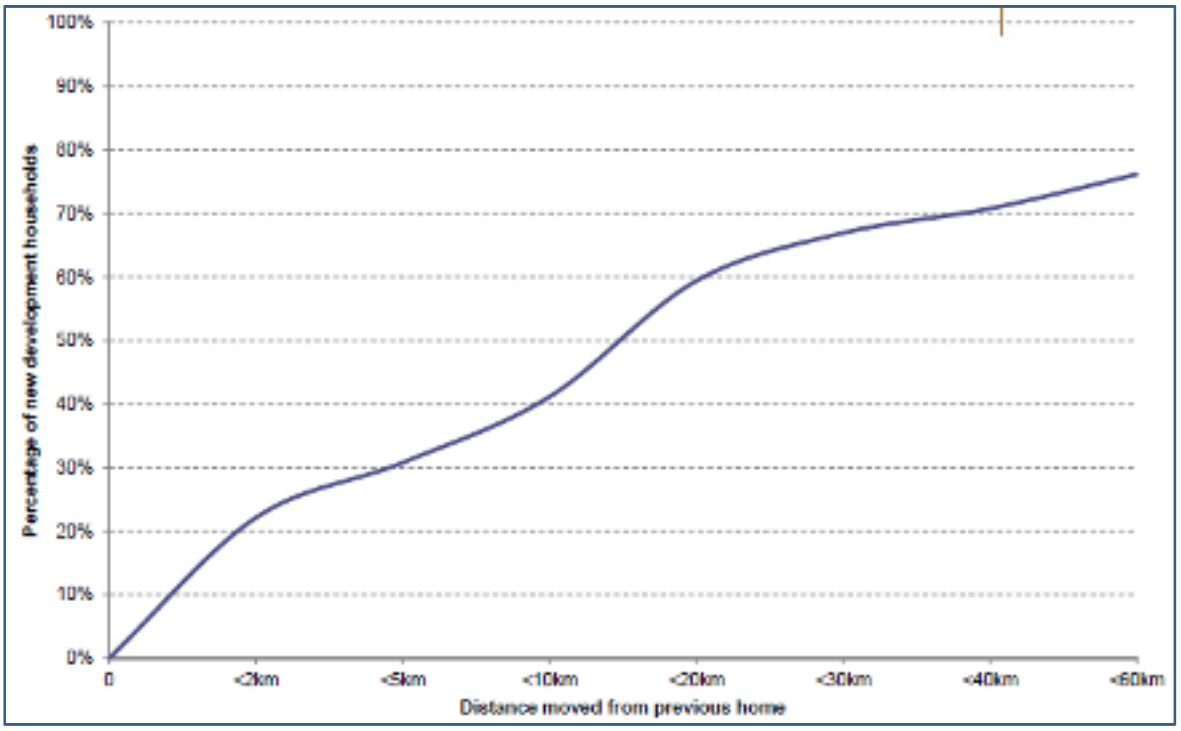
- To move to a larger or smaller home.
- Wanting to set up own home.
- To move nearer to work or new job.

The main "pull factors" for people moving are:

- Like the design of the new home or development.
- Price/affordability compared to neighbouring areas.
- Like the idea of living in a new development.

There is almost a linear relationship between the numbers of people in new developments and the distance moved, with over 70% of new residents having moved over 40km

Figure 20: Where do people move from?



There is a mix of movement between tenures with the largest move seen from the private rented sector to the owner occupied sector.

Figure 21: Moves between tenures

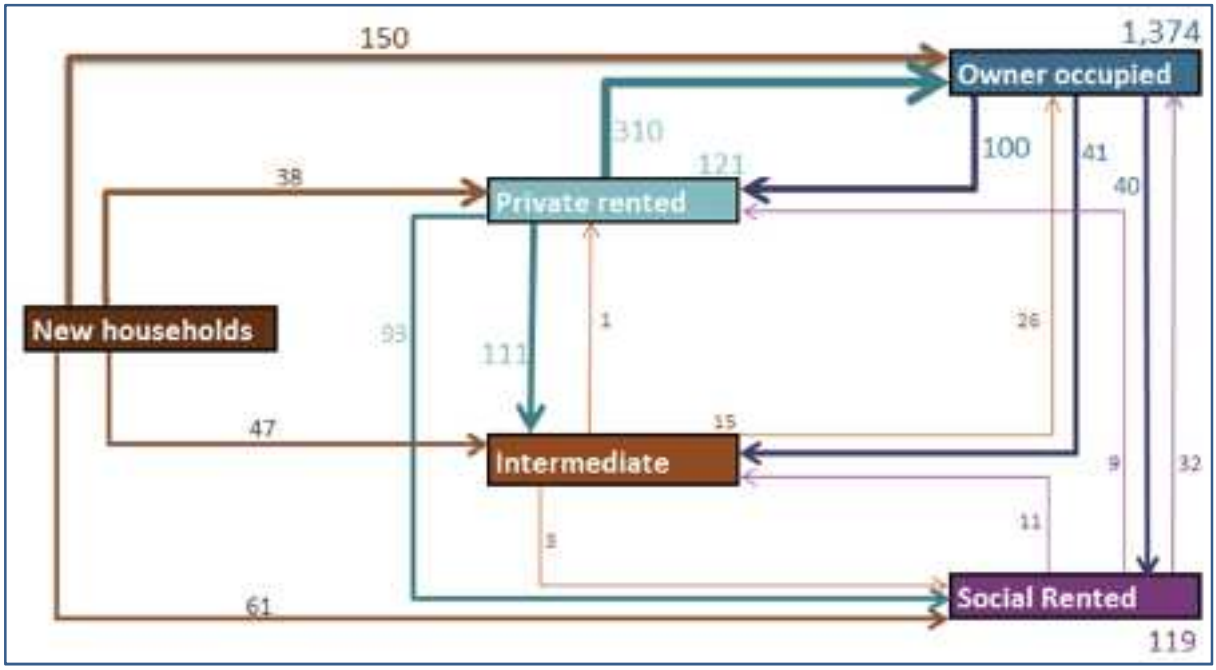
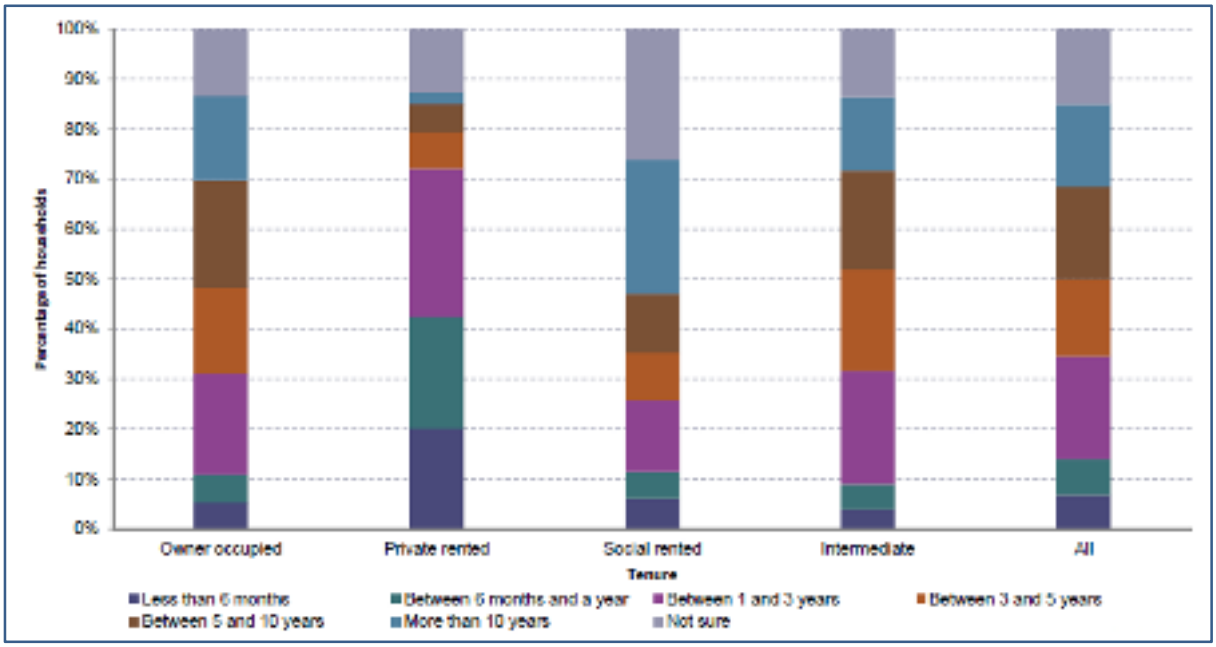
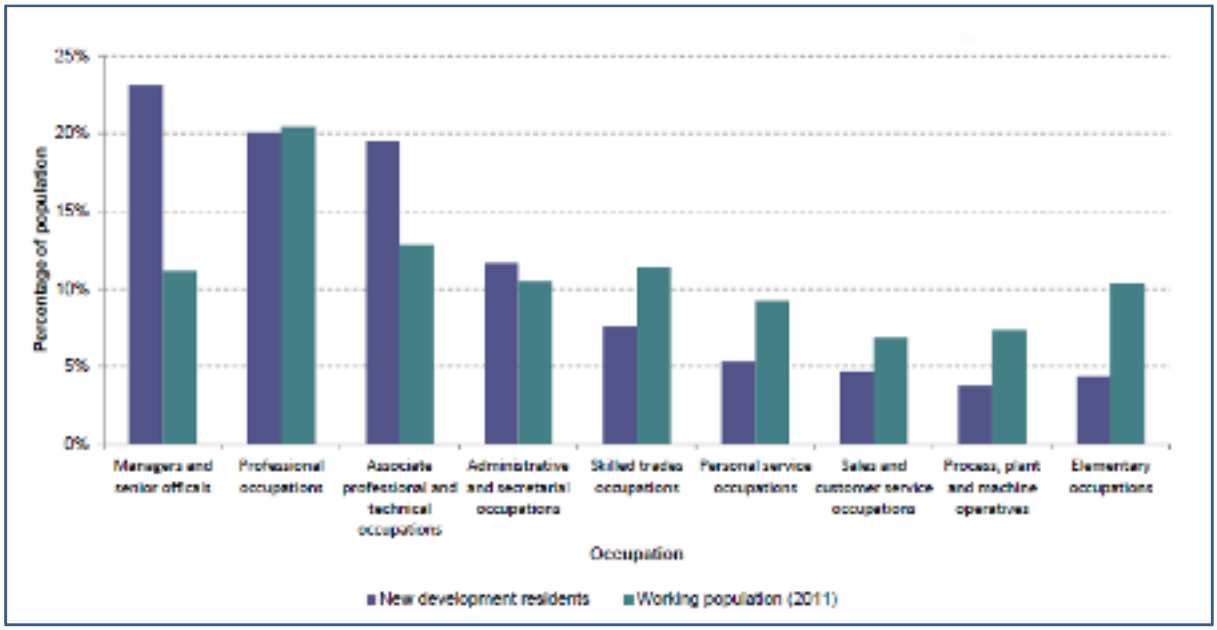


Figure 22: How long do people intend to stay at their current address?



There is a marked difference between those occupying private rented market homes and other tenures in the amount of time those occupiers intend to stay in those properties, with the majority intending to stay less than three years. This is replicated in the moves between tenures (Figure 8 above) indicating that private rented may be a stop-gap location until people can afford to buy, this has implications for service delivery in new developments as outlined in Chapter Four.

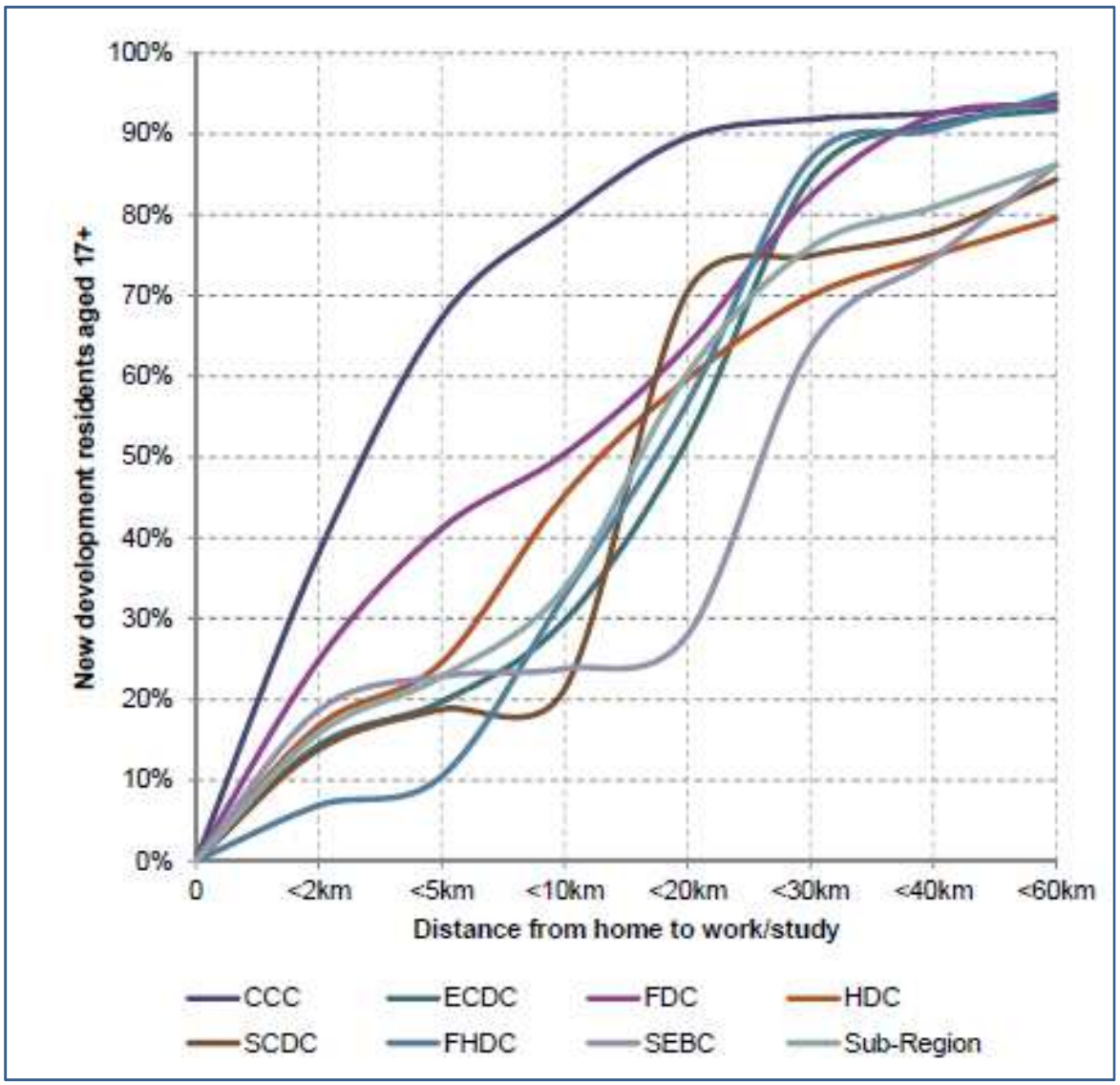
Figure 23: Occupation of new developmentresidents and working population



The occupiers in new developments show a difference in occupations compared to the working population as a whole with more residents employed in the: managers and senior officials, associate professional and technical occupation sectors and less in the skilled trade, sales and customer service, process, plant and machine, and elementary occupation

sectors. This may be related to the location of new developments and income v's house prices.

Figure 24: Where do people work?



Cambridge is a major centre of employment for most of the new development residents eg 28% of residents in Cambourne, 18% of residents in Forest Heath. Peterborough is a more important centre for households in the north of Huntingdonshire and Fenland.

Specific issues – why do people move?

Attractions

- To be near a school with good reputation.
- Access to good quality shopping, entertainment, education & health care.
- Good links to other areaseg Cambridge, Peterborough and Bury St Edmunds for both employment and non-food shopping.
- Good public transport. More satisfied with public transport where there is rail and less satisfied where the development is only served by bus.

Deterrents

- A lack of facilities.
- A poor range of shops.

- The lack of a post office.
- The lack of a pub.
- The lack of sporting facilities.

Sizes of homes
The most popular reasons for wanting to move was “to find a larger or smaller home”. This implies a mix of property sizes helps encourage moves, and so may help attract people.

Tenure
Some people were positive about the mix of social groups and tenures on their development.However, some mentioned the mix of tenures as a negative factor. Typically, people were negative about the amount of social housing developed, however, in Cambridge some respondents felt there were too many privately rented properties.

Design of homes and the development
Respondents said the most popular reason for choosing a new home was design or appearance of the home or development. The second most popular reason was price or affordability compared to neighbouring areas. The idea of living in a new development was also attractive for many, as is the quality of the development and its landscape and maintenance, respondents also mentioned that new homes are cheaper to run.

On the negative side respondents didn’t like the lack of privacy due to being overlooked, small or no garden and living on a partially finished development. Respondents also had concerns about anti-social and youth behaviour; it is uncertain if the design of new developments contributes to this.

Terms such as “friendly” and “good community spirit” were mentioned more than the negative terms such as “unfriendly” and “no community spirit”. However, some people said that they felt isolated, again it is uncertain if the design of new developments is a contributory factor.

Population comparison
New towns and substantial developments have:
- Higher numbers of under-16s than in the ‘host’ district.
- Higher proportion of 30-44 year olds.
- Lower proportion of older people.

In-fill sites
- Slightly older population than new towns and substantial developments with more people aged 60+.
- Although the proportion of 60+ is lower than the ‘host’ district.

Travel
Some 77% of new development residents in the sub-region travel to work/study by car (alone or shared). Across all the new development surveys, new housing development residents have a slightly higher number of cars per household, compared to the ‘host district’ population, however, Cambridge, East Cambridgeshire and Fenland are exceptions where there are fewer cars per household compared to all residents.

Figure 25: How do you travel to work?

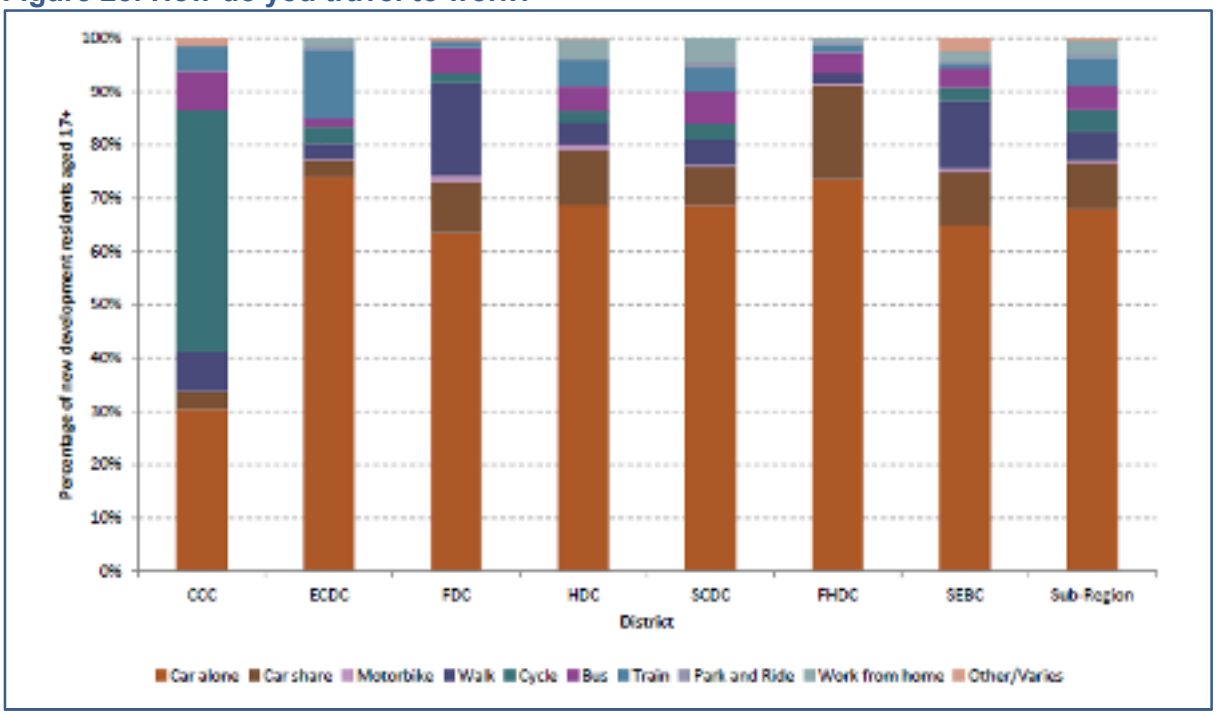


Figure 26: Summary of the "best" things and "worst" things about living in a new development, by development

BEST THINGS				
Quiet	Attractive area	Local facilities	Close to shops	Other
George Nuttall Close	Ely North	Hales Barn	March	Cromwell Road
Littleport	Ely West	Hanchett End	King's Ripton	Headlands
Soham	Barford Road	Hardwick Gate	Cotton Lane	NIAB
Sutton	Mill Lane		Springfield Gate	Co-op Farm
Chatteris	Pig Lane			Red Lodge
Villages	Roman Way			
Whittlesey	Cambourne			
Wisbech				
Bury Road				

WORST THINGS				
Parking	Traffic/busy roads/ speeding	Lack of/ quality of shopping facilities	Lack of facilities/services	Other
Cromwell Road	Sutton	NIAB	March	Cotton Lane
George Nuttall Close	Headlands	Ely North	Whittlesey	Soham
Barford Road	Kings Ripton Road	Ely West	Co-op Farm	Wisbech
Hales Barn	Pig Lane	Littleport	Cambourne	Chatteris
Hanchett End	Roman Way	Bury Road		Mill Lane
Hardwick Gate		Red Lodge		Villages
Springfield Gate				

ASSETS AND SERVICES

1. KEY FINDINGS

- Planning processes – A joint strategy is needed to develop a way to engage and attract the leisure market into new communities early in the development. This could be through ensuring the units are built early, opening units at discounted/nil business rate, allowing locals to use the units as pop up shops etc.

- Further research to understand the length that referral to Social Services cases are open, and what was the primary reason for referral to better conclude if there are particular social reasons for referrals that can help establish whether new communities are prone to certain social needs.

- During the pre-application stage of the planning process, services and the community should be engaged and a working group of people centred support established so that there is a clear co-ordinated effort and communication channels between services and the planning of the new community. This will enable co-ordinate response to planning applications through to service/support delivery. Where possible these groups should be led by the community whether this is parish council, residents association etc. with support from the local authority. Where the community is not willing or able to lead, the local authority will lead but with a clear hand over strategy for when the community is able to lead. These groups will have engagement from the widest group of services (but not necessarily attending physically) and agree, achievable action and communication plans

- Additional support to be provided to schools to enable them to deal with the additional challenges that new community schools can expect to face. Ensure that during the selection process these challenges are clearly detailed and ask how the prospective sponsor of the school would face these challenges and work with the community to help secure positive outcomes for all new community schools.

- Provide incentives to attract full day care/early years providers to developments, such as free plots of serviced land etc.

- Further research into categories of crime committed and to look into other new communities and compare them to the county

2. INTRODUCTION

2.1 Summary

The vision for new growth in Cambridgeshire includes a commitment to deliver high quality, sustainable new communities. Sustainable new communities are more than just economic and environmentally sustainable but also socially sustainable. To be sustainable, a community must promote health and wellbeing as well as foster social cohesion and inclusion. To support and promote health and wellbeing, new communities will require access to certain support and services to help them stay healthy and well. However, it is important that the assets of new communities are taken account of in planning and that these assets are built upon when considering what services are needed in new communities.

Assets are a thing, person or quality that services as an advantage, support or source of strength. Assets in new communities are very important because they are the primary building blocks of sustainable community development. Each new community is different so it is impossible to provide an asset assessment for new communities, however, looking primarily at the new communities of Cambourne, Southern Fringe and Loves Farm several themes have emerged:

- Purpose built community facilities.
- The existing community.
- Community leaders and shared experience.
- Ability to design optimal solutions in partnership with the community.
- Funding (capital and revenue).

There are a number of new communities in Cambridgeshire, of the larger new communities feedback from some frontline practitioners, including housing, children's social care and family workers, report that they are seeing higher needs in the initial years in new communities. Using data from some new communities in Cambridgeshire we can analyse whether these reports of higher needs in new communities are translating into increased utilisation of health and social care services. This is not to take the focus from assets but to understand what services have been utilised to establish whether there is a gap in support in new communities.

From data available, of three of the four new communities there are higher referral rates to higher tier children's services, expected/average referrals to lower tier children's services and very low use of adult social care. In regard to children's services, Orchard Park has very low usage of any children's services at all tiers (data was not available to assess adult social care). Commercial leisure services that impact health and wellbeing are lacking in new communities and although voluntary services and local authorities try to fill the void they are unable to provide the level of services provided by commercial sector.

Engaging services early in the planning process is essential to ensure that the right infrastructure is available and so there is a co-ordinated plan to use the assets available to develop healthy new communities and to prevent the high needs. Due to the complexity and changeable nature of services and because each new community is different it is not possible to provide a comprehensive list of all services needed in new community. However, to help replicate and develop good practice the chapter provides the following outcomes and guiding principles which have been established based on experience of new and developing communities in Cambridgeshire.

Outcomes identified:

- All people, regardless of their needs, live well independently.
- People are and feel safe.
- People lead a healthy lifestyle.
- Local economy prospers for all.
- All people have a voice and control in decision that affect their community.

In order to achieve the outcomes it is crucial that activities are delivered effectively and in a co-ordinated manner to avoid duplication or gaps in provision. The following principles are intended to support achieving the identified outcomes.

- Partnership working
- Co-location and integration
- Community Resilience
- Timing

The success of the outcomes cannot be the sole responsibility of one agency but will require the whole planning and delivery system to work together.

The chapter also recognises that there are going to be barriers to services and assets being utilised and recommends some possible mitigation so these do not block new communities being delivered in the most effective way. Barriers include:

- Lack of co-ordination and clear communication.
- Long planning and delivery process.
- Funding and lack of capacity.
- Existing community and local representatives.
- Digital infrastructure.

2.2 Introduction – what are assets and services?

Sustainable new communities are more than just economic and environmentally sustainable but also socially sustainable.To be sustainable, a community must promote health and wellbeing as well as foster social cohesion and inclusion. To support and promote health and wellbeing, new communities will require access to certain support and services to help them stay healthy and well. However, it is important that the assets of new communities are taken account of in planning and that these assets are built upon when considering what services are needed in new communities.

There are many services that support us to stay healthy and well and it would be impossible to name them all. For clarity, when this chapter refers to services these are services that can be provided by a variety of organisations (public, voluntary or community sector) that contribute to health and wellbeing of the community. There are many municipal services that contribute to our health and wellbeing such as water supply but these types of services will not be included in this chapter as they are so firmly established. Therefore, this chapter is solely focused on services that deliver people-centred support (ie services that work directly with people).

This chapter seeks to understand the assets available in new communities and the utilisation of services in new communities with the aim of replicating or developing good practice to ensure that new and evolving new communities are well-served.

2.2.1 Assets

An asset is defined as ‘thing, person, quality, etc, that serves as an advantage, support, or source of strength. (74) The assets of a community are very important because they are the primary building blocks of sustainable community development. Not recognising the significant assets available in new communities may result in only seeing needs in the community and ignoring the strengths. This may result in services coming in and ‘doing to’ the community rather than using all available assets to ‘work with’ the community to help build a strong, sustainable, and healthy new community.

2.2.2 Purpose built community facilities

New community facilities are often made available at little or no cost to the community or to public services, as they are typically funded by the developer. Consequently, these facilities can be designed to act as flexible, accessible multifunctional spaces that provide the community with a place to meet, participate in activities and afford access to public, voluntary and community-led services.

There can be some risks and issues associated with community facilities in new communities. For example, schools are considered to be community facilities which can sometimes mean that minimal additional space is provided for the wider community. There are some notable examples of community-focused schools (such as Cambridgeshire village colleges) and, because schools are often built first, they can provide the community with indoor space right from first occupation. It is important to recognise however that the primary purpose of school buildings is the education of children and young people and the needs of the students will naturally be put above those of the wider community. Schools may not always be able to provide the access that the community needs. They may also have to restrict access to the public while pupils are present due to safeguarding concerns. Furthermore, school buildings can alienate some population who may not see the school as a space for them due to previous negative experiences at schools

Examples of this include use of the marketing suite in the Southern Fringe development, or the use of a temporary community wing (or similar) in the primary school in Loves Farm (also planned for Northstowe). However, caution must be taken to ensure that adequate community space is available throughout the development.

In large developments, it may not be practical to make the definitive community buildings available from the outset. It is recognised that, due to the often lengthy build- out rate of new communities, the provision of permanent facilities scaled for the whole community and available from the very beginning may not be practical or financially responsible, as they may be underused for an indeterminate length of time until the community becomes larger. However, as reference in much research and more locally in the 'Lessons from Cambourne' article published in 2007, the community needs a place for people to meet from very early on and informal places to meet.(65)Therefore, in order to ensure that there will always be space available for the community, the utilisation of temporary facilities is a suitable interim stage.

2.2.3 Existing Community

It is very rare that a new community is built with no established existing community in the vicinity. The established community can be a huge asset to a new community with existing groups and activities open to new residents to join and access to already developed social networks. It also allows for community involvement at the early stages of planning, thus representing the views of people living in the area.

However, sometimes an existing community does not always welcome the presence of a new community and a 'us and them' attitude can become established. If new community facilities risk putting existing facilities out of business this can cause division and is of benefit to no one. In addition, new communities have brand new facilities which could lead to existing communities seeing it as the new development being favoured over the existing community. Furthermore, if the existing community objected to the new community from the planning stages then there can be opposition that is very difficult to overcome. Ensuring that the existing community is able to engage with the new development and that it receives reliable communication can help to stop divisions between the new and old communities.

Case Study 6: Southern Fringe

Case Study – Southern Fringe
In the Southern Fringe development, a community development officer has been working part time with the existing community prior to the development beginning to be built. This has helped to ensure that all new community facilities complement the existing facilities rather than put them out of business and supports the building of closer connections to the new and existing community.

Furthermore, volunteers from Trumpington are welcoming new residentsthrough the issuing of welcome packs and inviting them to already established community groups. The residents' association is also helping to share the culture and history of the area with the new community so that they can develop roots in the community giving them a sense of belonging. Community development officers and funding for public art/community are important tools to help facilitate and co-ordinate the community building between existing and new. This has been evident in southern fringe where the community developer officer has played a key role in facilitating linking existing and new but has done it in such a way that the community is still leading and therefore owning it so that it is sustainable.

2.2.4 Community leaders and shared experience

When people move they are making a fresh start and are often interested in taking up new activities and making the community they live in sustainable and ultimately a nice place to live. Often the first residents to new communities are willing to do the work to achieve an established positive community; one which relies less on public services. Furthermore, as all residents are new residents there is an automatic connection between them.

New residents are usually willing to volunteer, whether that is to set up community groups (if they donot already exist) or volunteer for other community groups or wider organisations such as Homestart, or a statutory service such as the local library.

Nurturing and supporting volunteering and leaders in the community will ensure that the community feels it has ownership of what is in its community and a say on how things are run. This again is an important role of community development officers and other local groups.

This support ensures that there is the help to support volunteers so that they do not come across avoidable barriers in volunteering or becoming community leaders.

In Cambridgeshire libraries currently have three times as many volunteers as staff. All communities will have access to a library, whether that is a mobile library, a permanent library in a neighbouring village/town or a brand new library built for the new community.

Support such as the local churches in Trumpington which have helped identify needs and set up new groups with volunteers from the congregation.

2.2.5 Ability to design optimal solutions in partnership with the community

Not only do new communities present an opportunity to build new community facilities but they also provide an opportunity to develop optimal solutions in conjunction with the community.Service commissioners and providers can work with the new community to co-

produce services allowing the community to shape what support is available and how it is delivered. This will allow the community to feel ownership for the services and, where relevant, run the service themselves.

However, this means that organisations need to co-ordinate and work together with the community. This can often be challenging and it requires someone to take the lead to bring the community and the services together. In addition, as the community is constantly changing, it will be a challenge to ensure that all the community is represented and kept informed.

2.2.6 Additional funding

New communities often benefit from additional funding to establish new infrastructure and activities in the area. Section 106 funding and CIL are available for new developments and while they primarily support large infrastructure, they can also provide revenue funding to fund community development, services and activities.

As recognised in the previous JSNA on New Communities, new communities bring new opportunities to look at services afresh, and to explore new and more appropriate models of delivery.

However, developers routinely assert that the projects' viability limits the scope for providing funds. This can jeopardise securing developer funding as obligations for community development and revenue funding is frequently compromised when development viability is threatened. Furthermore, even when funding is secured there is a tendency for overreliance on the developer funding and insufficient planning to ensure sustainability after the funding ends.

2.3 Services

To have a positive physical, social and mental state people will need and want. Access to day-to-day services such as shops, entertainment facilities and restaurants where they can meet others, relax and enjoy themselves promotes a positive physical, social and mental state. Access to good quality facilities for shopping and entertainment are highlighted as attractions of new developments. (66)

Lessons from Cambourne demonstrated that one of the reasons people did not likeCambourne was the poor range of shops – shops not arriving until later in the development caused frustration and resentment (73).

Without a destination or activity people are more likely to remain isolated and lonely which can result in anxiety, depression and other mental health issues.
However, these types of services are market driven and with the long build out rates of new communities it is difficult to entice these services to set up early in new communities as it is difficult to make a profit. Many community groups, voluntary and statutory services have attempted to fill the void with community cafés and other activities that provide entertainment and a chance to meet with other people.

In Southern Fringe the local residents association run a soft play café every Saturday morning and the local church runs a café on Wednesday mornings but feedback from those working is that there is never community events on that suits their lifestyle.

However, these types of events may not appeal to everyone and they are only available at limited times. For example, a commercial café will be open almost every day for a number of hours whereas a community café may only be open for one morning a week; this may not be convenient for people or fit with their work schedule and therefore limits people's choice.

Voluntary organisations, community groups and statutory services have a very valuable role to play in bringing about the benefits that the leisure sector bring but financial constraints will limit their ability to provide these services.

2.3.1 Essential service available when they are needed

Engaging services early in the planning process is essential to ensure that the right infrastructure is available and so there is a co-ordinate plan to use the assets available to develop healthy new communities and to prevent the high needs.

Due to the complexity and changeable nature of services and because each new community is different it is not possible to provide a comprehensive list of all services needed in new community. Each new community is different and will have access to different resources and assets depending on a variety of factors such as location and demographics. Listing services would be too prescriptive and would limit the community's role in shaping service delivery in their community.

3. LOCAL DATA

The vision for new growth in Cambridgeshire includes a commitment to deliver high quality, sustainable new communities

The new communities in Cambridgeshire have possessed many assets that support the health and wellbeing of the community. Each new and developing new community is different so it is impossible to provide an asset assessment for new communities. However, looking primarily at the new communities ofCambourne, Southern Fringe and Loves Farm in Cambridgeshire, several themes have emerged:

- Purpose built community facilities.
- The existing community.
- Community leaders and shared experience.
- Ability to design optimal solutions in partnership with the community.
- Funding (capital and revenue).

Often permanent community facilities are not delivered until later into the development, such as with the Loves Farm development where the permanent community building opened in October 2015, some seven years after the start of the development. If access to good quality temporary provision had been in place then this may have not been a problem, but once the primary school needed to use the temporary space previously provided to the community, the community were left without any indoor community facilities for three years. It is essential that continuity of access to good quality provision is sustained. If temporary accommodation is provided in schools there should be no gap in provision when the temporary access ceases.

In addition, the management and cost of running community facilities must be considered when determining the need and designing the community facility. Many new facilities will need financial support to make them viable in the early years and to ensure that the facilities are able to offer space for the whole community rather than just for the community that can afford it. For example, Trumpington pavilion located near the new community of Southern Fringe received developer funding to improve the building. The City Council own the land and property and lease it to the residents association to manage on the City Council's behalf. The City Council give a set fee each year to assist with the running costs in the form of a service level agreement; the agreement includes a requirement to allocate 10 hours a week of free community use so groups which may otherwise struggle to afford to rent the space are able to use the building.

However, it is important to note that communities of the past have often had a high turnover of residents because many of the properties are 'bought to let'. This may have an impact on the community development as it requires people to be committed to the area. If a large proportion of the residents are not intending to stay then they are less likely to put effort into establishing roots within the community. This may cause a division between those who have bought their homes and those on short term lets and impair the ability of the community to build.

3.1 Health and social care utilisation in new communities

There are a number of new communities in Cambridgeshire,of the larger new communities feedback from some frontline practitioners, including housing, children's social care and family workers, report that they are seeing higher needs in the initial years in new communities. In a County Council Member led review in 2010, it was acknowledged that new communities have unique needs, generally higher levels of mental health issues and

greater prevalence of domestic issues: the challenges faced by public services in new communities are, very frequently greater than they are elsewhere.(66)

Using data from some new communities in Cambridgeshire we can analyse whether these reports of higher needs in new communities are translating into increased utilisation of health and social care services.

This is not to take focus from assets but to understand what services have been utilised to establish whether there is a gap in support in new communities. By identifying gaps, we can look to the assets and how to build upon those to close any gaps in future new communities.

The following services are not an exhaustive list of all services that are in new communities but are services where we have been able to access data.

Figure 27: Health Visitor Referrals in the New Developments

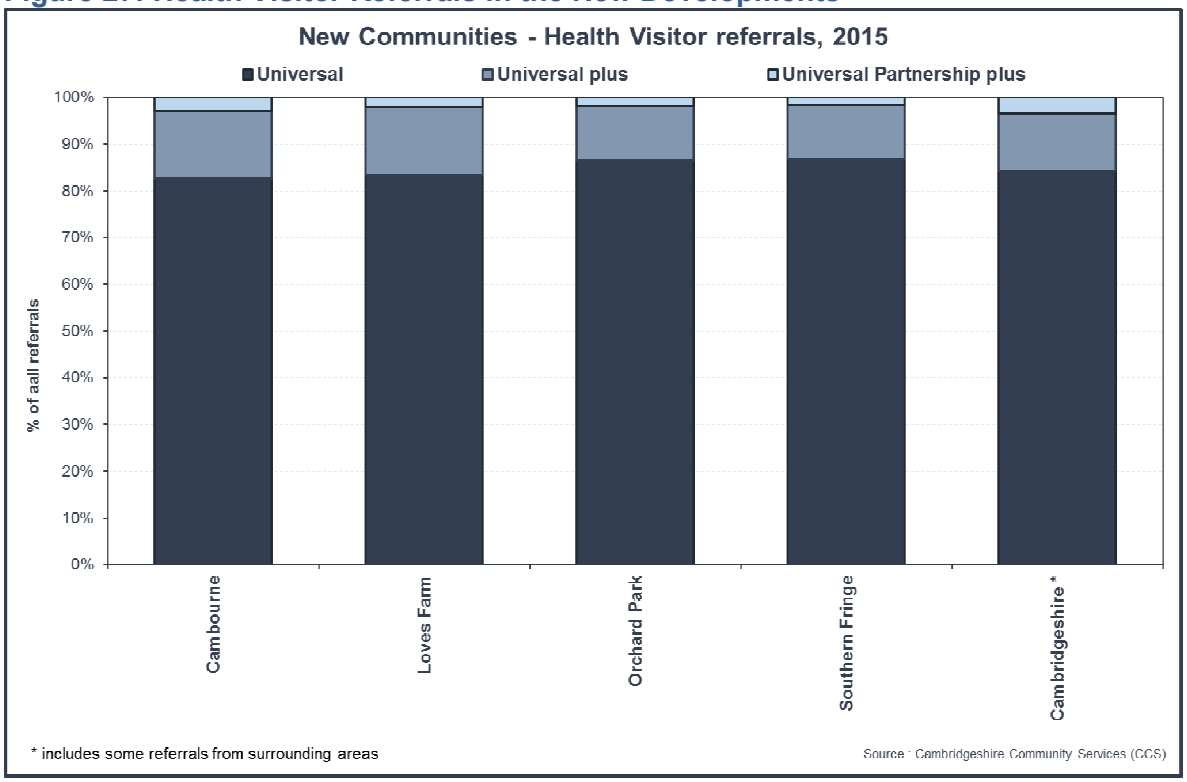


Table 18: Health visitor referrals 2015

Development	Universal		Universal plus		Universal Partnership plus		Total	Number of births	Rate of referrals per 100 births	95% confidence intervals
	Number	% of development total	Number	% of development total	Number	% of development total				
Cambourne	484	82.7%	84	14.4%	17	2.9%	585	203	288.2	(0.0 - 0.0)
Loves Farm	241	83.4%	42	14.5%	6	2.1%	289	118	244.9	(0.0 - 0.0)
Orchard Park	96	86.5%	-	-	-	-	111	40	277.5	(0.0 - 0.0)
Southern Fringe	204	86.8%	-	-	-	-	235	70	335.7	(0.0 - 0.0)
Cambridgeshire *	18,651	84.1%	2,752	12.4%	766	3.5%	22,169	7,795	284.4	(0.0 - 0.0)

	Statistically significantly higher than Cambridgeshire
	Statistically significantly lower than Cambridgeshire
-	denotes fewer than 6 cases or removed due to disclosure
*	includes some referrals from surrounding areas

Cambourne appears to have a higher rate of universal plus referrals per 100 births than Cambridgeshire but, due to small numbers, the rate does not differ significantly.

Figure 28: New Communities Hospital Admission & Attendance rates

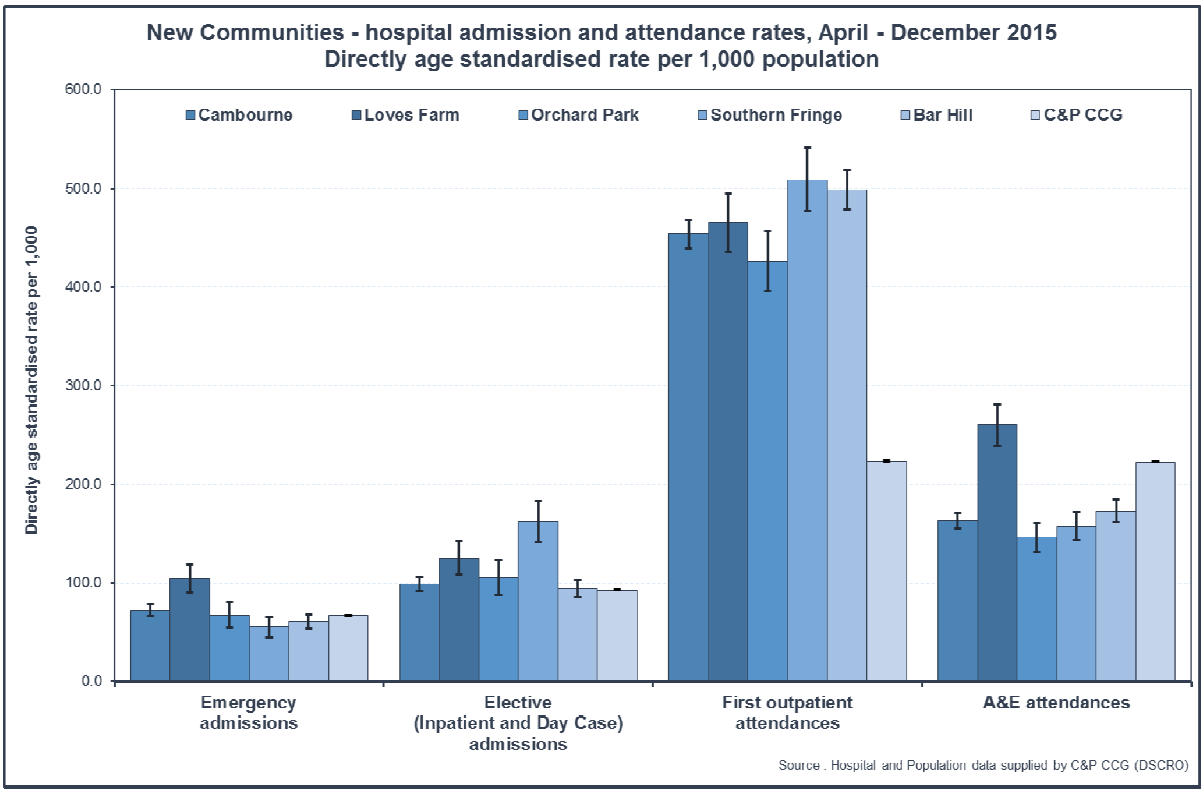


Table 19: Hospital Did Not Attend Figures 2014/15

Development	First outpatients		
	Number of DNA's	% DNA	95% CI
Cambourne	182	5.1%	(4.6% - 6.1%)
LovesFarm	102	7.8%	(7.1% - 10.2%)
Orchard Park	40	5.5%	(4.3% - 7.8%)
SouthernFringe	46	6.3%	(5.1% - 8.9%)
C&P CCG	370	5.8%	(5.6% - 6.8%)

Table 20: Hospital data, April - December 2015

Development	Emergency			Electives (Inpatient and day case)			First outpatient			A&E		
	Number	DASR per 1,000	95% CI	Number	DASR per 1,000	95% CI	Number	DASR per 1,000	95% CI	Number	DASR per 1,000	95% CI
Cambourne	520	72.4	(66.2 - 78.7)	712	98.9	(91.7 - 106.2)	3,584	453.8	(438.9 - 468.7)	1,694	163.1	(155.3 - 170.9)
LovesFarm	215	104.6	(90.6 - 118.6)	246	125.5	(117.7 - 151.3)	967	465.2	(435.9 - 494.5)	592	260.5	(239.6 - 281.5)
Orchard Park	107	67.6	(54.8 - 80.4)	136	105.7	(88.0 - 123.5)	775	426.6	(401.4 - 462.2)	389	146.3	(131.8 - 160.9)
SouthernFringe	114	55.5	(45.3 - 65.7)	235	162.5	(141.7 - 183.2)	955	509.1	(476.8 - 541.4)	466	157.3	(143.0 - 171.6)
C&P CCG	57,757	67.0	(66.5 - 67.6)	77,601	92.8	(92.2 - 93.5)	196,555	223.1	(222.1 - 224.1)	207,291	222.8	(221.9 - 223.8)
Bar Hill	288	61.2	(54.1 - 68.3)	452	94.5	(85.8 - 103.3)	2,396	498.8	(478.8 - 518.8)	866	173.1	(161.6 - 184.6)

3.1.1 Cambridgeshire County Council Children's Services

Cambridgeshire County Council supports children, young people and their families via two different but linked services: Children's Social Care and Enhanced and Preventative Services. Enhanced and Presentative services support children and young people with emerging and additional needs whereas children's social care support children and young people whose needs are more complex, severe and who may need protection[i].

Children's social care services protect children who may be in danger or at risk of harm. Children's social care does this by supporting children and families and providing protection services and child protection plans. Where it is not possible for children to remain in their families, social workers support children with extended family, foster carers or adoptive parents.

Cambridgeshire County Council Enhanced and Preventative Services deliver a range of universal preventative services for children, young people and their families and some more specialist services for vulnerable children, young people and their families. Many of the services provided by Enhanced and Preventative Services are delivered by one of 14 multi-disciplinary locality teams. These teams are responsible for providing joined up, responsive services for children and families living in each area. Locality teams provide a range of support such as providing information and advice on education, employment and training, they work with young people who have behavioural problems, and provide support and advice for families who need additional help with parenting.

To understand how children's services are being utilised in new communities the number of referrals to children's social care and locality teams have been compared to the rest of the locality in which each development is located in (removing the referrals from the new community within the locality).

Due to how recent the new communities are being developed and the continued expansion due to new housing, it is very difficult to get accurate estimates of the 0-19 population for the new communities. Therefore, the 0-19 population of new communities considered in this research(67) has been estimated based on total number of completed houses in the new developments at that period of time multiplied by the average number of children per dwelling in Cambourne 2006 (0.74). This method of estimating population was chosen as it factored that new communities tend to have a higher than average younger person population and allowed for the constant increases in population due to the continued building of houses. Population of the localities was determined from the CFA Metrics provided by the CCC Children, Families and Adults Management Information team minus the population estimates of the new community.

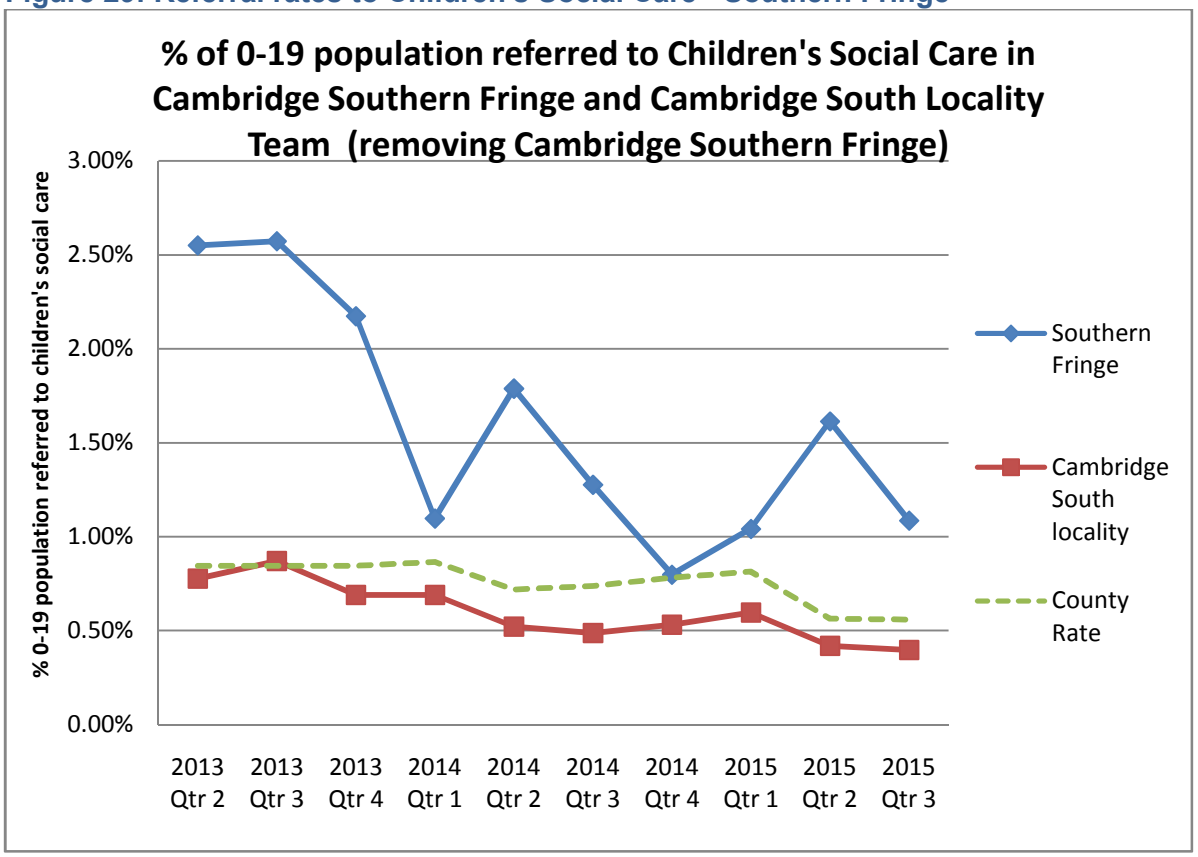
3.1.2 Children's Social Care

Due to changes in 2011 in how CCC recorded children's social care data only data from 2011 onwards is accessible. Furthermore, it is only possible to run reports of social care usage based on the child or young person's current address (as of January 2016) rather than their address at the point of the referral. Therefore, it is not possible to determine whether the child or young person was living at their current address at the point of referral or at a different address.

3.1.3 Southern Fringe

There were on average more referrals to children's social care per population from Southern Fringe development compared to the rest of the locality. From the second quarter of 2013 to the third quarter of 2015 (data from 2012 has not been used because numbers of housing completions were very low) an average of 1.60% of the 0-19 population in Southern Fringe development were referred to children' social care in comparison to 0.60% of the Cambridge South locality.

Figure 29: Referral rates to Children's Social Care - Southern Fringe



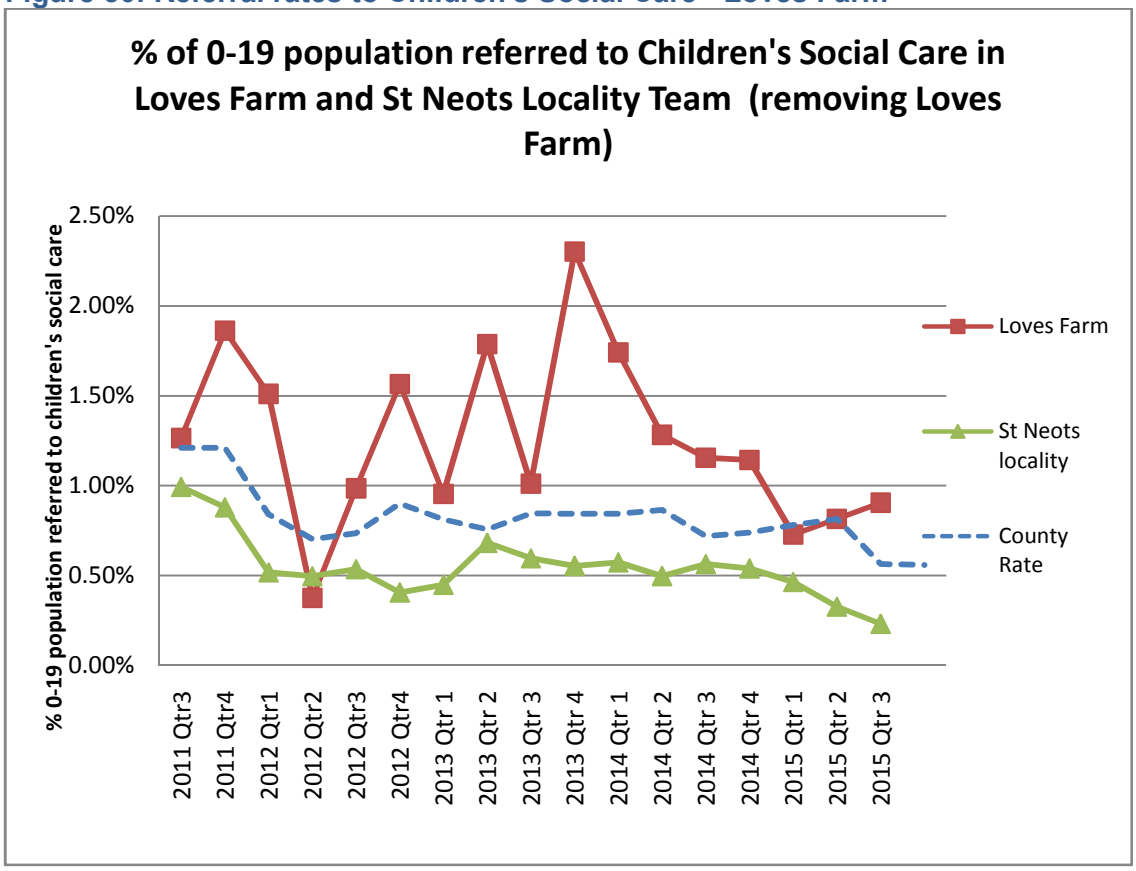
Source: One ICS, CFA Management Information Team and Strategy Service

In 2013-14 of the children and young people referred to children's social care in the Southern Fringe 73% of those referred had previously accessed children and young people's services from CCC (including Enhanced and preventative service) and 27% had never accessed children and young people's services prior to moving to the new community
The average distance the families who were referred to children's social care in Southern Fringe moved is seven miles.

3.1.4 Loves Farm

There were also on average more referrals to children's social care per population from the Loves Farm development compared to the rest of the locality. From the third quarter of 2011 to the third quarter of 2015 there was an average of 1.26% of the 0-19 population of Loves Farm referred to children's social care compared to 0.55% of the St Neots Locality.

Figure 30: Referral rates to Children's Social Care - Loves Farm



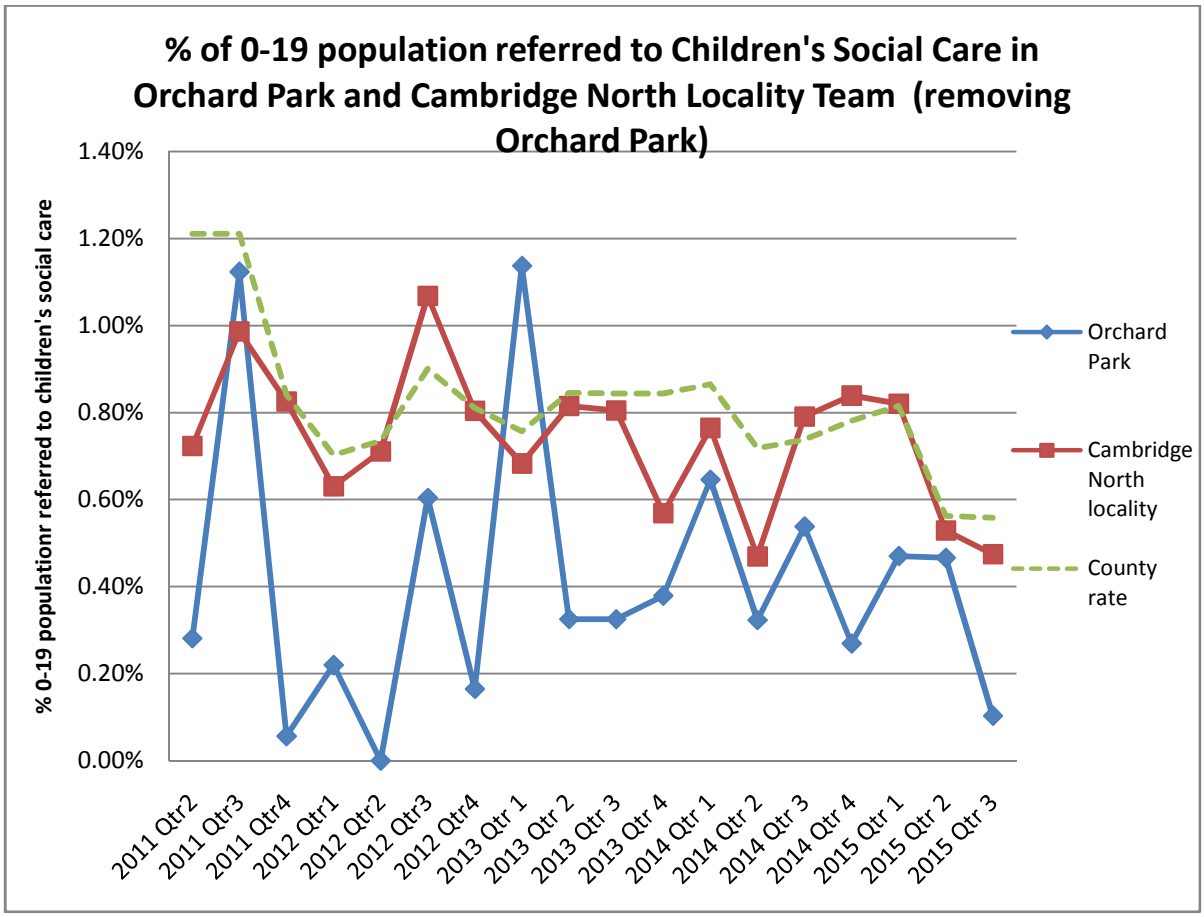
Source: One ICS, CFA Management Information Team and Strategy Service

From 2011-2014 of the children and young people referred to children's social care in Loves Farm, 55% had previously accessed children and young people's services from CCC (including Enhanced and Preventative service) and 45% had never accessed children and young people's services prior to moving to the new community. The average distance the families who were referred to children's social care in Loves Farm moved is six miles.

3.1.5 Orchard Park

On average in Orchard Park there were less referrals to children's social care per population compared to the rest of the locality. From the second quarter of 2011 to the third quarter of 2015 an average of 0.41% of the Orchard Park 0-19 population were referred to children' social care in comparison to 0.74% of the Cambridge North Locality.

Figure 31: Referral rates to Children's Social Care - : Referral rates to Children's Social Care - Orchard Park

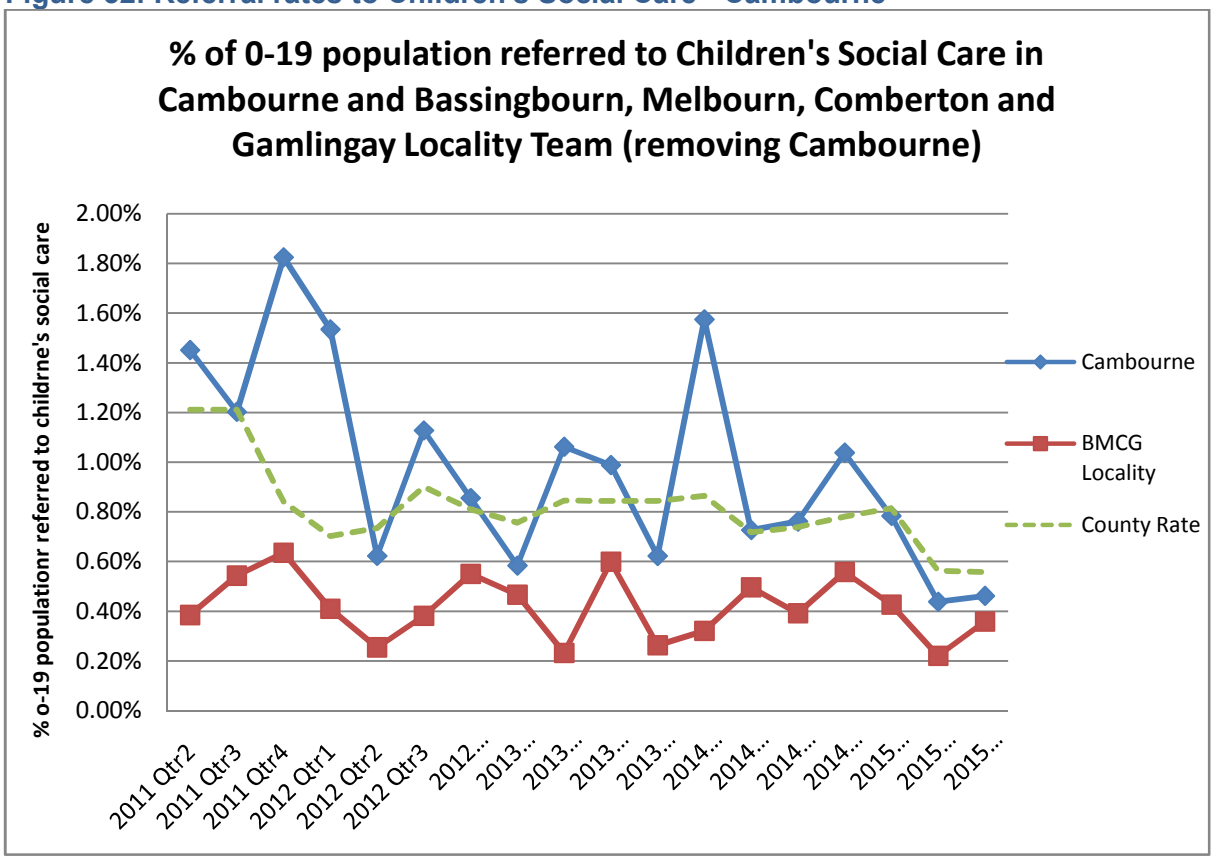


Source: One ICS, CFA Management Information Team and Strategy Service

3.1.6 Cambourne

For Cambourne there were on average more referrals from Cambourne per population compared to the rest of the locality. In Cambourne, from the second quarter of 2011 to the third quarter of 2015 an average of 0.98% of the 0-19 population were referred to children' social care in comparison to 0.42% of the Bassingbourn, Melbourn, Comberton and Gamlingay Locality

Figure 32: Referral rates to Children's Social Care - Cambourne



Source: One ICS, CFA Enhanced and Preventative Service and Strategy Service

3.2 Enhanced and Preventative Services

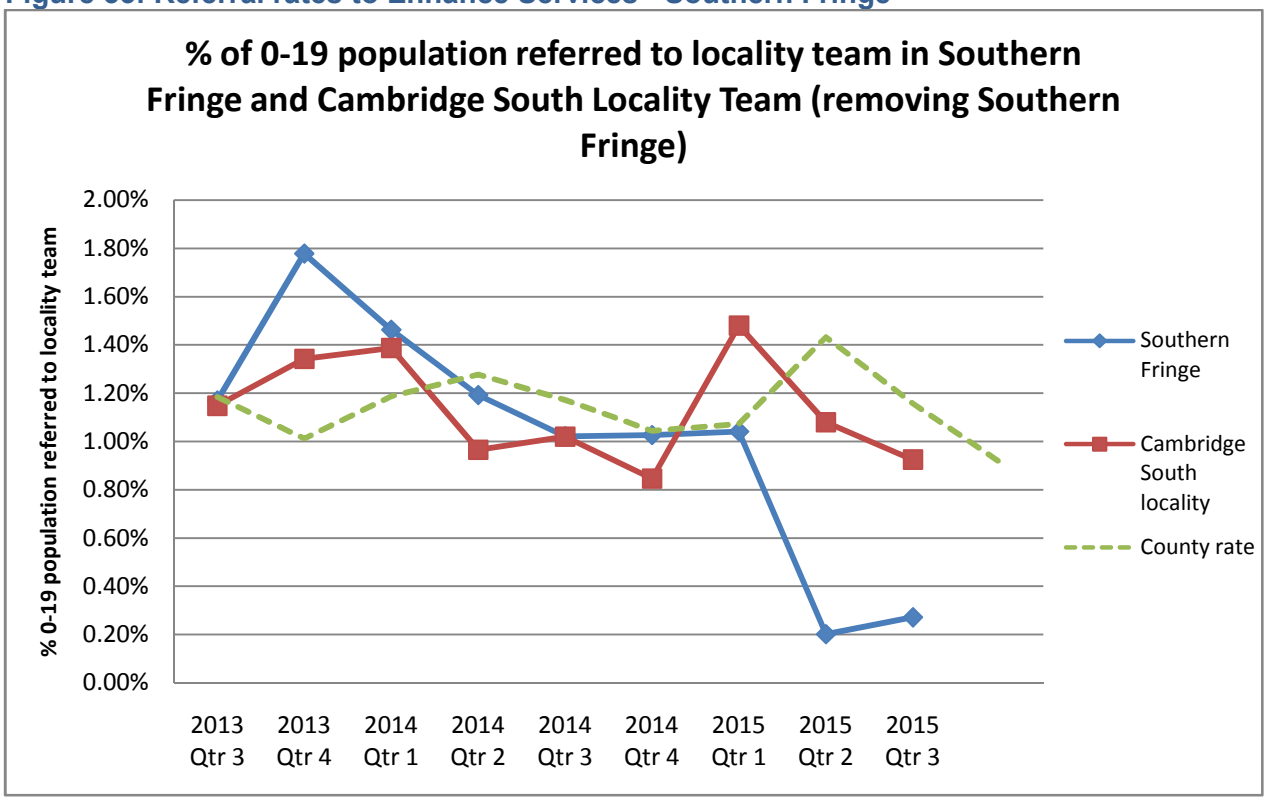
Data for locality referrals is only available from April 2013 as any data available prior to this date is less consistent. As with data from children's social care, it is only possible to run reports of locality usage based on the child or young person's current address (as of January 2016) rather than their address at the point of the referral. Therefore, it is not possible to determine whether the child or young person was living at their current address at the point of referral or at a different address.

It is also important to note that the referrals do not include all services that the locality provides as not all services provided by locality teams are accessed via the referrals, for example locality teams also do group work and drop in sessions which are not reflected within the referral data. Therefore, the data below should be seen as only part of how locality teams support communities.

3.2.1 Southern Fringe

Referrals to Cambridge South locality from Southern Fringe development were consistently higher than the rest of the locality for 2013-2014, however, there was a distinct dip in referrals in 2015. From the third quarter of 2013 to the third quarter of 2015 on average 1.02% of the Southern Fringe 0-19 population were referred to locality team compared to 1.13% of the locality. However in the first three quarters of 2015 an average of only 0.5% of the Southern Fringe 0-19 population were referred to locality team compared to an average of 1.13% Cambridge South locality.

Figure 33: Referral rates to Enhance Services - Southern Fringe

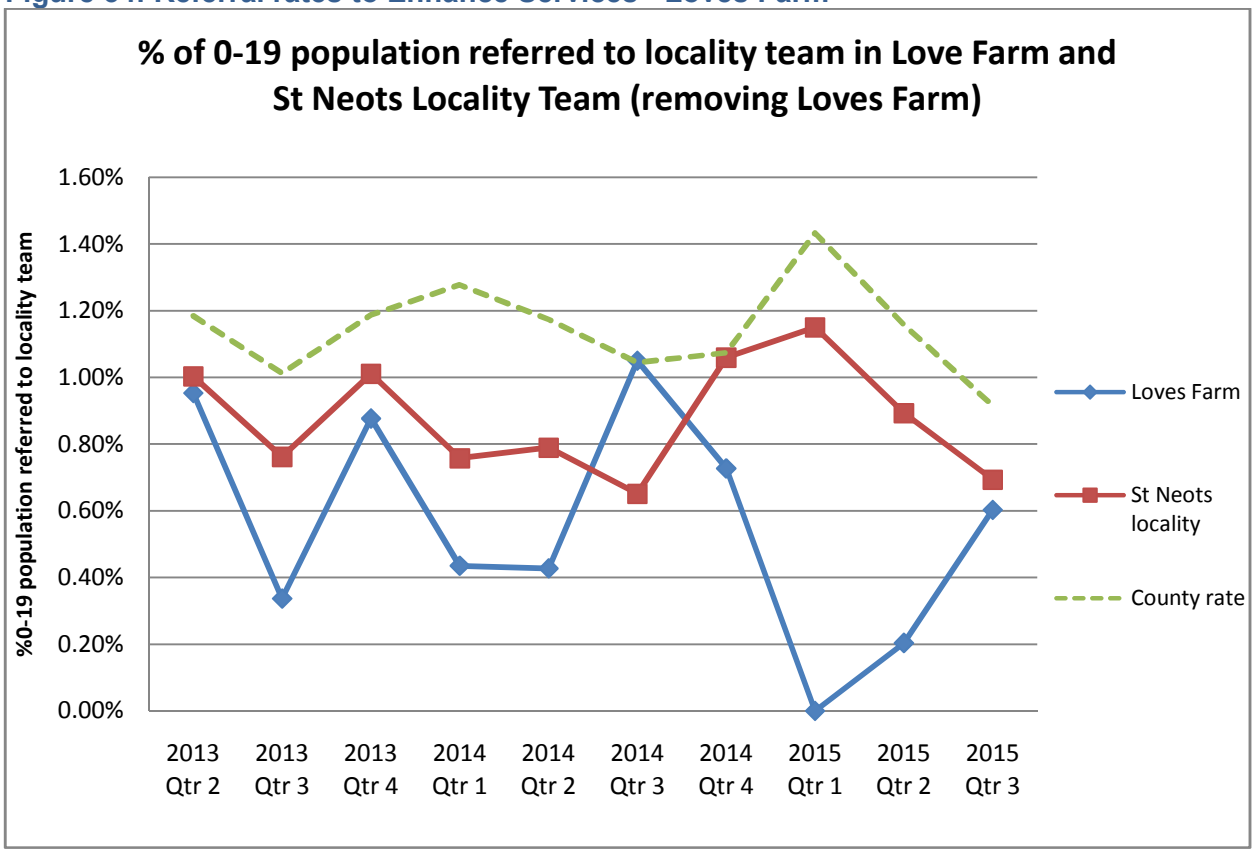


Source: One ICS, CFA Enhanced and Preventative Service and Strategy Service

3.2.2 Loves Farm

Referrals to St Neots locality team from Loves Farm are all but one quarter lower per population compared to the rest of the locality. From second quarter 2013 to the third quarter 2015 on average 0.56% of Loves Farm 0-19 population were referred to the locality team compared to 0.88% of the rest of the locality

Figure 34: Referral rates to Enhance Services - Loves Farm

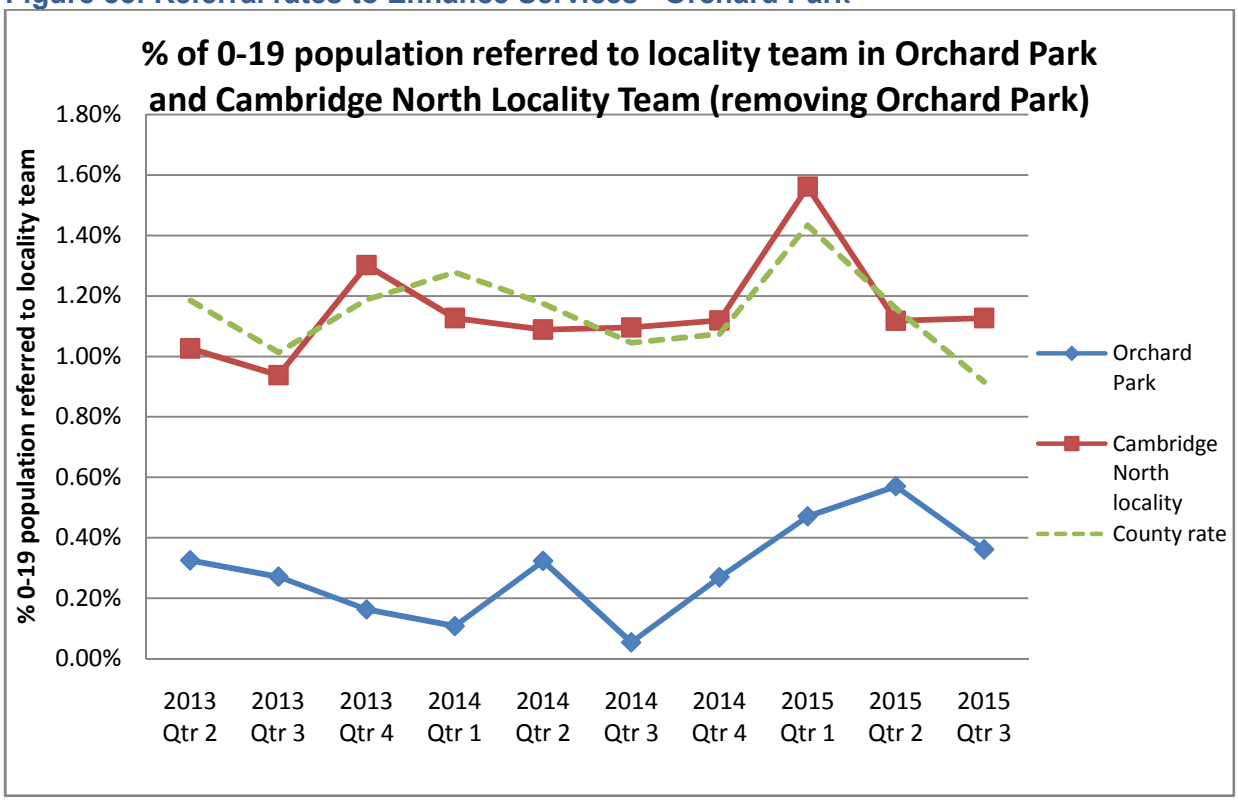


Source: One ICS, CFA Enhanced and Preventative Service and Strategy Service

3.2.3 Orchard Park

Referrals to the locality team from Orchard Park are lower than the rest of the locality. In contrast to Loves Farm and Southern Fringe, Orchard Park is consistently lower than the rest of the Cambridge north locality. On average, from the second quarter of 2013 to the third quarter of 2015 0.29% of Orchard Park 0-19 population were referred to the Cambridge North locality team compared to 1.15% of the rest of the locality.

Figure 35: Referral rates to Enhance Services - Orchard Park

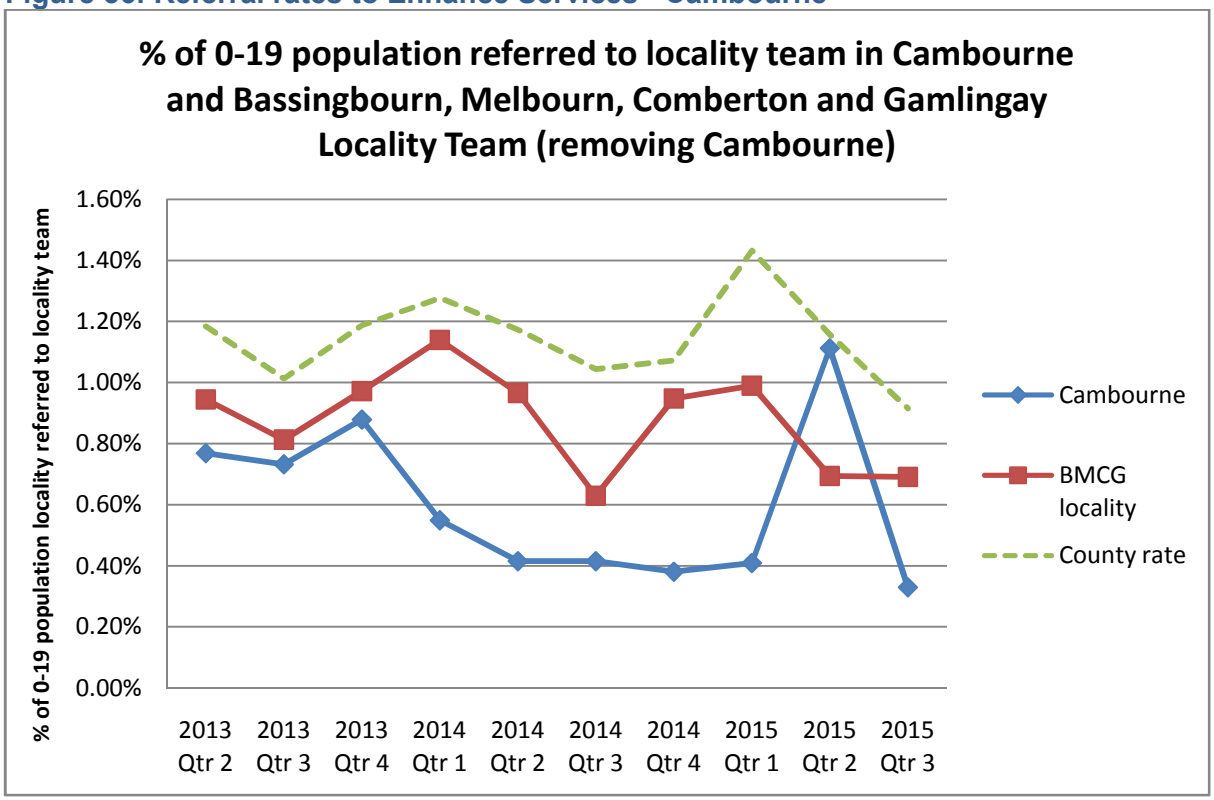


Source: One ICS, CFA Enhanced and Preventative Service and Strategy Service

3.2.4 Cambourne

Other than one quarter, the percentage of the 0-19 population in Cambourne referred to the locality team is also consistently lower than the rest of the locality. From second quarter of 2013 until the third quarter of 2015 on average, 0.6% of the Cambourne 0-19 population was referred to Bassingbourn, Melbourn, Comberton and Gamlingay Locality Team (BMCG) locality team compared to an average of 0.88% for the rest of the locality.

Figure 36: Referral rates to Enhance Services - Cambourne



Source: One ICS, CFA Enhanced and Preventative Service and Strategy Service

3.2.5 Conclusion

Although social care referrals are higher in Loves Farm and Cambourne, the referrals to locality teams are lower than the rest of the locality. In Southern Fringe while prior to 2015 referrals to locality are around the same if not slightly higher than the rest of the locality they are not much higher, whereas referrals to social care are on average quite a bit higher than the rest of the locality.

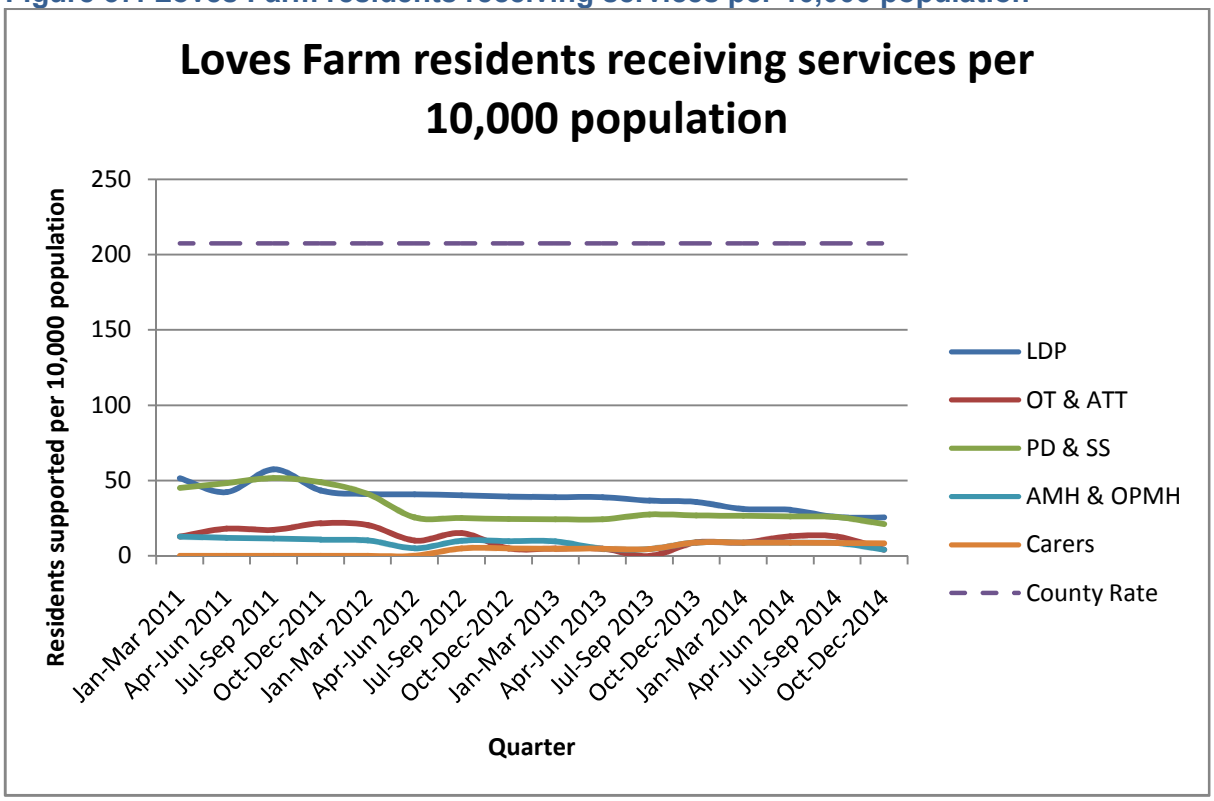
What referrals do not show is how long cases stay open or if there are any patterns for the primary reasons for referrals.

3.3 Adult Social care

Adult social care (including Older People and Mental Health (OPMH)) support adults who meet eligibility criteria set by the Care Act, due to their needs being assessed as significant and in need of specific packages of support which might take place in the home, community or in an institutional setting. This may include people who have difficulty carrying out basic personal care or domestic routines, struggle to carry out family responsibilities or are at significant risks in terms of their wellbeing. Adult social care supports these adults to maintain choice and to live healthy, socially engaged independent lives. They also offer support and advice and assessment to people who pay for their own care and their careers.

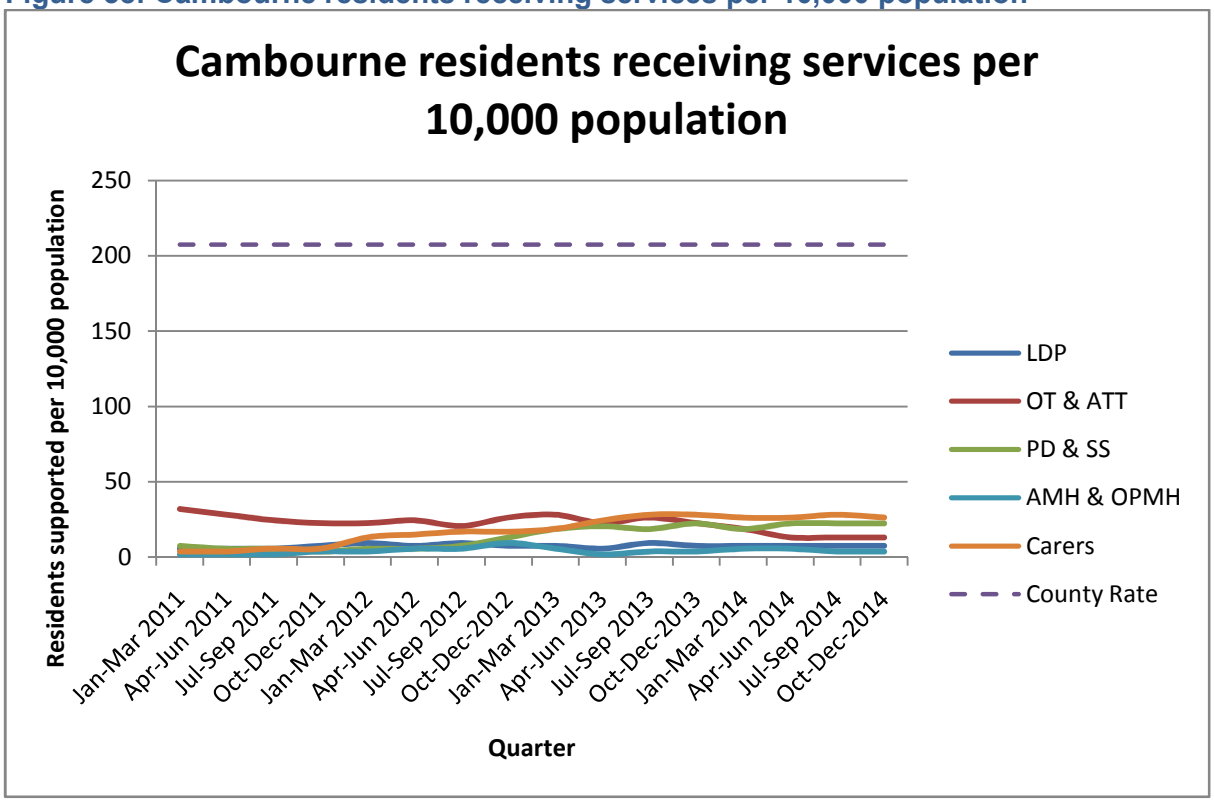
In Loves Farm and Cambourne there are significantly less people who access CCC adult social care services and older people services compared to the county average. (NB Southern Fringe was not included in the analysis because the numbers were too small). Adult social care services include: Learning Disability Partnership (LDP), Occupational Therapy and Assistive Technology and Tele-care (OT & ATT), Physical Disability and Sensory Service (PD & SS), Adult Mental Health and Older People Mental Health (AMH and OPMH), Carers and Older People Services.

Figure 37: Loves Farm residents receiving services per 10,000 population



Source: Swift. Population of Loves Farm was estimated by multiplying the number of houses by average number of adults per household in Cambourne (Cambridgeshire County Council & NHS Cambridgeshire, 2010)

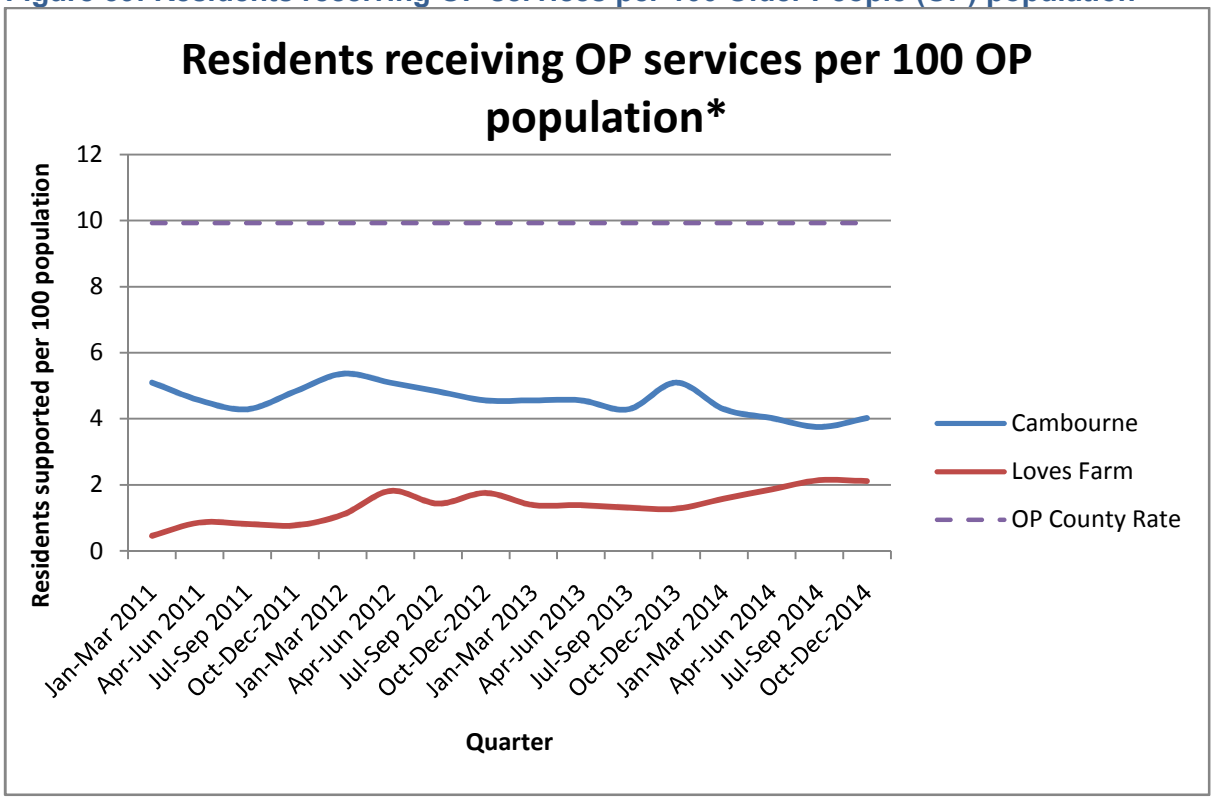
Figure 38: Cambourne residents receiving services per 10,000 population



Source: CFA Management Information, Swift. ONS mid population predictions 2013

The same conclusion for older people services:

Figure 39: Residents receiving OP services per 100 Older People (OP) population



Source: Swift. CFA Management Information Team *Cambourne population calculated using ONS Mid-year 2013 Data (Residents aged 65+). Loves Farm population calculated using increasing quarterly estimate

3.4 Schools and Early Years

While the school building is a recognised asset in new communities there are certain challenges faced by schools in new communities that are not faced by schools in more established communities. The 2010 County Council member led review noted that the sudden increase in pupil number and higher turnover of pupils, existing socio-demographics and high numbers of pupils with English as a second languages placed pressure of new community schools unlike schools within established communities.(66)

The majority of new schools opening in Cambourne, Loves Farm, Orchard Park and Southern Fringe have received good Ofsted inspection judgements, however, some of the schools have struggled in the early years.

Table 21: Ofsted findings for schools in New Developments in Cambridgeshire

School	Year Open	Ofsted inspection overall judgement
Monkfield Park Primary School, Cambourne	1999	2001 – no judgement, positive report 2006 – Good 2011 – Good 2015 – Good
The Vine Inter-Church primary school, Cambourne	2005	2007 – Satisfactory 2010 – Good 2014 – Good

Jeavons Wood Primary School, Cambourne	2009	2011 – Good 2015 - Good
Cambourne Village College (Secondary), Cambourne	2013	2015 – Outstanding
The Round House Primary School/Academy, Loves Farm	2008	2010 – Satisfactory 2013 – Requires Improvement 2015 – Good (first inspection as an academy)
Orchard Park Community Primary School, Orchard Park	2007	2009 – Good 2011 – Good
Trumpington Meadows Primary School, Southern Fringe	2012	2014 – Inadequate 2015 – Requires Improvement

Source: http://reports.ofsted.gov.uk/

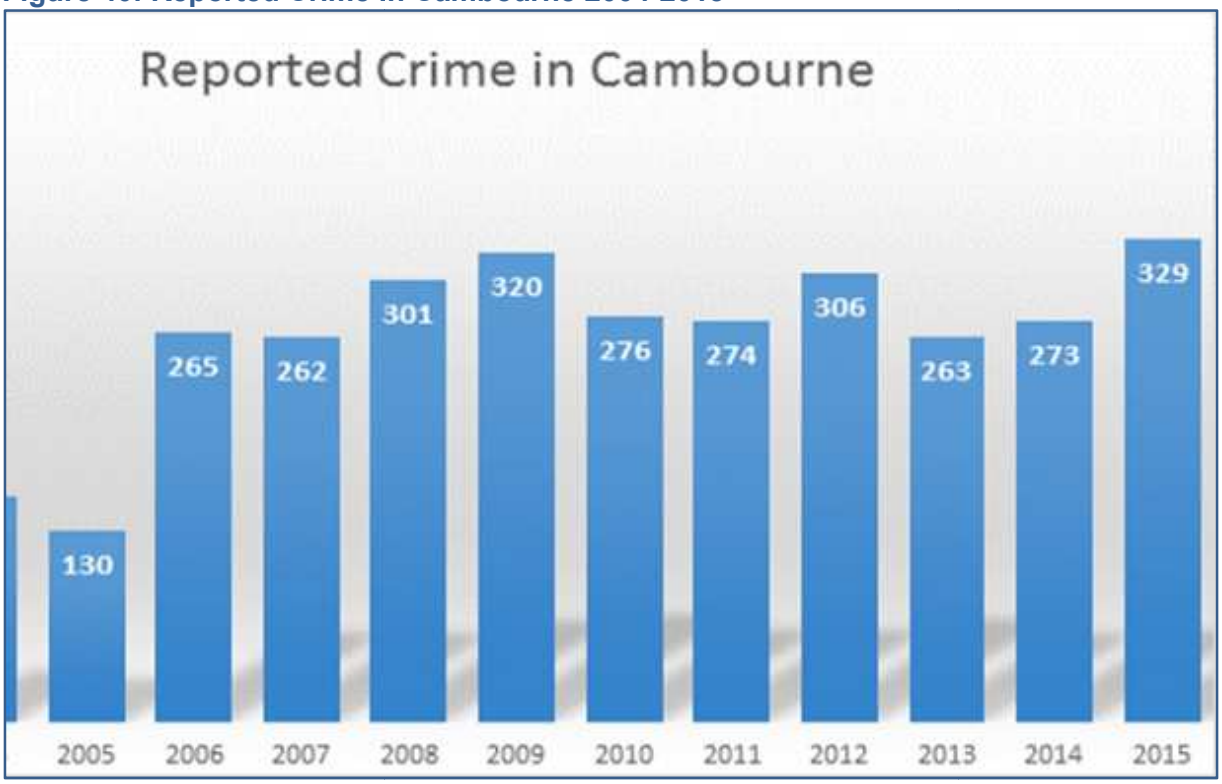
The Ofsted inspections of almost all schools listed above note that the same challenges recognised in the Member-led review are still occurring. The schools have to deal with the rapid growth due to significant increase in pupil numbers, high numbers of staff joining the school at the same time. Half of the class teachers at Vine Inter-Church School in Cambourne had joined the year of their Ofsted inspection, high staff turnover, vastly higher rates of pupil mobility (total movement in and out of school by pupils other than at the usual times of joining and leaving). The schools also tend to have above average number of students who speak a variety of languages and a number ethnic backgrounds are represented. Some of these challenges can put extreme pressure on new community schools outside the usual pressures schools face – this can make it very difficult to ensure smooth running and can lead to poorer outcomes.

In addition to schools, new communities face pressure on early years (children below five years old) care/education. New communities on the whole still face higher birth rates which has a significant impact on the need for early years provision (this include child minders, nurseries, pre-schools etc.). Although the Local Authority can ensure that space is provided for sessional provision there is often short falls in full day care on new developments. This is currently occurring in Southern Fringe, where it is proving difficult to get providers in early enough to meet the needs of the community meaning that parents are having to travel distances to ensure adequate care for their young children, if they can access it at all, this may mean that parents are not in employment when they want to be due to lack of childcare.

3.5 Crime data

Due to limitations of available data it is only possible to provide details of reported crime in Cambourne from 2004. What is interesting from the data is that that reported crime doubled in Cambourne between 2005 and 2006 and then remained constant ever since – even though almost an additional 2,000 houses have been built since 2006.

Figure 40: Reported Crime in Cambourne 2004-2015



Source: Area Commander- South Cambridgeshire

It is not clear why this doubling occurred. There were an additional 377 houses completed in financial year 2005-06, in 2005 the second primary school opened in temporary accommodation, and in 2006 the youth building was completed, the vets and dentist opened and the pub opened.

Table 22: Number of dwelling completions in Cambourne 2001-2007

Year	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
Dwellings built in year	213	337	620	151	377	267	219
Cumulative total	574	911	1531	1682	2059	2326	2545

Source: Cambridgeshire County Council, Research and Performance Team 2012

3.6 Libraries

Although there is no local data for usage in new communities a recent study into health and wellbeing benefits of library engagement found that library use is positively associated with subjective wellbeing, high life satisfaction, higher happiness and higher sense of purpose in life.(68) Libraries are a valued part of society and have a role in people's quality of life with 76% of library users in principle willing to pay an increase in council taxes to keep all services their local library offers, and 63% of non-library users would be willing to pay something. (68) These benefits can save the public purse with benefits that can reduce GP visits, social

The provision of libraries is a statutory duty of local authorities and they are one of the few universal services provided by local authorities. Libraries do not just lend books but also provide computer access, children's activities, activities for older people, act as an information hub, host and provide training courses, lectures and meeting spaces.

care usage and improve education, skills training and employment.

3.7 Are there patterns that can tell us something?

Building community resilience and developing the community is essential to the health and wellbeing of the community and to reduce progression to problems that require more intensive services. Simply making more opportunities for people to meet will not reduce this high need and pressure on services – for some people new developments are lonely and they need support to help them settle. (65) Building meeting spaces is just one of the steps involved: it is the services and support that are key to community development .

To help replicate and develop good practice some outcomes and guiding principles have been developed. These outcomes and principles have been established based on experience of new and developing communities in Cambridgeshire.

3.7.1 Outcomes

If we have been successful in supporting the development of sustainable new communities that are healthy and well, we could expect the following five outcomes to have been achieved. These cannot be the sole responsibility of one agency but will require the whole planning and delivery system to work together with the community towards an agreed vision

All people, regardless of their needs, live well independently
All residents of new communities should be resilient, able to live well and independently, especially those who may be vulnerable to social isolation, and engage with their community without the need of intervention. All barriers that could block someone's engagement in the community are removed and all members of the community should be involved as much as they choose and have control over their own lives

People are and feel safe
All residents of new communities should feel and be safe within their environment whether out in the community or at home. This will enable all residents, especially those at higher risk of harm, to have the opportunity to be positive contributors to their community and society as a whole and enjoy being engaged with all members of the community.

People lead a healthy lifestyle
All residents of new communities can pursue a healthy lifestyle, families are able to make healthy choices, be active, and free of substance misuse

Local economy prospers for all
All residents of new communities are able to achieve their learning potential, are equipped and have the opportunity to go onto further learning or work, maintain employment, and have the knowledge, skills, and confidence to make positive changes in their communities. All barriers to learning and employment are removed and communities are supported to enable them to maximise their full potential; building on the assets of the community rather than by being dictated by organisational structures and boundaries.

All people have a voice and control in decisions that affect their community
All residents are able to activity engage in decision making. There are high levels of community participation in decision making and the planning and delivery of services at local and strategic level.

3.7.2 Principles

In order to achieve the outcomes, it is crucial that activities are delivered effectively and in a co-ordinated manner to avoid duplication or gaps in provision. The outcomes define what it is we want to achieve and the guiding principles detail how we go about doing it.

Partnership working
Lessons learnt in previous new communities have shown that service and support can often appear disjointed and confusing to new residents. All services throughout the planning and delivery of new communities must work together and with the community to ensure best use of assets and to help ensure services are available when the community needs them. Co-ordinated effective partnership working will help to ensure that the community are appropriately supported early to prevent escalation and are supported back to independence. Several services providing similar activities to the same families/individuals is not only financially irresponsible but does a disservice to the family and individual.

Co-location
It is important to provide a central focal point for the community and services so that all members of the community are able to meet together and access services from within the community. Co-locating community spaces and service provision not only increases opportunities for community cohesion but is also more financially sustainable as it enables the sharing of overheads and running costs. This does not necessarily mean a large structure but rather is flexible space that provides focal point which all the community can access.

Co-locating various spaces provides the community with necessary community space and allows them to access a variety of services. Anchoring in a neutral universal service such as a library or GP surgery means that all members of the community will use the building and also provides a degree of anonymity as no one will know which services or activity you are accessing as all are based in one location. Co-location also provides greater opportunity for better integration between services which benefits the services and the community and they receive a better service.

However, there is a risk with co-location in that if they are large, with a number of public services based in them then then is much less likely to be run by the local community. It is important that the principles of co-location are not lost regardless of the size, but also essential that the needs and assets of the community are looked at when considering type and management options of a community space.

Community Resilience
As detailed in Chapter 3 – Social Cohesion, community building/resilience/development is essential in new communities. Community development uses the assets of a community to build resilience. Services have an interest in supporting community development as a resilient community with high social capital is less likely to need more intensive and invasive services. This will help maintain capacity within services so they are able to support people and enables them to have shorter intervention as a resilient community will be better placed to support the individual or family rather than continuous need of services.

Timing
All people centred services and the community need to be engaged in the planning process at the earliest stage (pre-application where possible) and kept involved through to delivery. Ensuring that all services are aware and able to engage with the planning of the new community will enable services to plan together to ensure the new community is well supported to develop into a healthy and well community, enable them to effect design of

infrastructure and ensure clear communication between all levels of services and the community.

It is also imperative that support, services and infrastructure are available at the right time for the community. Ensuring that all services and the community are engaged in the planning process will aid delivery of infrastructure, support and services when the community need it.

Case Study 7: Southern Fringe - Community Development

Case study: Southern Fringe Children, families, community development and wellbeing subgroup:

The group consists of Children's Centre and locality team, communities, arts and recreation service (City Council), local schools, local churches, residents association, housing association, representative from Haslingfield and officer from South Cambridgeshire District Council. Health are often not represented but are linked in through other partnership groups. The group meets every other month

The purpose of the group is to develop a Southern Fringe Community Development Action Plan, to plan and implement arrangements for welcoming new residents, provide information and advice to local services on occupations, create opportunities for new and existing residents to meet and develop joint community activities and services, build the knowledge, skills and confidence of residents to enable them to create and sustain community groups, social networks and representative community organisations, support community engagements and administer the Community Chest (funding for community activities).

The group is very beneficial for networking and has many successes to date including: identifying potential strains on services by sharing information regarding new occupations, target services where new hot-spots are identified, identified shared community needs and responded – such as running welcome events, event for volunteers, show-casing community projects, run targeted workshops on specific themes. In the coming year the group will be coordinating meeting for facility managers to share experience and support each other and looking at capacity and how voluntary sector may be able to take on more as Section106 funding finishes.

3.8 Barriers to services and assets being utilised

In the past there have been some barriers that have resulted in a new community being put at a disadvantage and not being delivered in the most effective way. It is hoped that the outcomes and principles detailed above can alleviate some of these barriers but this may not always be possible.

Lack of co-ordination and clear communication

Lack of communication can make it very challenging for services to adequately plan and can frustrate the local community. This can result in rumours emerging which can be hard to dispel and may be a catalyst for the community to oppose the development.

> Potential mitigation: at the pre-application stage the planning authority/developer produces a communication strategy and action plan that must be agreed by developer and statutory services prior to planning application being submitted for all sites over 100 homes.

Long planning and delivery process
The planning process and delivery of new communities can take 10-20 years to complete. Services are often working on annual plans and due to uncertainty with finances it can be difficult to contribute to planning for a community that is so far in the future. Staff turnover during this long process can also result in things becoming lost and never completed.

> Potential mitigation: Working groups formed (detailed in recommendation above) and create agreed objectives and action plan. This is monitored and amended by the group as the new community is developed.

Funding and lack of capacity
Even when services are engaged and willing they may not be able to support the development of the new community due to lack of capacity. Reducing budgets increases in population and higher needs in new communities' results in services simply not having the financial capacity to grow with the population and adequately serve the existing and new community.

> Potential mitigation: Well evidenced and co-ordinated requests for developer funding are submitted to ensure there is appropriate capacity in the early years of the new community when needs are highest. Clear communication and co-ordination enables service planning to take account of the growth sites in advance so that new communities are not discounted.

Existing community and local representatives
Although an important asset the existing community and local representatives may instead be a barrier if they do not support the new development. Although it is essential that the local community have a voice and can object to the planning application, it can result in the local community being less willing to engage. This can make it very difficult to engage the community, even parts of the population who may be supportive of the proposed development, which may mean they miss opportunities to influence the planning application or to co-produce services using existing assets.

> Potential mitigation: clear communication strategy is agreed from pre-application stage so that the community and local representatives and privy to all information and able to engage appropriately with local planning authorities and services regardless of their views towards the development.

Digital infrastructure
As technology advances many services are supporting and serving people virtually. This means that good access to the internet is required for the community to access these services (not to mention the potential the online community has for advancing community cohesion). However, some new communities are left without quality access leaving them unable to access necessary services and information. For example, it took 18 months until there was a reliable broadband connection in the Southern Fringe development.

> Potential mitigation: planning requirements necessitate that digital infrastructure is delivered at the same time as other necessary infrastructure and prior to any

NHS COMMISSIONING

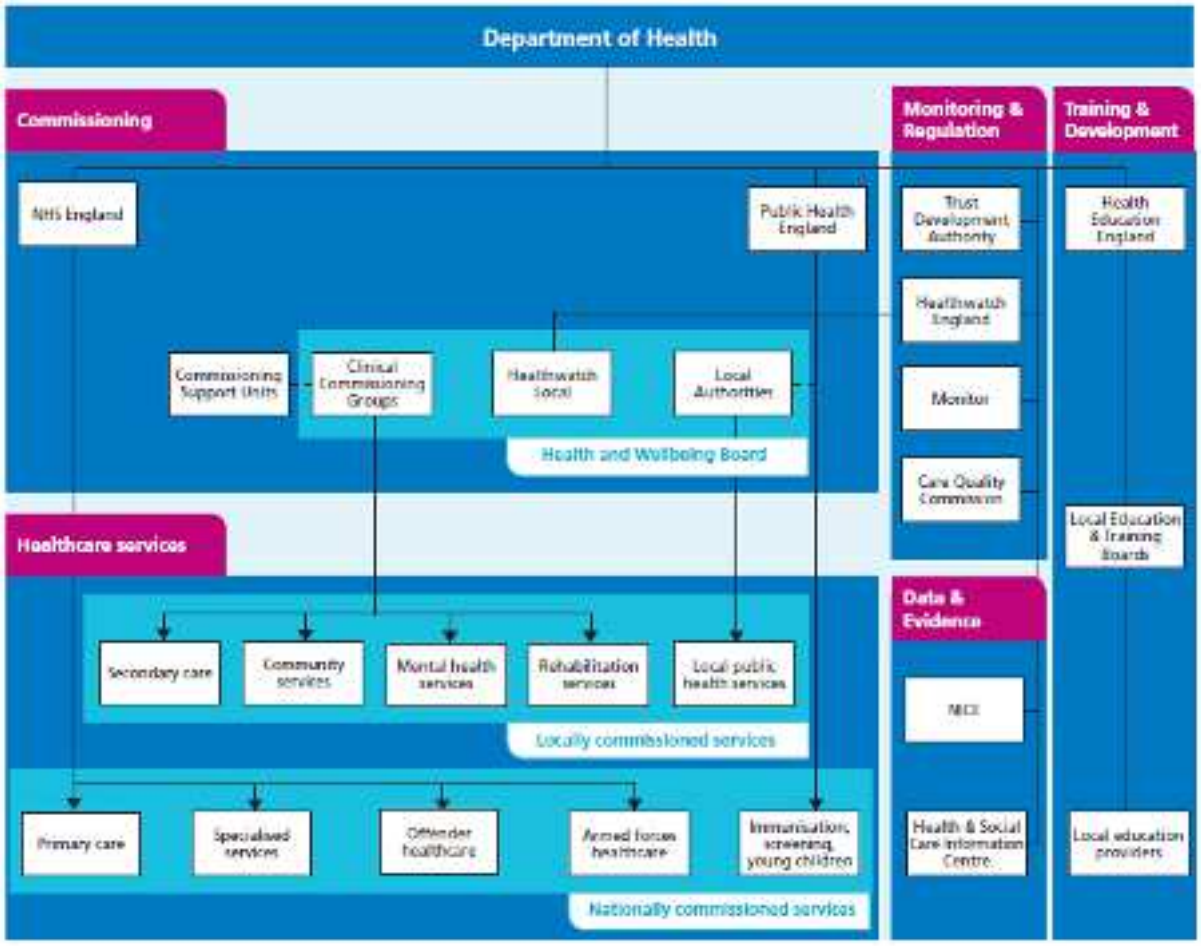
1. KEY FINDINGS

- The current engagement between Planning Authorities, CCG and NHSEngland need to be improved.
- NHSEngland/CCG need a robust case when seeking Section 106/CIL contributions with a defined need and costed solution.
- Ensure that all health partners including Primary Care Practices are consulted on planning applications. In addition, health partners should come together at the earliest opportunity to discuss needs at strategic sites.

2. INTRODUCTION – WHAT IS THE CURRENT NATIONAL NHS COMMISSIONING LANDSCAPE?

2.1 WHAT ARE THE MAIN NHS SERVICES AND WHO COMMISSIONS THEM?

Figure 41: The NHS Commissioning Landscape



Source: UNDERSTANDING THE NEW NHS – A guide for everyone working and training within the NHS, NHS England 2014

NHS services are many and varied, ranging from services delivered on a national basis to local services delivered in General Practice settings. This JSNA is primarily concerned with the local NHS services needed in new communities and how they are provided.

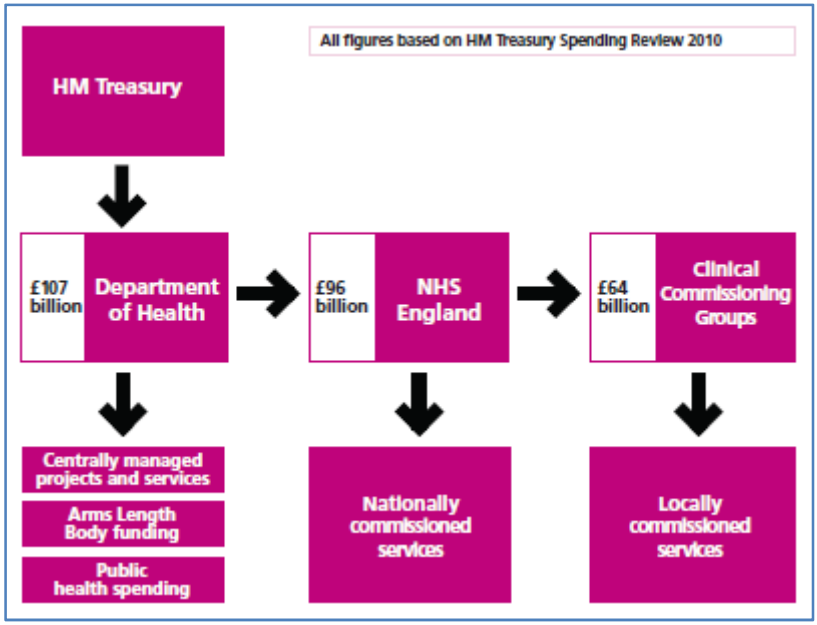
The Secretary of State for Health - *has overall responsibility for the work of the Department of Health (DH). DH provides strategic leadership for public health, the NHS and social care in England.*

Who does what? The Department of Health - *is responsible for strategic leadership and funding for both health and social care in England.*

Most services required in a new community will be delivered in a primary care facility, around 90% of patient's first point of contact with the NHS is with primary care services, and includes GP practices, dental practices, community pharmacies and optometrists.

How is the NHS Funded?

Figure 42: The NHS Funding Flows



Source: UNDERSTANDING THE NEW NHS – A guide for everyone working and training within the NHS, NHS England 2014

2.1.1 Primary Care

Within the current legal framework, NHS England is responsible for commissioning primary medical services for anyone present in England. This includes the services that NHS England commissions from GP practices under GMS, PMS or APMS contracts (which are explained further below) and the out-of-hours services that CCGs commission on NHS England's behalf. However, CCGs have a duty to support NHS England in securing continuous improvements in the quality of primary medical care[ii].

In May 2014, Simon Stevens invited CCGs to take on an increased role in the commissioning of primary care services and it is expected that many CCGs will opt to

implement joint or delegated primary care commissioning arrangements. However, should a CCG assume co-commissioning responsibilities, NHS England will retain liability for the discharge of its statutory functions in relation to primary care commissioning.

In addition, a CCG may commission services in its own right from GP practices, provided that:

- The services go beyond what a practice is required to provide under the current GMS, PMS or APMS contracts held by NHS England.
- The CCG follows an appropriate procurement route, which may (depending on the circumstances) involve undertaking a competitive procurement, establishing a framework of providers from which patients can choose, or procuring through a single tender action (for instance where there are no other capable providers).
- The CCG manages any conflicts of interest in accordance with NHS England guidance: Managing conflicts of interests: Guidance for clinical commissioning groups and code of practice: Managing conflicts of interest where GP practices are potential providers of CCG-commissioned services.

CCGs can fund GP practices to improve the quality of existing primary care services provided that:

- The improvement can be expected to improve wider outcomes for the CCG's population.
- The area team agrees it is over and above what it would expect a GP practice to provide under its existing GP contract.

For example:
Under the national childhood immunisation target payment scheme, NHS England pays GP practices for immunising children with the recommended vaccines, with rewards for 70% uptake by age two and 90% uptake by age five. If a CCG is concerned about achievement in its area (compared to other similar CCGs), it could introduce additional incentives to encourage practices to exceed these target levels of uptake.

Under statute financial and legal accountability for the improvement remains with the CCG.

A CCG may invest in developmental support for GP practices or GP premises development provided that the CCG can demonstrate that the investment is calculated to facilitate, or is conducive or incidental to the provision of primary medical care and that no other body has a statutory duty to provide that funding.

How are General Practices funded?
General Practices' receive income through a number of different funding streams for different services including essential services, additional services, the Quality and Outcomes Framework (QOF) and enhanced services. Some practices may also receive seniority factor payments and payments for dispensing services.

The General Medical Services (GMS) contract is the contract between general practices and NHS England for delivering primary care services to local communities.
The GMS contract covers:

- The global sum, which uses the Carr-Hill formula to distribute the core funding. It covers essential and some additional services. Payments are made according to the needs of a practice's patients and the cost of providing primary care services. The formula takes into account issues such as age and deprivation. The Global sum is commissioned by NHS England.

- The quality and outcomes framework (QOF), which covers the two areas of clinical and public health. (QOF is voluntary but most practices with GMS contracts, as well as many with Personal Medical Services (PMS) contracts, take part in QOF).
- Enhanced services (ES), which covers additional services that practices can choose to provide. These services can be commissioned nationally or locally to meet local healthcare needs.

Who does what?
NHS England *- is an independent body, at arm's length to the government. Its main role is to improve health outcomes for people in England. It also commissions primary care and specialist services*

The Personal Medical Services (PMS) contract is similar to the GMS contract but allows flexibility to pay additional monies above the GMS contract level to GP Practices, eg for additional costsassociated with a new GP practice in a growth area. Both the GMS and PMS contracts are reviewed quarterly.

What is a federated model of GP Provision?
A Federation is a group of practices and primary care teams working together, sharing responsibility for developing and delivering high quality, patient focussed services for their local communities.

Who does what?
Clinical commissioning groups (CCGs) *are responsible for the planning and commissioning of healthcare services for their local area. They commission most secondary care services.*

The concept of a primary care Federation was first set by the Royal College of General Practitioners in September 2007. Its publication, *The RCGP Roadmap*, focused on a model where practices would work together more closely to share resources, expertise and services. A Federation, whilst not typically part of the day-to-day language of NHS general practice and primary care, has however gradually come further to the fore, usually in relation to practices grouping together for either commissioning or service provision activity.

2.1.2 Dentistry

NHS England commissions all dental services, which includes primary, community and hospital services and urgent and emergency dental care. NHS England commissioners each have Local Professional Networks (LPNs) for dentistry. The LPN Chairs together with Public Health England (PHE) Consultants in Dental Public Health (CsDePH) are the clinical voices to dental commissioners. Public Health departments within the Local Authority commission dental screening and oral health improvement.

Dental practices usually accept NHS patients and private patients. The amount of NHS dentistry a practice can carry out is agreed annually with NHS England. Once a dental practice has reached its annual limit it can then only offer dentistry on a private basis.

There are currently two types of contract for NHS dentists: the General Dental Services (GDS) contract and the Personal Dental Services (PDS) agreement.

A GDS contract gives dentists the flexibility of taking on a partner but sometimes have lower Units of Dental Activity (UDA) values.

Since April 2006, UK NHS dentists have been paid according to how many "Units of Dental Activity" (UDA) they do in a year. One UDA is worth between £15 and £25 - it varies around the country. A UDA depends on the type of work undertaken. A dentist is contracted by NHS England to do a set number of UDAs and dentists have to be within 4% of their targets.

2.1.3 Pharmacy

Any organisation can commission services from community pharmacies. Those most likely to do so are the CCG and local authorities. However, they can only commission services that are not NHS Pharmaceutical Services as defined by the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 and the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013 and therefore cannot be described as enhanced services.

NHS England is the only organisation that can commission NHS Pharmaceutical Services. They are therefore responsible for managing and performance monitoring the Community Pharmacy Contractual Framework.

Where there is evidence of a change in needs for pharmaceutical services then the Health and Wellbeing Board (HWB) is required to decide whether it needs to produce a new Pharmaceutical Needs Assessment (PNA). If as a result a new service is needed, Commissioners are required to consider the new NHS (Procurement, Patient Choice & Competition) Regulations 2013 when commissioning the required service.

What is a Pharmaceutical Needs Assessment (PNA)? *The statutory responsibility for producing the PNA rests with the Health and Wellbeing Boards. NHS England's decision can be appealed and challenged via the courts, it is therefore important that PNAs are kept up-to-date.*

Decisions on whether to open new pharmacies are made by NHS England.Pharmacies must submit a formal application to NHS England for approval. The relevant NHS England Area Team reviews the application and decides if there is a need for a new pharmacy in the proposed location. NHS England is required to refer to the local Pharmaceutical Needs Assessment (PNA) as part of its decision making process.

2.1.4 Optometry

NHS England is responsible for the commissioning and administration of NHS General Ophthalmic Services (GOS) which include NHS sight tests and vouchers for spectacles for eligible individuals, including children. Optical contractors are commissioned to carry out a sight test for a fee.

CCGs commission services from community optometrists for the provision of community ophthalmic services. These arrangements are outside the GOS contract and the service specifications and remuneration would need are negotiated by the commissioner and provider.

Unlike GPs and dentists, optical contractors are not normally responsible for screening orrefining their own referrals under the GOS. They are neither paid nor allowed to managepatients in their own practices within the limits of their clinical competency. Instead they mustrefer all patients who show signs of injury, disease or abnormality in the eye, or elsewhere,and require medical treatment or are unlikely to see satisfactorily with corrective lenses. Thisis required by their GOS contract

Normally, optometrist referrals would go straight to ophthalmology outpatient departmentsbut unrefined referrals can clutter these clinics unnecessarily. Referral refinement servicesand other locally commissioned or enhanced services provided in high street optometristpractices can prevent or greatly reduce this.

These type ofservices include:

- Referral refinement and/or assessment especially to eliminate false positive glaucoma suspects.
- Cataract monitoring – pre and post extraction.
- Low vision services including low vision aids.
- Stable glaucoma monitoring.
- Red eye/acute anterior segment.

Children's vision screening services, eg screening at school entry are the responsibility of Local Authority Public Health Departments.

2.1.5 Secondary Care

Clinical commissioning groups commission secondary care, which includes:

- planned hospital care (Electives)
- rehabilitative care
- urgent and emergency care (including out-of-hours)
- most community health services
- mental health and learning disability services

Who does what?
Acute Trusts *- Hospitals in England are managed by acute trusts – some of which already have gained foundation trust status. Acute trusts ensure hospitals provide high-quality healthcare and check that they spend their money efficiently. They also decide how a hospital will develop, so that services improve.*
Acute trusts employ a large part of the NHS workforce, including nurses, doctors, pharmacists, midwives and health visitors. They also employ people doing jobs related to medicine, such as physiotherapists, radiographers, podiatrists, speech and language therapists, counsellors, occupational therapists, psychologists and healthcare scientists.

There are many other non-medical staff employed by acute trusts, including receptionists, porters, cleaners, specialists in information technology, managers, engineers, caterers, and domestic and security staff.
Some acute trusts are regional or national centres for more specialised care, while others are attached to universities and help to train health professionals.

Acute trusts can also provide services in the community – for example, through health centres, clinics or in people's homes.

Who does what?
NHS foundation trusts*, first introduced in April 2004, differ from other existing NHS trusts. They are independent legal entities and have unique governance arrangements. They are accountable to local people, who can become members and governors. Each NHS foundation trust has a duty to consult and involve a board of governors (including patients, staff, members of the public and partner organisations) in the strategic planning of the organisation.*

They are set free from central government control and are no longer performance managed by health authorities. As self-standing, self-governing organisations, NHS foundation trusts are free to determine their own future.

They have financial freedoms and can raise capital from both the public and private sectors within borrowing limits determined by projected cash flows, and are therefore based on affordability. They can retain financial surpluses to invest in the delivery of new NHS services.
Foundation trusts are overseen by Monitor.

Table 23: Differences between Trusts

Differences between NHS foundation and NHS trusts		
	NHS foundation trust	NHS trust
Government involvement	Not directed by government, therefore more freedom to make strategic decisions	Directed by government
Regulation: Financial Quality	Monitor CQC	Trust Development Authority CQC
Finance	Free to make their own financial decisions according to an agreed framework set out in law and by regulators. Can retain and reinvest surpluses	Financially accountable to government

Who does what?
Mental health trusts *provide health and social care services for people with mental health problems.*

Mental health services can be provided through GPs, other primary care services, or through more specialist care. This might include counselling and other psychological therapies, community and family support, or general health screening. For example, people experiencing bereavement, depression, stress or anxiety can get help from primary care or informal community support. If they need more involved support, they can be referred for specialist care.

More specialist care is normally provided by mental health trusts or local council social services departments. Services range from psychological therapy to very specialist medical and training services for people with severe mental health problems. At least one in four people experiences a diagnosable mental health problem in any one year, and one in six experiences this at any one time.

Who does what?
Public Health England (PHE) – *is an operationally autonomous executive agency of the Department of Health and was established in April 2013 in place of the Health Protection Agency.*

The main functions of PHE are:			
Health protection	Health improvement	Knowledge and information	Operations
For example, notifiable disease outbreak prevention, recording and management and major incident response	Responsible for developing a 21st century health and wellbeing service addressing health inequalities – for example, health promotion and screening services	For example, disease registration, research and development	Ensuring delivery of consistently high-quality services – for example, the national microbiology unit

Section 106 Planning Contributions for Health Facilities

Developers applying for planning permission can be asked to contribute financially and in other ways to the infrastructure needed to support the new development, including health infrastructure. See Chapter 2 on the Built Environment for an outline of the Planning System.

Section 106 of The Town and Country Planning Act 1990 allows local authorities to enter into a legal agreement with a developer to ensure the appropriate infrastructure and/or financial contribution is provided. Section106 is therefore one way of funding new healthcare facilities and services to cope with the changing population.

The Healthy Urban Design Unit (HUDU) has developed a model to calculate indicative health contributions arising from development proposals which is in widespread use across London (and by some NHS organisations outside London).

HUDU Model

The HUDU Planning Contributions Model is a comprehensive tool to assess the health service requirements and cost impacts of new residential developments. The model is licensed by HUDU for use within the NHS.

The model uses a range of assumptions based on the most up to date information available. However, users can also manually adjust or input new assumptions – for example, where an area may have carried out a recent survey of the population characteristics of new residential developments occurring in an area.

The model calculates:

- The net increase in population resulting from new development.
- Health activity levels.
- Primary healthcare needs (GPs and community health facilities).
- Hospital beds and floor space requirements.
- Other healthcare floorspace.
- Capital and revenue cost impacts.

This information can then be used to influence the planning process via Section 106 planning negotiations or CIL and to gain necessary resources for health improvements or expansion.

Current land values when negotiating Section 106 developer contributions are approximately: £10k per acre agriculture, £150k per acre Greenfield (with planning permission) £500k per acre Brownfield. Comparing it to other infrastructure costs, it costs £150k for 100m single estate road, and for dual carriageways the costs are greater with costs of £10m per mile-Complete, £1200 per linear mile tarmac (no junction), and £5m per junction.

Recent case law has confirmed that Section 106 requirements for healthcare facilities need to be precise, and related to the specific development in question, as the case study below shows.

Case Study – Section 106 and Health Care Facilities
Appeal Decisions
Decision date: 29 July 2015
Appeal A: APP/X1545/A/14/2224678
Land south of New Moor Farm and east of North End, Southminster

The appellant company has also been working to address a number of mattersrelating to the securing of the provision of infrastructure related to thedevelopment. Two signed and completed unilateral planning obligations undersection 106 of the Town and Country Planning Act (UUs) were submitted atthe Inquiry dealing with the following matters;

- commuted healthcare contribution (both appeals), including provision of landfor a medical facility (Appeal B only);

Health provision

The appeal proposals would generate additional residents who, quitereasonably, could expect to access local health provision. The problem, aseloquently put by Ms Morley, Practice Manager for the William Fisher MedicalCentre, is that the existing practice, whilst still accepting new residents, isworking at capacity. With new housing developments in Southminstercurrently under construction, the residents of which the Practice has agreed totake on, extreme pressure on the working of the Practice and the ability forresidents to access health services will ensue. The responsible body in respectof health provision in Southminster is NHS England. Ms Morley was unaware ofany forward planning or strategy in place for the development of healthcareservices in this area by NHS England or the Council.

The evidence of Mr Addae-Bosompra, on behalf of the Council, was that with nohealth facility in place to ensure access to health provision for the futureresidents of the development, permission should be withheld until such time asan appropriate medical facility was provided, ideally before the new houseswere occupied. He suggested an embargo on further development in thevillage until such time as this deficiency had been addressed. He alsosuggested, as a solution, the imposition of a planning condition that workwould not commence until such time as a medical centre had been built.

However, the provision of a new medical centre to serve not only the futureresidents of the proposed developments but also the rest of the village, wouldbe a disproportionate and unjustified response, out of scale and kind to thedevelopment proposed, which would place an onerous burden on the appellantcompany. Moreover, a Council imposed embargo on development wouldfrustrate development and would not further Government aims to boost thesupply of housing.

The responsibility for health provision lies with NHS England. The appellant company agreed to a health care contribution as promoted by NHS England paid through the termsof the UUs. However, the calculation of thiscontribution was not adequately explained. In addition, no evidence wassubmitted by NHS England that further provision was required over and above the contributions secured. No evidence was provided either, of a specified project or area of service improvement which has been identified which could beconsidered to be directly related to the development, other than a general capacity issue.

The respective sums would not be sufficient to build a new medical centre, and there was no suggestion that there were pooled contributions available from other new developments in Southminster to either contribute to a new medical centre, or that there was a strategy in place either with NHS England or the Council or in partnership to address this situation.

From the evidence I heard, it seems to me that the proposed development would generate a need for additional local health services. However, whilst I heard anecdotally that existing facilities were stretched and would continue to be so possibly to a point of closing the practice to new patients, the response of the responsible body was that an appropriate financial contribution would mitigate the effect of the appeal proposals on health care services (although as set out above, it was not clear how). The appellant company has responded to the request for such a requirement. Also, in response to the concern of the Council, land has been reserved for a medical facility within Appeal B51. I heard from Ms Morley that the William Fisher Medical Centre has no money to build a new centre even if the land were a gift. NHS England favours schemes involving the rental of premises rather than new build, although there is some money available for capital projects, but this is administered by NHS England on a priority basis. There was no evidence that NHS England would support or fund a new medical centre in Southminster.

In closing the Council highlighted that in their view no solution to this problem had been identified and that this was not an acceptable state of affairs. I agree. The stifling of development due to a perceived capacity issue would stifle the provision of much needed housing, including affordable housing in the District. However, the appellant company has complied with the request from NHS England to provide a healthcare contribution and that is all that has been asked of them by the relevant provider of that service. Whilst I acknowledge the concerns of the practitioners at the William Fisher Medical Centre and others, the weight of evidence is that NHS England is content that such a contribution would address the impact of the development appropriately. On this basis it is only for me to consider whether the extent of that contribution is justified or not.

Paragraph 204 of the Framework sets out that planning obligations should only be sought where they are necessary to make the development acceptable in planning terms; directly related to the development; and fairly and reasonably related in scale and kind to the development. This is in accordance with Regulation 122 of the Community Infrastructure Levy (CIL) Regulations.

Taking into account the lack of direction/details from NHS England in respect of the development of health provision in Southminster and the immediate locality, I heard nothing that gave me confidence that the contribution requested was likely to be spent in accordance with the relevant tests. For this reason, I do not consider it reasonable to take this aspect of the UUs into account. The lack of a NHS plan where the available funding would beappropriately targeted is a serious flaw which undermines any justification forthe contribution. Further, without an official explanation for and commitmentto build a new health centre in Southminster, the requirement for land for suchprovision would be a benevolent offer on behalf of the appellant company, butnot justified on the evidence before me.

3. LOCAL DATA

3.1 LOCAL NHS PRESSURES

Some Primary Care practices in or near the major growth sites are struggling to cope with the current and forecasted demand for services, this is not helped by a national shortage of GPs.

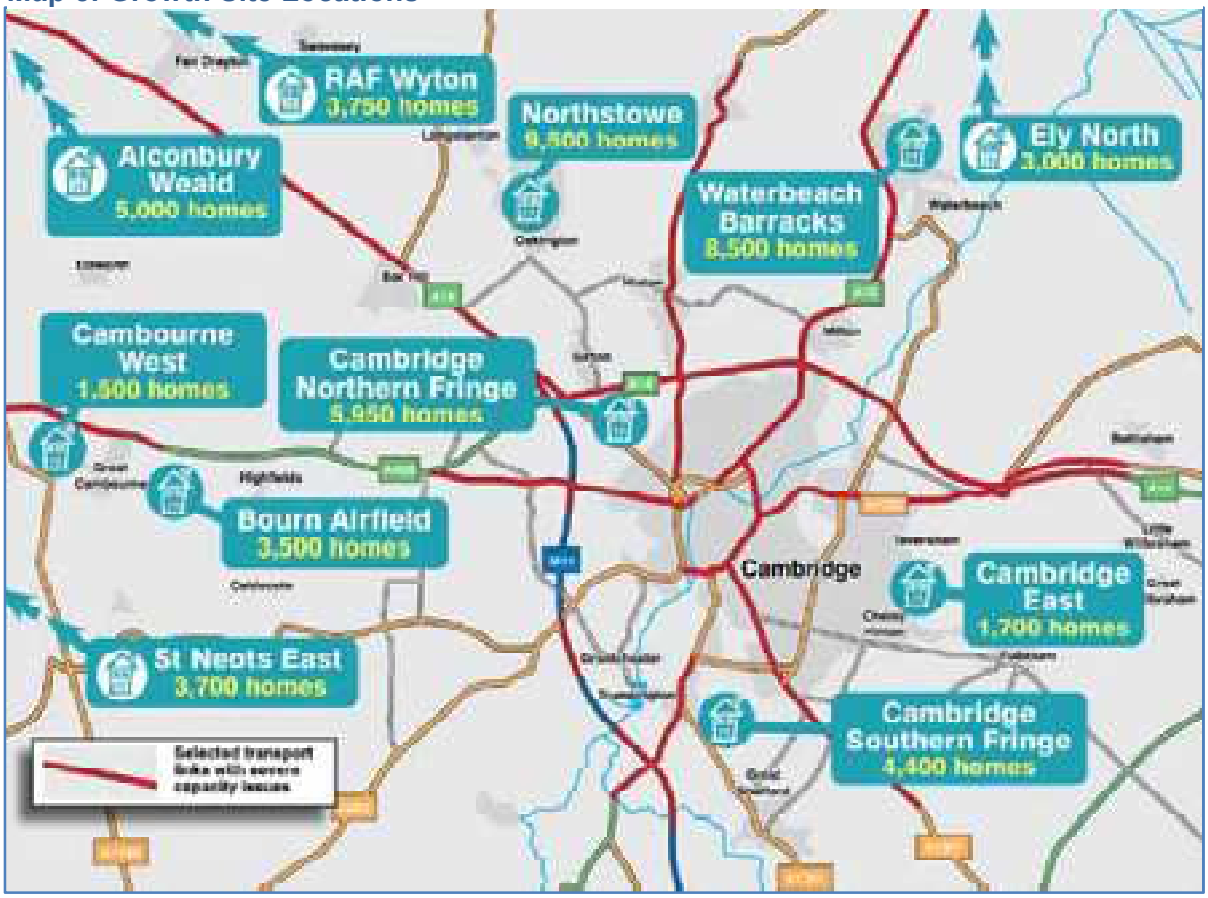
Property portfolio overview

There are 212 NHS related properties across Cambridgeshire and Peterborough, comprising of 184 clinical sites, 21 hospital buildings, six office administration. There is a mixture of tenure of properties, some a freehold, some leased, some owned by NHS Property Services.

Who does what?
NHS Property Services *is a limited company owned by the Department of Health in the United Kingdom that took over the ownership of around 3,600 National Health Service facilities in April 2013.*

GP Capacity by practice in the growth sites

Map 5: Growth Site Locations



Map of GP Catchment Areas

Awaiting data from CCG/NHSE to overlay the GP catchment areas and capacity pressure with the map of the growth sites.

Primary Care Transformation Fund

The Primary Care Transformation (formerly Infrastructure) Fund is a multi-year £1billion investment programme to help general practice make improvements, including in premises and technology. It is part of the additional NHS funding, announced by the Government in December 2014, to enable the direction of travel set out in the NHS Five Year Forward View.

Delegated commissioning

Cambridgeshire and Peterborough are seeking to take on delegated commissioning responsibilities for primary medical services from NHS England from 1 April 2016.

The scope of the delegated responsibility for the CCG can be quantified as follows:

- 106 primary medical services contracts **(c.£84.6m)**
  - GMS, PMS (£73.7m)
  - APMS incl. pipeline of re-commissioning (£4.7m)
  - Portfolio of enhanced services (DES, LES) (£6.2m)
- Quality and Outcomes Framework (QOF) **(c.£10.1m)**
- Premises reimbursements **(c.£13.2m)**
- Other primary care contracts **(c.£10m)**
- In addition to CCG commissioned services **(c.£9.3m excl. OOH and 111)**
- **Total c.£127m**

Local Authority Infrastructure Development Strategies.

Each District has produced an infrastructure delivery strategy/plan which identifies the capital requirements to deliver infrastructure across the county.Health requirements have been captured in these plans and can be seen in Appendix 1.

Mismatch between LA Planning system (sec 106) and primary care commissioning system

There is a mismatch between the system required by the “NHS” for GP practices to submit business cases for funding and the Local Authority Planning system. These systems need to align to make the best use of funding sources.

CASE STUDIES

Case Study 9: Orchard Park

Case Study - Orchard Park
Following a Member's suggestion at Council in June 2014 Scrutiny & Overview Committee agreed on 3 July 2014 to set up a Working Group to review the lessons learned from Orchard Park. It was agreed that the group's remit would be to look at how the recommendations made in 2008 by the Scrutiny and Overview Committee regarding Orchard Park [then called Arbury Park] had been implemented, if they had been applied to subsequent developments and what the effects of them had been. The initial timescale for this work was estimated to be 12 months. However, in the light of the NJDCC being required to consider in July the application for Phase 2 of that development, the interim recommendations of the Working Group were considered to provide useful information to support its deliberations and were presented to them for that purpose.

Interim recommendations were presented to the Scrutiny and Overview Committee on 30 April 2015 and endorsed by Cabinet on 9 July 2015. The interim recommendations were also presented to the NJDCC for consideration and were endorsed prior to its deliberations on 29 July 2015:

Recommendation 1 – The decision to require a road adoption strategy for Northstoweshould be replicated on all future developments.

Recommendation 2 – The good practice of school provision concurrent with first occupations should be continued.

Recommendation 3 – More consideration should be given to a greater variety of opportunities for social interaction for early occupants of new developments.

Recommendation 4 – South Cambridgeshire District Council should adopt the charging strategy used by Cambridge City Council in connection with pre-application advice.

Recommendation 5 – Consideration should be given to further work being carried out on 'New Town Blues' and the referral rates to social services and their impacts on costs for councils and other public services.

Recommendation 6 – Funding should be secured for training and/or technical support to be provided for parish councils affected by strategic development applications. There should be greater flexibility in the use of funds allocated.

Orchard Park cont

The following additional recommendations have been agreed by the Working Group:
Recommendation 7 – Further clarification should be sought from the County Council on their guidance to developers regarding materials so that conflict at the point of road adoption is avoided.

There is still some evidence of contrary views on the use of new technologies/materials at different stages in the process, notably at pre-application and adoption stages. Delays in road adoption are cited by residents as a significant cause for concern. This recommendation seeks to resolve one of the issues that may cause those delays.

Recommendation 8 – Despite individual phases having their own design code, consideration needs to be given to including a review mechanism so that lessons can be incorporated as required particularly in developments with long build out rates.

This recommendation has been made in view of evidence gathered that some flexibility is required to allow for advances in design etc over long build out periods.

Recommendation 9 – Consideration be given to strengthening the formal monitoring process and increasing the proportion of developments scoring highly in connection with 'Building for Life'.
'Building for Life' allows a real measure of the quality of life that residents can expect. Its value should be emphasized through this recommendation.

Recommendation 10 – Care should be taken to ensure community development work continues to focus on building resilient empowered communities rather than dependent communities. This should be done together with other key agencies.
To achieve the best outcomes it is now acknowledged that responsibility lies with all stakeholders and that all statutory agencies can benefit from active participation in building resilient empowered communities.

Recommendation 11 – Appropriate noise readings should be considered on any future development where a noise barrier is proposed and where there are residential developments on both sides.
The original recommendation reflected apparently unique circumstances to date. It is considered, however, that this recommendation is a necessary precaution against similar circumstances arising in the future.

Recommendation 12 – Consideration should be given to providing advice/guidance to clerks of parishes affected by large scale developments and clerks should be included as officers in officer working groups.
This recommendation seeks to learn from the very good practice at Cambourne where an experienced clerk has been included in officer working groups. This has allowed the benefit of local knowledge as well as increasing community engagement.

Recommendation 13 – The Council should develop some local principles for carrying out Community Governance Reviews, making it clear how and when a review will be considered in major growth areas.
Experience has shown that there is a fine balance to be struck in the timing of carrying out a Community Governance Review. This recommendation seeks to endorse work that is being undertaken to establish good practice.

Recommendation 14a – Replicate on other developments the good practice at Northstowe where close communication between the site manager and local residents has been established to address local concerns effectively and promptly.
Recommendation 14b: A communications protocol should be established at the start of each development to be used by the local authorities, master developers, house builders etc.
The value of communication can never be overstated and efforts for continuous improvement should be pursued.

Recommendation 15 – Permissions and S106 Agreements should always recognise the possibility that a master developer may not remain on site for the complete duration of the build out.
It is acknowledged that with the increasing size of developments coming forward and the consequent long build out it may not be reasonable to expect that the master developer will be there for the whole period. This recommendation seeks to ensure that precautions are taken against this eventuality and avoid unnecessary complications that may result.

Recommendation 16 – Master developers should be asked to consider facilitating with parcel developers a central information point.
Previous experience at Cambourne, which was developed by a consortium of developers, showed the value of a central information point. Where a consortium is not in place there may not be spontaneous motivation to provide this resource.

Recommendation 17 – Ensure that all health partners are consulted on planning applications and take on board the findings of the New Communities Joint Strategic Needs Assessment which will outline a mechanism for health partners to come together. In addition, health partners should come together at the earliest opportunity to discuss needs at strategic sites.
This links to recommendation 10 and supports achievement of the same beneficial outcomes.

Recommendation 18 – That both these recommendations and those from 2007 apply not just to strategic sites, but as appropriate to all majors.
This review process has been acknowledged by stakeholders to have been beneficial to efforts for continuous improvement and it has been suggested that for consistency the recommendations should apply more widely.

Recommendation 19 – That this exercise is repeated at appropriate intervals. This might be in conjunction with the drafting of a new local plan.
As with recommendation 18, stakeholders have identified the benefits of carrying out a review and have suggested it should be repeated at appropriate intervals. It has been suggested that the appropriate time might be to coincide with the drafting of a new local plan in order that any recommendations can be appropriately reflected in policy.

Recommendation 20 – Developers should be encouraged to commence engagement with parish councils at pre-application stage.
The original task and finish group was convened to carry out work when something has already been identified as having gone wrong. This recommendation reflects a desire to be proactive and avoid as much as possible, any recurrence of such a need.

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APPENDIX 1 – INFRASTRUCTURE DELIVERY PLANS

To follow as a Technical Appendix.

[i] For more information on the different level of needs please see the Model of Staged Intervention framework available at: http://www.cambridgeshire.gov.uk/info/20076/children_and_families_practitioners_and_providers_information/298/children_and_families_procedures_and_resources/6

[ii] Section 14S of the NHS Act 2006, as amended by the Health and Social Care Act (2012)

HEALTH AND WELLBEING BOARD FORWARD AGENDA PLAN

MEETING DATE	ITEM	REPORT AUTHOR	TO DEMOCRATIC SERVICES R YULE BY
21 April 2016	***Additional reserve date – no theme***		
			Thursday 7 April 2016
	Membership of the Cambridgeshire Health and Wellbeing Board	Dr Liz Robin / Adrian Lyne	
	Better Care Fund Update [standing item]	Adrian Loades / Andy Vowles/ Geoff Hinkins	
26 May 2016	***Priority 6 - Work together effectively: first meeting of municipal year***		
	Election of Vice-Chairman/woman	Oral	**Thursday 12 May**
	Person's story	TBC	
	Approach to refreshing the Cambridgeshire Health and Wellbeing Strategy	Dr Liz Robin	
	Review of themed HWB meetings	Dr Liz Robin / Adrian Lyne	
	General business		
	Alcohol and Drugs JSNA report	Val Thomas	
	CCG's Choice of Local Quality Premium Indicators	Jessica Bawden	
	The Handyperson Scheme	Iain Green	
	Update on termination of Older People and Adult Community Services Contract (?)	Jess Bawden / Andy Vowles	
	Annual Public Health Report	Dr Liz Robin	
	Cambridgeshire and Peterborough Health and Care System Transformation Programme [standing item]	Andy Vowles / Dr Modha	
	Better Care Fund Update [standing item]	Adrian Loades / Andy Vowles/ Geoff Hinkins	

MEETING DATE	ITEM	REPORT AUTHOR	TO DEMOCRATIC SERVICES R YULE BY
7 July 2016			
	Person's story	TBC	**Thursday 23 June**
	JSNA on Long-Term Conditions – update on actions	Angelique Mavrodaris	
	Migrants and Refugees JSNA	Iain Green / Angelique Mavrodaris	
	Work in relation to safeguarding being undertaken with the universities	Claire Bruin	
	Update on implementation of the Community Resilience Strategy	Sarah Ferguson	
	Cambridgeshire and Peterborough Health and Care System Transformation Programme [standing item]	Andy Vowles / Dr Modha	
	Better Care Fund Update [standing item]	Adrian Loades / Andy Vowles/ Geoff Hinkins	
15 September 2016			
	Person's story	TBC	**Thursday 1 September**
	Safeguarding Adults Board (SAB) Annual Report 2015/16	Claire Bruin / Ivan Molyneux	
	Cambridgeshire Local Safeguarding Children Board (LSCB) Annual Report 2015-16	Felicity Schofield / Andy Jarvis	
	Effective safeguarding during the transition into adults services	Adrian Loades / Andy Jarvis / Ivan Molyneux	
	Cambridgeshire and Peterborough Health and Care System Transformation Programme [standing item]	Andy Vowles / Dr Modha	
	Better Care Fund Update [standing item]	Adrian Loades / Andy Vowles/ Geoff Hinkins	

MEETING DATE	ITEM	REPORT AUTHOR	TO DEMOCRATIC SERVICES R YULE BY
17 November 2016			
	Person's story	TBC	**Thursday 3 November**
	Cambridgeshire and Peterborough Health and Care System Transformation Programme [standing item]	Andy Vowles / Dr Modha	
	Better Care Fund Update [standing item]	Adrian Loades / Andy Vowles/ Geoff Hinkins	
19 January 2017			
	Person's story	TBC	**Thursday 5 January**
	Cambridgeshire and Peterborough Health and Care System Transformation Programme [standing item]	Andy Vowles / Dr Modha	
	Better Care Fund Update [standing item]	Adrian Loades / Andy Vowles/ Geoff Hinkins	
30 March 2017			
			Thursday 16 March
1 June 2017	***No theme: first meeting of municipal year***		
	Election of Vice-Chairman/woman		**Wednesday 17 May**

To be scheduled:

- Cambridgeshire Executive Partnership Board (CEPB) governance arrangements
- Actions arising from New Communities JSNA (Iain Green)

Update: RY 9 March 2016

Update on System Transformation Programme and Fit for the Future, Sustainability and Transformation Plan

To: Health and Wellbeing Board

Date: 17th March 2016

From: Jessica Bawden, Director of Corporate Affairs, Cambridgeshire and Peterborough Clinical Commissioning Group (CCG).

1.0 PURPOSE

1.1 To update the board on the progress of the System Transformation Programme and to introduce Fit for the Future, Sustainability and Transformation programme for the Cambridgeshire and Peterborough Area. Further documentation will be available on 14 March and will be circulated to the Board.

2.0 BACKGROUND

2.1 Cambridgeshire and Peterborough has been identified nationally as a 'challenged health economy'. In the local System Transformation Understanding Today, Designing Tomorrow change document, published in 2014, the health system's key challenges are identified as follows:

- The Cambridgeshire and Peterborough health system is not financially sustainable and if nothing is done, it will face a financial gap of at least £250m by 2018/19
- The population of Cambridgeshire and Peterborough is increasing and there will be a greater proportion of older people in five years' time
- Demand for health services continues to increase
- There are significant levels of deprivation and inequality that need to be addressed
- People are living longer and health outcomes are generally good but there are significant differences in people's health across the system
- The health system has multiple stakeholders.

2.2 Over the last year the System Transformation programme worked to outline the issues and develop ideas to transform healthcare across the region. This work will now be carried forward by the Sustainability and Transformation programme, overseen by the Health and Care Executive, whose membership includes the Cambridgeshire and Peterborough local authority Chief Executive, Gillian Beasley. A clear governance framework is being developed and will be available shortly.

3.0 THE NATIONAL CONTEXT.

3.1 The leading national health and care bodies in England have come together to publish 'Delivering the Forward View: NHS Shared Planning Guidance 2016/17 – 2020/21', setting out the steps to help local organisations deliver a sustainable, transformed health service and improve the quality of care, wellbeing and NHS finances.

It is published by NHS England, NHS Improvement (the new body which will bring together Monitor and the NHS Trust Development Authority), the Care Quality Commission, Public Health England, Health Education England and NICE – the bodies which developed the Five Year Forward View in October 2014.

As part of this all NHS organisations are asked to produce a local health and care system 'Sustainability and Transformation Plan', which will cover the period October 2016 to March 2021.

The Cambridgeshire and Peterborough Sustainability and Transformation Plan will incorporate the work of its Urgent and Emergency Care (UEC) Vanguard Programme.

3.2 **Vanguard:** There are currently 50 Vanguard sites across England that are part of the national New Care Models Programme. They have been chosen to lead on developing new ways of planning, delivering and paying for sustainable health and care services. The aim is to provide safer, faster and better care for patients, now and in the future.

Cambridgeshire and Peterborough UEC Vanguard Programme has received £970,000 of funding as one of eight selected 'UEC Vanguards' for the new care models programme which is playing a key part in the delivery of the Five Year Forward View – the vision for the future of the NHS. Vanguards are leading on developing new care models that will act as blueprints for the future of the health and care system in England.

4.0 FIT FOR THE FUTURE, SUSTAINABILITY AND TRANSFORMATION PROGRAMME

4.1 The Cambridgeshire and Peterborough Health System Sustainability and Transformation programme has been formed as a cross-system team to look at how the significant challenges that Cambridgeshire and Peterborough's health economy faces can be addressed.

The programme is a cross-system programme involving:

- Monitor
- NHS England
- Trust Development Authority TDA
- Cambridgeshire and Peterborough Clinical Commissioning Group
- Cambridge University Hospitals NHS Foundation Trust
- Peterborough and Stamford Hospitals NHS Foundation Trust
- Hinchingbrooke Health Care Trust
- Cambridgeshire and Peterborough NHS Foundation Trust
- Cambridgeshire Community Services NHS Trust
- Papworth Hospital NHS Foundation Trust
- Cambridgeshire County Council
- Peterborough City Council
- Healthwatch
- Voluntary organisations

4.2 **Overall programme**

The local picture

- Our health system needs to change to be Fit for the Future
- Our clinical models could be more effective
- We have a growing and ageing population
- We have financial pressures that are the imperative for change
- We want to work with local people to design a local health system that is Fit for the Future
- We need a health and care system that is financially and clinically sustainable.

The national picture

- The future shortfall in funding faced by the NHS in England is estimated to be at £30 billion by 2020/21
- NHS organisations are asked to produce a local health and care system 'Sustainability and Transformation Plan', which will cover the period October 2016 to March 2021 to provide a sustainable, transformed health service and improve the quality of care, wellbeing and NHS finances
- Transforming the health system in the best interests of patients is at the heart of the Fit for the Future NHS Sustainability & Transformation programme
- NHS England's Five Year Forward View (October 2014) recognises that the world has changed and health services needs to evolve to meet the challenges NHS health services face
- The Sustainability & Transformation programme is looking at all hospital-based, GP and community healthcare services in Cambridgeshire and Peterborough
- This is very much in line with NHS England's Five Year Forward View

4.3 **New Governance Structure – workstream programmes**

Under the new governance structure, the programme of work in 2016/17 will focus on the following, with a Clinical Advisory Group to oversee all the work of the clinically led workstreams, as detailed below:

4.3.1 **Clinical Advisory Group –Summary and scope**

- To recommend a sustainable clinical five year vision for health and care, including the transformation required to deliver it
- To recommend short term opportunities to improve the effectiveness and efficiency of care, and medium term options for service configuration (including primary, community, mental health, acute, specialised and social care delivered in Cambridgeshire and Peterborough)
- To assure clinically a) any consultations that may be undertaken b) a Cambridgeshire and Peterborough Mental Health strategy and c) a Five Year Sustainability and Transformation Plan

4.3.2 **Workstream: Proactive Care and Prevention (including LTCs, Mental Health & Primary Care at Scale) – Summary and scope**

- To develop the long-term vision for proactive community based care (including the sustainability of primary care, mental health, social care and community services) and care for people with long term conditions
- To reduce unnecessary admissions amongst patients with long term conditions and severe mental illness
- The work is taking forward the Health System Prevention Plan as discussed at both the Cambridgeshire and Peterborough Health and Wellbeing Boards

4.3.3 **Workstream: Urgent and Emergency Vanguard (UEC) Programme – summary and scope**

- To develop the long-term vision for sustainable urgent and emergency care that will reduce preventable A&E attendances and admissions by implementing physical and mental health services that implement the national urgent and emergency care vision (covering 111, ambulance, MH crisis, JET, ICTs, neighbourhood teams, acute care, supporting IT platform/ Directory of Services)
- To review options for urgent and emergency care, taking into account national standards, key clinical standards and delivery of 7 day services across all settings

4.3.4 **Workstream: Elective Care Design Programme (incl. Specialty specific sub-groups) – summary and scope**

- To develop the long-term vision for elective care (including all cancer care), with further detailed specifications on a vision for elective pathways including orthopaedics, cardiology , ENT and ophthalmology (including care models, standards and pathways)

4.3.5 **Workstream: Maternity and Neonatal Clinical Working Group – summary and scope**

- To develop the long-term vision for sustainable maternity and neonatal care, in line with the National Review's recommendations

4.3.6 **Workstream: Children and Young People Clinical Working Group – summary and scope**

- To propose a care model and service specifications for acutely unwell children and young people, children and young people with LTCs and children and young people with life limiting conditions
- To review options for paediatric and children's health services in primary, secondary and community, linking in to the joint commissioning strategy

5.0 GOVERNANCE STRUCTURE

5.1 The new governance structure for the Sustainability and Transformation programme is attached as appendix A.

5.2 Stakeholders and the wider public will also be very much involved at all stages of the work, with a series of Public Involvement Assemblies (PIAs) to be held in March, which will invite stakeholders to participate in discussions about upcoming work and share their views. They will build on the existing work of the System Transformation Programme sessions held last year, allowing residents across Cambridgeshire and Peterborough to get involved in shaping local health services.

5.3 We are currently working on a detailed Communications and Engagement plan to reinforce this work and take it forwards following the next round of PIAs.

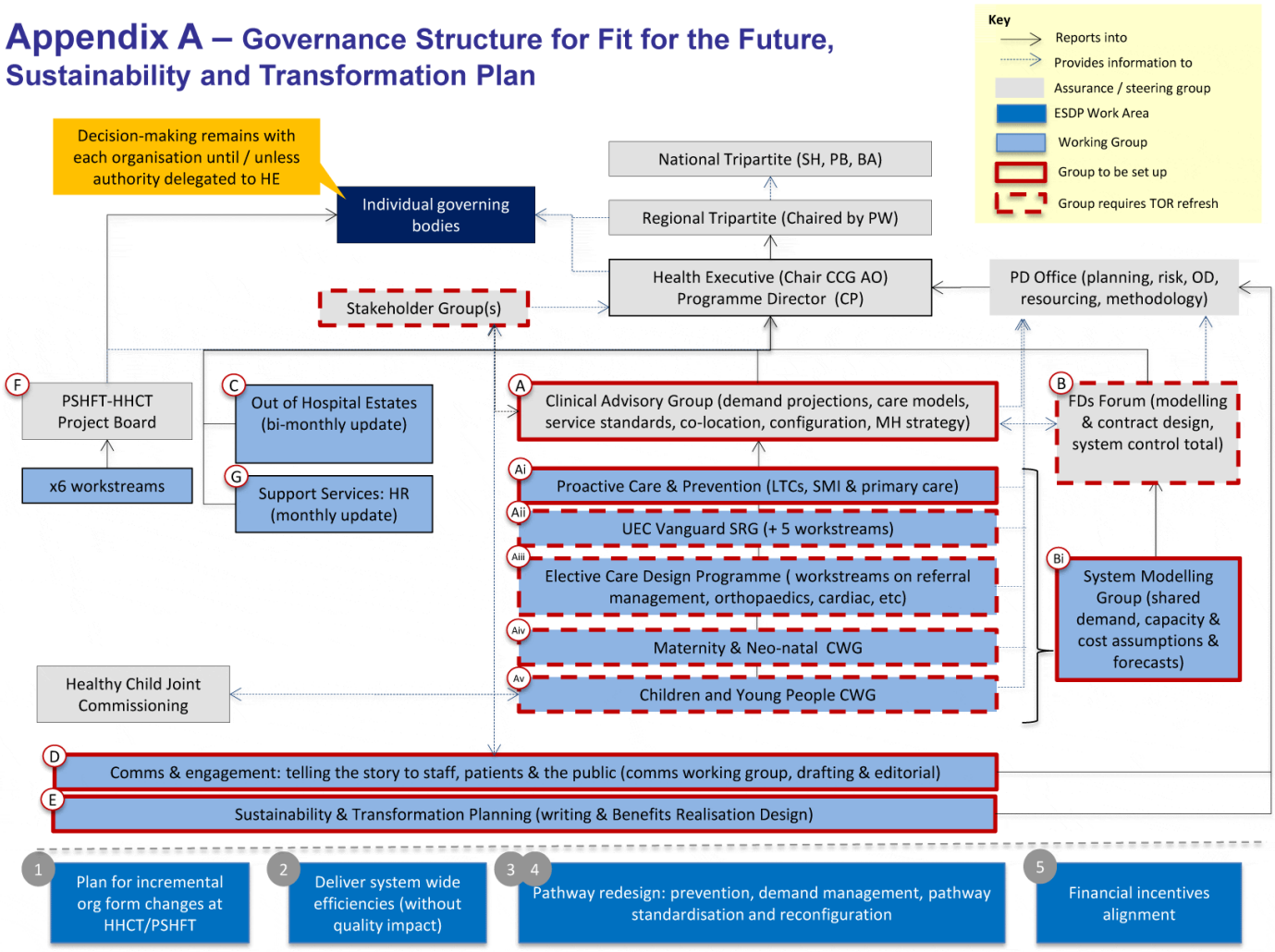
6.0 RECOMMENDATION/DECISION REQUIRED

6.1 The Board is asked to note the direction of Fit for the Future as well as the CCG's Sustainability and Transformation programme for 2016/17 and beyond.

Source Documents	Location
NHS Shared Planning Guidance 2016/17	*https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf*

Jessica Bawden, Director of Corporate Affairs
17 February 2016

APPENDIX A – STP Governance Structure



March 2016

Fit for the Future

Working together to keep people well

Evidence for change

Foreword to the people of Cambridgeshire and Peterborough

Like you, we care deeply about the quality of care delivered in Cambridgeshire & Peterborough. However, our local health and care system would benefit from transformation, like many others across England. This transformation will enable us to meet the pressures of growing demand due to population growth and ageing, to make sure we deliver consistent high quality care as accessible as possible and we make best use of the funding available to us.

To bring about this transformation, we, as leaders of the local system have established a new clinically led programme of work – which we launch today, with our *Evidence for Change*. In it you will find evidence of where local health and care services are not as good as our staff and patients tell us they should be and what could be improved.

We find this evidence makes a powerful case for transforming the health and care system to set it on a firm footing, clinically and financially, for the long term. The team of local clinicians who have assessed this evidence are now starting to develop a common vision for the future system. In the coming weeks, we will discuss the evidence with patients, staff and members of the public at events across Cambridgeshire and Peterborough to reach a shared understanding of what needs to change and gather your ideas for improvements to refine our vision.

Informed by your feedback and ideas, the clinical team will soon begin designing solutions. We will present their proposals to you in the summer, to discuss and refine together. We will then hold a formal public consultation on any proposed changes starting at the end of this year.

Many of you reading this will be aware of recent efforts to improve aspects of the local health and care system that have faltered. This programme is different:

- It focuses on the system as a whole, rather than on individual organisations or services;
- It is led by frontline clinical staff who comprise our 'Clinical Advisory Group';
- It is governed collaboratively by all system leaders;
- It has constant support from the relevant national regulatory bodies, NHS England and NHS Improvement;
- And, it involves you, the people served by the health and care system, to a much greater extent.

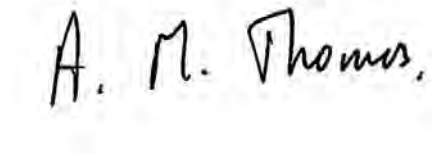
We urge you to join us in making the system serve you better. We look forward to improving it together.

Signed,

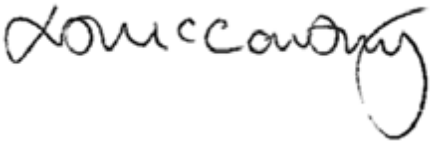
Dr Neil Modha
Accountable Officer, Cambridgeshire &
Peterborough Clinical Commissioning Group

March 2016

Dr Alexander Gimson
Chair, Clinical Advisory Group

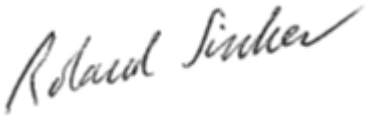


Aidan Thomas
Chief Executive, Cambridgeshire and Peterborough NHS Foundation Trust



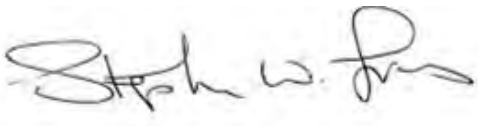
Lance McCarthy,
Chief Executive, Hinchingbrooke Health Care NHS Trust

Matthew Winn,
Chief Executive, Cambridgeshire Community Services NHS Trust



Roland Sinker,
Chief Executive, Cambridge University Hospitals NHS Foundation Trust

Stephen Bridge,
Chief Executive, Papworth Hospital NHS Foundation Trust



Stephen Graves,
Chief Executive, Peterborough and Stamford NHS Foundation Trust

Contents

1. Summary

The health and care system in Cambridgeshire and Peterborough includes well-loved NHS organisations, world class research facilities and clinical training programmes, and staff dedicated to delivering the best possible patient care. But rapidly rising demand for local health services and a large and growing financial challenge mean the system is under increasing pressure. In its current form, we aren't always able to meet the high quality standards we aspire to for everybody.

So, the partners represented in the box below have come together and established the Sustainability and Transformation Programme (*Fit for the Future*) to see how we can improve the health and care system for local people. The programme is led by a Clinical Advisory Group, made up of local clinicians and patient representatives, which reports to the governing body for this programme, the Health and Care Executive. The Health and Care Executive includes chief executive (or equivalent) representation from each of the partner organisations, together with the Chair of the Clinical Advisory Group. It is responsible for ensuring local health and care services increasingly operate as an integrated system.

Partners leading the Cambridgeshire and Peterborough Sustainability and Transformation Programme:

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

The team of local clinicians and patient representatives is reviewing how the health and care system currently meets local people's needs, and is developing a vision for the standards of care they believe we should be providing. This is based on their knowledge of best practice, the changing needs of patients in the area and our understanding of local people's preferences from feedback we've been gathering.

This document presents the evidence for changing the health system that the clinical team has uncovered so far. Its aim is to show everyone in Cambridgeshire and Peterborough where current health and care services in the area differ from our vision for the future and how they could be better.

Overall, the evidence shows we need to transform fundamentally how we deliver care if we're going to provide high quality services that are both clinically and financially sustainable. There are four main reasons:

1. Population trends are adding to demands on the health system, which is already showing signs of strain

2. The current system of care is not delivering the high quality, integrated care we aspire to, for both our patients and our staff. In particular:

    - *Health and Wellbeing* needs to be a higher priority: currently, the system spends most of its resources treating illnesses which can be prevented or whose impact can be substantially reduced with proactive management and support for self-care;
    - *Primary care services* are under pressure and a long way from being seamlessly integrated with community, hospital, social and mental health care;
    - *Patients with Mental Health and/or Long-Term Conditions* often receive fragmented, disease-specific services, not the holistic, proactive and seamless care we aspire to;
    - *Urgent and Emergency Care* is already struggling with current levels of demand, and patients are not able to go home as soon as they're ready as the extra help they need isn't available. Providing enhanced access to rapid, community-based services that can divert demand away from A&Es and help get people home quickly is essential to make these services sustainable;
    - *Maternity and Neonatal Care* is variable; some services are finding it difficult to maintain safety standards every day of the week while providing appropriate choice for mothers over where to have their baby;
    - *Children & Young People's Services* are generally good now but operating at full stretch in terms of their physical and workforce capacity. However we can improve the quality and experience of care if we provide more preventative and community-based care. We must also address urgently some key gaps in the support available for children's mental health;
    - *Elective Care* includes some high quality, responsive services, but faces significantly rising demand, which taken together with the knock-on effects of increasing demand for emergency care, means our local people are waiting longer than they should. Through the systematic adoption of good practice across the county we believe we can make better use of the resources available for elective patients;
    - *Social care services* are strongly tied to health services, as they help support patients with self-care and independent living. While there are a number of areas where social care and health care are becoming better

integrated, such as child health, there needs to be significant progress on this front, particularly with regards to services for adults and older people.

3. All the providers of health and care services in the region are having recruitment difficulties. As a result, they have to rely on temporary staff, affecting both the quality of services and their financial viability. The whole system needs to plan for future patient needs in terms of both the numbers and types of staff

4. The system's financial challenges are significant and growing: our deficit for 2015/16 for NHS care is currently forecast to be about £150 million, which is about 9% of our total collective budget. Unless we radically change the way services are provided, this deficit is projected to increase to £250 million (12% of projected resources) by 2020/21. We know that we can get better at living within our means by mobilising everyone involved, including our staff, patients and carers, to redesign services and tackle any waste that can be reduced or eliminated without eroding the quality of care

Having gathered the evidence for change, our clinical team will turn soon to developing proposals for solutions. To do this, we are learning from elsewhere. Many of the challenges faced by our local system are shared by others. We have much to learn here from the national strategies and innovations being tested across the country.

We will be discussing this evidence with patients, staff and the public across Cambridgeshire and Peterborough in coming weeks, in order to improve our collective understanding of what needs to change and gather ideas for making things better. Local people's feedback and their ideas for change will inform the clinical team's proposed solutions, which we will share in the summer for further discussion with local people and staff.

Many reading this will be aware of recent efforts to improve aspects of the local health and care system that have faltered. This Sustainability and Transformation Programme differs from them in a number of ways: it focuses on the system as a whole, rather than on individual organisations or services; it is led by frontline staff; representatives of all the organisations in the health system are collaborating on the Health and Care Executive; it is involving patients and the public to a much greater extent; and it has constant support from the relevant national regulatory bodies, NHS England and NHS Improvement.

As a team of NHS and local authority leaders, we believe that this work is essential for ensuring the people of Cambridgeshire and Peterborough get the best possible care over the next decade and we hope local people will take this opportunity to help us shape the future.

2. National Context

The key challenges facing local health and care systems across England are similar to those facing Cambridgeshire and Peterborough. So there is much to be learned from the national strategies and innovations being piloted across the country.

Health care has changed dramatically since the NHS' inception in 1948. People now live longer, often survive cancer and are much less likely to die from heart disease. Technology and treatments have changed the way diseases are diagnosed and treated. Looking to the next decade, people's needs will continue to change:

- Where patients were typically treated for 'acute' illnesses (which were typically treated over a short period of time), many now have a range of chronic "long-term conditions" (such as diabetes and dementia), which often require ongoing and continuous management; (NHS England, The Five Year Forward View, p6);
- Obesity levels across the country have been rising steadily, partly because of unhealthy behaviour such as poor diet and lack of exercise. Obese patients are significantly more likely to require healthcare support, due to links between obesity and a range of disease such as type 2 diabetes, stroke, coronary heart disease and arthritis (World Health Organization, Global Health Observatory (GHO) data- risk factors)

Coupled with these changing healthcare needs, the levels of quality of care and personalisation expected have also increased. As a result, there is considerable pressure for all local health and care systems to adapt, to better meet people's needs and expectations.

In response, in October 2014 the national NHS organisations[1] came together to publish a 5-year strategy for the NHS. This document, The Five Year Forward View, described three gaps which would result from continuing with the status quo:

- The Health and Wellbeing Gap: The NHS, together with local authorities and wider society, must focus more on prevention and become better at keeping people healthy, or else progress in life expectancy will stall and inequalities will widen;
- The Care and Quality Gap: New models of care, that build from enhanced primary care, and harness new

[1] The Care Quality Commission, Health Education England, Monitor, NHS England, Public Health England and the Trust Development Authority

technologies must be adopted to drive down unnecessary variation in quality of care;

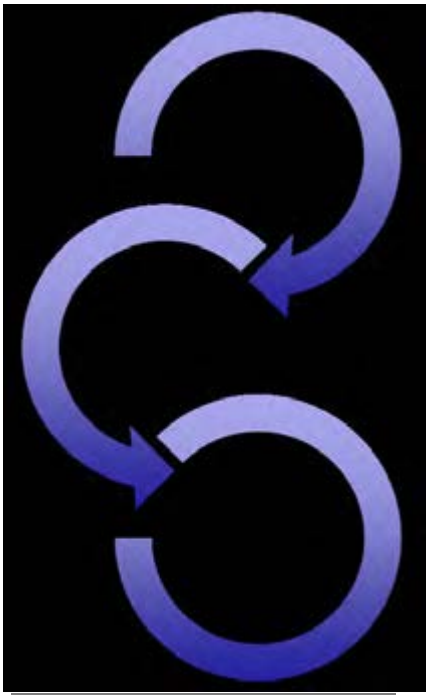
- The Funding and Efficiency gap: The NHS faces a deficit of £21 billion[2] in 2020/21. It must become more efficient to avoid the worst of all scenarios: poor quality services, fewer staff and restrictions on new treatments (NHS England, The Five Year Forward View)

Taken together with pressure on local authority funding, every health and social care organisation must re-imagine how care is delivered in the future.

Financially, we must get better value for patients and the public from each pound spent on services. The Carter Report, published in 2016, identified opportunities to improve hospital productivity, with the aim of saving £5 billion through reducing waste in the system across both clinical and non-clinical functions (Operational Productivity and performance in English NHS acute hospitals: Unwarranted variations, 2016). We will be implementing the recommendations so we can improve our use of scarce resources, directing it at the care for patients.

Since the Five Year Forward View, we've been asked by NHS England and NHS Improvement to work as a system to break down the walls between our organisations and to create a 'place-based system of care'. We are committed to working together to serve our population, rather than as separate entities. Central to this is a national ambition to deliver triply integrated care, which brings together primary and hospital care, mental and physical care, and social and health care.

Figure 1: Triple Integration



We see greater integration as a key part of the future we envisage: which is for proactive, seamless care delivered through a person-centric care model, far from the disjointed, organisation-focused care which too many people currently receive. Across the country, local NHS and social care organisations are designing, testing and rolling out innovative ways of delivering triply integrated care – so there's lots of scope for us to learn from what's being tried elsewhere.

The government also set out its priorities for the NHS for 2016/17, as well as longer-term goals for 2020 (Department of Health, The Government's mandate to NHS England for 2016-17). As a local system, we will

[2] Scenario One, assumes flat real terms budget combined with 0.8% productivity gains

need to address each of these asks:

- *7-day services*: Achieving the same standards of care 7-days a week, in order to more efficiently use resources and increase accessibility and responsiveness of services;
- *Primary Care*: improving 7-day access for routine GP appointments, and identification of new care models in primary care to improve the quality and resilience of primary care services;
- *Mental Health*: Reducing the health gap between people with mental health problems[3] and the population as a whole, including improving access and waiting times for mental health services;
- *Maternity and Neonatal Services*[4]: Offering full choice to women for where they receive their ante-natal and post-natal care and the type of care setting where they choose to give birth (National Maternity review: Better Births, Improving outcomes of maternity services in England, 2016);
- *Cancer services*: Improving the rates of one-year survival, and achieving the 62-day cancer waiting time standards (whereby a patient waits a maximum of 62 days from a referral to their first treatment);
- *A&E wait times*: Ensuring high responsiveness of emergency departments, including the requirement for at least 95% of patients at Accident & Emergency (A&E) to be seen within four hours, which requires effective flow through the entirety of urgent and emergency services across the system

Summary: the National Context

- The challenges faced nationally are very similar to those faced by Cambridgeshire and Peterborough, so there is much to be learned from the national strategies and innovations piloted across the country
- The population is getting older, with more chronic long-term conditions and higher levels of obesity, all of which contribute to rising levels of demand on the system
- The NHS is struggling financially, with a deficit of £21 billion forecast between 2014/15 and 2019/20
- The Government has identified a mandate for the NHS which identified a number of priorities for the system, including improving waiting times for key services, improving accessibility of services 7 days a week, and improving choice of services offered to patients

[3] As well as learning disabilities and autism
[4] This requirement stemmed from the National Maternity review, rather than the Government Mandate

3. Cambridgeshire and Peterborough's changing health needs

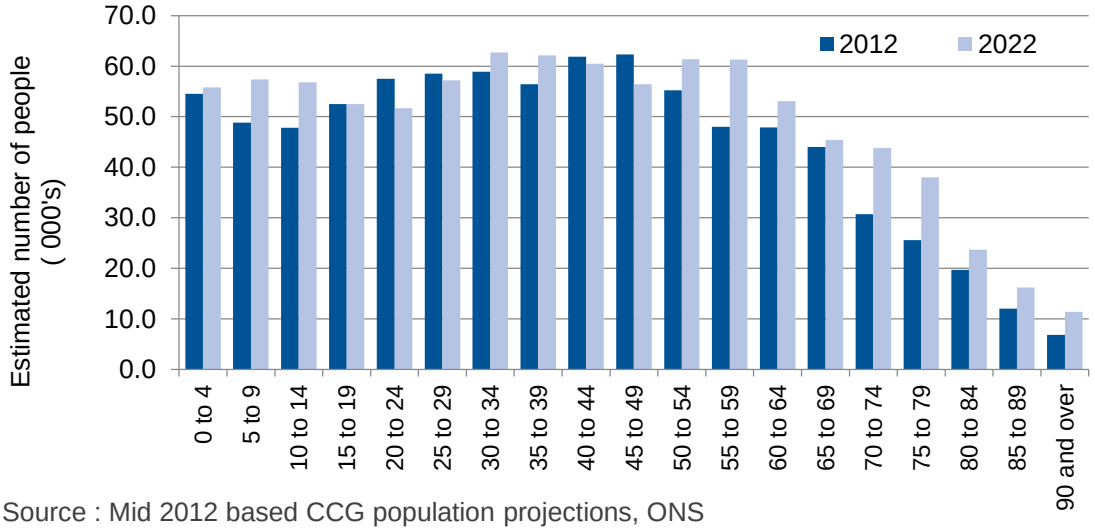
The size and average age of the local population are both increasing, in some cases more than other parts of the country. This means more people are experiencing health problems, and need greater levels of health and care services. In addition, our patients have told us that current services could be improved to better meet their needs. Further, our population is diverse – the needs of people who live in Peterborough, are not the same as those who live in Huntingdon, or Cambridge, or in the Fens.

3.1. The population and prevalence of illness are growing

Our local population in Cambridgeshire and Peterborough is growing quickly. Between 2013 and 2031, the Cambridgeshire population is forecast to grow by 22.7%, and Peterborough by 24.3%. South Cambridgeshire is expected to experience the greatest increase, at nearly 30% growth over the same period. In terms of the elderly population, there is expected to be substantially higher growth: 55.5% in Peterborough, and over 60% in Cambridgeshire. Huntington's elderly population is forecast to experience the greatest growth in over-65s, with a 70% increase between 2013 and 2031 (Population forecasts, mid 2012 based, Research and Performance Team, Cambridgeshire County Council).

As elderly people are more likely to have chronic, long-term conditions, their needs from the services will change. Finally, we're becoming more obese: the latest projection for rates of obesity is a rise from 22.2% in 2012 to 23.8% in 2018, reaching nearly 28% by 2031. As mentioned within the national context, obese patients typically have associated diseases requiring significant support, such as diabetes and coronary heart disease. They are also more complex to manage within the hospital, with higher complication rates and longer lengths of hospital stay (Makary et al., 2011).

Figure 2: Cambridgeshire & Peterborough Population Projections



Source : Mid 2012 based CCG population projections, ONS

Alongside the expected growth in demand for physical health services, local people also increasingly need support from mental health services. Right now, it is estimated that at least 86,000 adults have a common mental health disorder; this number is expected to increase by 13% to 97,500 by 2026 (Adult Psychiatric Survey, 2012). Moreover, as the population ages, the incidence of dementia is likely to increase: between 2012 and 2026, the number of people over 90 years is forecast to double and the expected number of people with dementia will increase by 64% (Older People's Mental Health JSNA, 2014).

3.2. People's health needs and preferences are changing

During 2015, we held a number of listening events with local people across Cambridgeshire and Peterborough to develop a better understanding of what local people want from their health and care system. The following messages came over loud and clear:

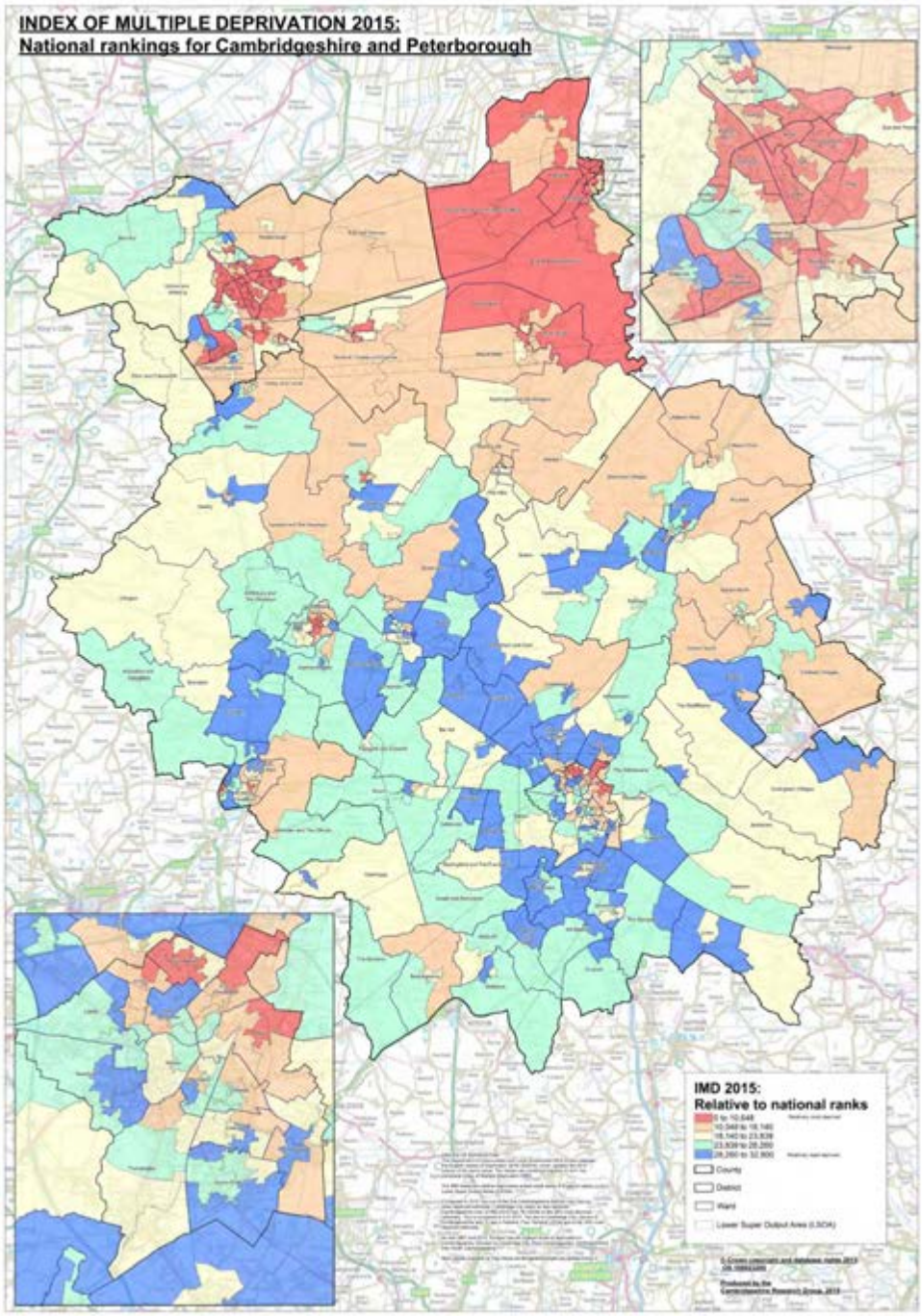
- Patients want to be empowered to stay healthy;
- Patients want easy access to information about their health (they use Google and pharmacies);
- Patients want to be educated to understand how to access the health and care services appropriately;
- Patients would rather use a community facility than be sent to A&E;
- Patients want consistent access (e.g. opening hours for services) across Cambridgeshire and Peterborough;
- Patients want care as close to home as possible;
- Children's services need to be more co-ordinated (they are currently too fragmented);
- Patients would happily see nurses at home if this meant that they could be discharged from hospital sooner;
- Patients do not want to be discharged too early with no support as they are concerned about being readmitted;
- There needs to be better communication for discharge planning;
- Patients want providers to collaborate to work more effectively together

There are important themes in this feedback. Local people care about improved preventative health and wellbeing services, and they want an accessible, well-designed system which they understand. They want services to be better co-ordinated, with providers collaborating together to deliver better services. They care deeply about receiving care close to home, so long as these services are safe, and communication with patients is good. These themes will shape the development of solutions by the clinical teams.

3.3. People's needs and outcomes differ within the area

Our population across Cambridgeshire and Peterborough is diverse, and local needs differ. Cambridgeshire is less deprived than Peterborough, although there are pockets of deprivation in Fenland, North East Cambridge and North Huntington. In Peterborough, 26% of the population lives in areas which are among the 20% most deprived in the country (Summary JSNA).

Figure 3: Geographical distribution of deprivation in Cambridgeshire & Peterborough



Source: Cambridgeshire Insight, 2015

Cambridgeshire and Peterborough has a lower disease prevalence rate than the UK average (QOF Database, 2015); however there are around 100,000 people in Cambridgeshire and Peterborough who have multiple long term conditions which lead to complex health needs and increased demand on the health and care system (Cambridgeshire and Peterborough Prevention Strategy, 2015).

Additionally there is significant variation between the health outcomes for Cambridgeshire and Peterborough. For example, while life expectancy is generally higher than the national average in Cambridgeshire, the reverse is true in Peterborough (although there are variations within Cambridgeshire itself). Moreover, Peterborough has a much higher rate of cardiovascular disease than Cambridgeshire (Public Health and Outcomes Framework, 2015).

Summary: Cambridgeshire and Peterborough's Health Needs are Changing

- Population trends in Cambridgeshire and Peterborough are adding to demands on the health system
- There are inequalities in how healthy people are across the area, which mean that needs and outcomes differ: life expectancy in Peterborough is generally lower than Cambridgeshire, and both have pockets of significant deprivation

4. We Can Deliver Better Care

As a health and care system, we in Cambridgeshire and Peterborough have much to take pride from. For example, our cancer services are some of the best and most responsive in the country – importantly we are better at diagnosing cancer early than many other systems. In addition, fewer local people die from chronic heart disease compared with the national average, and there's also a low likelihood of dying early from chronic liver disease (The NHS Atlas of Variation in Healthcare, 2015).

However, we can and must do better. Below we present some of the opportunities for improvement we've identified so far and our emerging vision of what the health and care system could achieve in the future.

4.1. What we can and must do as a system

As a system, we must improve the quality of care consistently delivered for people needing health and care services, we must triply integrate care; we must make best use of local expertise and facilities; and we need to improve our offer for local staff, so we're more attractive to people looking for work and keep staff for longer.

4.1.1. Care Quality

The Care Quality Commission, which rates the quality of services provided by NHS organisations, has found the quality of care we provide locally to be variable, with pockets of exceptional service, but with too many areas requiring improvement:

Table 1: CQC Ratings by Type of Outcome

	Adden-brooke's (CUHFT)	Hinching-brooke (HHCT)	Papworth Hospital	Peterborough & Stamford (PSHFT)	Cambridge & Peterborough FT (CPFT)	Cambridge-shire Community Services (CCS)
Overall						
Safe						
Effective			★			
Caring	★		★			
Responsive						
Well-led						

Source: CQC. Legend (below):

Outstanding ★	Good	Requires Improvement	Inadequate

4.1.2. Integration of Care

Critically, the care we provide for patients doesn't always reflect their needs: it is too often disjointed, with duplication, delay, or poor coordination. As more and more local people require more than one service and have needs that would benefit from

proactive planning and support, this lack of integration is one of the biggest issues we must tackle as a system.

Patient and Carer Story: The Current State

Steve[5] is a carer for his partner, who has early-onset dementia.

Steve spends lots of time making telephone calls to try to co-ordinate his partner's care, because there are a lot of people looking after his partner. For instance, Steve's partner has a lot of visits with the community psychiatric nurse, community carers and the GP. However it isn't clear to Steve who is responsible for co-ordinating care.

Sometimes expected visits or procedures don't happen when Steve is expecting them to. Steve is struggling to cope in his role as a carer. As his carer's assessment shows, he is feeling under-appreciated, and does not feel well-informed enough to help his partner make decisions about his care.

Local people have told us they want high-quality care which is safe, accessible, coordinated, and respects their dignity. It also needs to be clinically and financially sustainable – we must meet national standards, we must have enough well trained staff, and we must be able to live within our means.

Our emerging vision for care in Cambridgeshire and Peterborough is:

For those with ongoing care needs:

"Integrated care that is person-centred, with a co-created care plan that has involved patients, carers, health, social care and/or third sector professionals. Frontline staff will need to work across organisational boundaries working from a single care record and focussing entirely on delivering optimum care to meet a person's needs."

And, for others, who may need care from time to time:

"Accessible and responsive care, as close to home as possible – with timely access to specialist input, which is delivered consistently to the highest standard."

Patient and Carer Story: Our Future Vision

Once Steve's partner was diagnosed with early-onset dementia, they were given a care co-ordinator. This care co-ordinator worked with the GP, who had overall responsibility for coordinating Steve's partner's care. The care co-ordinator gave Steve a phone number which he could ring day or night to get advice.

[5] Steve is a real person in Cambridgeshire & Peterborough. Steve's last name and his partner's name have been withheld to protect patient confidentiality.

Steve and his partner were also given information to understand Steve's partner's condition, and the types of care available. Both Steve and his partner were involved in developing a care plan, which meant that the plan was tailored to their specific needs and they understood who was providing what types of care and when. The plan included arrangements for what to do in a crisis, including information for the ambulance service on who Steve and his partner are, what medications his partner is on, and how to get in touch with their care co-ordinator, who can make sure any hospital spell goes smoothly.

They regularly review the care plan with the carers who look after Steve's partners. All interactions with the people who provide care to Steve's partner are recorded in a single set of patient notes, and these notes are available to everyone who provides care. This means that Steve and his partner do not need to provide the same information regularly to multiple people. Steve and his partner are also able to access their care plan online, as well as gain access to the various services which Steve's partner requires, making it easier for Steve to coordinate his partner's care.

Steve's partner also had access to a personal care budget, which allowed them to make decisions about the type of care Steve's partner needed. They used this to access additional carer support, which also gave Steve support and respite when necessary.

Steve's carer assessment, which identified his needs, helped him connect with carers' support groups, where he was able to meet other carers and share his experience. He was also told about an online community where people who are anxious about not coping can receive support from trained guides. This helped Steve to feel that the role he played in providing care to his partner was acknowledged and valued. It has stopped Steve feeling anxious and isolated.

4.1.3. Capacity and Demand

Two of our local hospitals have more patients wanting care there than they can currently cope with: Cambridge University Hospitals Foundation Trust (CUHFT, or Addenbrooke's) and Peterborough & Stamford Hospitals Foundation Trust (PSHFT). This had led, for example, to cancellations and postponement of planned procedures, particularly at Addenbrooke's (NHS England - Cancelled Elective Operations Data). On the other hand, Hinchingbrooke Care Trust (HHCT) has facilities which could be better utilised, such as unused operating theatres and hospital beds. Similarly, community facilities can be better used.

Capacity and demand are therefore mismatched, with a variety of opportunities to better utilise our staff and facilities, so that we can reduce waiting times, avoid cancellations and, by asking specialist staff to advise their colleagues working in other settings, we can provide more care locally.

4.1.4. Recruitment and Retention

All of the NHS providers in Cambridgeshire and Peterborough are struggling with some form of recruitment and retention problem. As elsewhere in England, we are currently highly dependent on temporary staff from agencies. While some level of agency staffing can be positive, giving us the flexibility to increase or decrease staffing levels according to demand, our current levels are very high. According to figures submitted to Health Education England, nearly all of us have gaps in the proportion of positions we can fill permanently. On nurses alone, estimates indicate we need nearly 700 more nurses (Health Education England). These challenges are particularly keen in the social care sector, where a number of people in the community have been identified as requiring home care, but are still waiting to receive this care due to challenges in recruiting staff. The system as a whole needs to address these challenges, because when people don't get the care they receive at home, it can lead to a risk of ending up in hospital.

Primary care provision in Cambridgeshire and Peterborough faces similar workforce challenges to those faced nationally: recruitment and retention is a challenge and many practices are led by practitioners ready to retire within a few years; demand for services is on the rise; and services that cross primary care, community provider and hospital settings are not as joined up as they could be – meaning GPs spend more time on administration and less time on seeing patients. A recent qualitative survey of GPs in Cambridgeshire and Peterborough highlighted the following challenges (General Practice Qualitative Survey C&P, March 2016):

- Vacancies continue to be a problem, with locum GPs playing a significant role in filing gaps; some practices experienced having a GP vacancy open for over a year;
- Lack of workforce has a direct impact on patients, with a reduction in appointments and increases in workload of current staff, being the main outcomes;
- Practices are looking at innovative methods to deal with recruitment challenges, particularly hiring less experienced staff and training them to meet needs (such as nurses from secondary care)

Sustainable, high-quality staffing depends on our services being attractive to prospective and current staff. Making services attractive involves: ensuring front-line staff are exposed to the learning opportunities they want and need for professional development; an appropriate work-life balance (for example, enough staff on rosters to allow for a rotation of on-call schedules); and a culture of respect and care for staff – they are the bedrock of our services. By working together across the system, we think we can get better at making our organisations attractive employers and stop harmful practices such as 'poaching' staff from each other.

4.1.5. Social Care

Social care in Cambridgeshire & Peterborough is provided by Cambridgeshire County Council and Peterborough City Council respectively. It includes a range of services, from early intervention and prevention services, to home-care support such as reablement and home adaptations, through to end-of-life services. These services support both patients and their carers, taking into account the relationship between health and other factors such as housing, education and poverty.

There is some well-established integrated care working in social services. For example, a Joint Child Health and Wellbeing team (comprising of Peterborough City Council, Cambridgeshire County Council, and the NHS) are working together to re-design child health and wellbeing services, including mental health. Through this work, we aspire to develop a detailed understanding of how to join up education, mental health, health visiting and primary care to promote emotional well-being and good health outcomes for local children.

For adults and older people, in response to the government's encouragement to bring together health and social care (for example, through the 'Better Care Fund'[6]) our teams of staff will need to integrate further. This integration is particularly critical at the points in the system where health and social care overlap, as struggles in one part of the system can then cause difficulties with the other. One particularly important area has to do with discharge of elderly patients from hospital: as many elderly patients require social care support upon leaving, health and social care need to work together seamlessly in order to ensure patients are discharged from hospital at the optimum point when they are medically safe to go home.

We have recently created an 'Integrated Adult Community Services' group to bring together clinical and management leads across health and social care (including both Cambridgeshire County Council and Peterborough City Council) to help address this need for integration. If we're to deliver care in line with our emerging vision, we need to do more to bring together health and social care. We need to work differently, in a close-knit partnership which recognises that there is no distinction between health and social care in the lives of patients.

4.2. What needs to be done service by service

The sections below outline in further detail the opportunities for improvement and our vision for each of the five key areas of care provided in Cambridgeshire and Peterborough: Proactive Care and Prevention; Urgent and Emergency Care;

[6] The Better Care Fund brings together NHS services and local authority services to better integrate health and care for patients (http://www.cambridgeshire.gov.uk/info/20166/working_together/575/better_care_fund and http://www.cambridgeshireandpeterboroughccg.nhs.uk/downloads/CCG/Have%20your%20say/Peterborough%20BCF%20-%20vision%20and%20schemes.pdf)

Maternity & Neonatal Services; Children & Young People's Services; and Elective Services.

4.2.1. Proactive Care and Prevention

The Five Year Forward View[7], which describes the future strategy of the NHS, states:

"The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all depend on a radical upgrade in prevention and public health."

It further states:

"The traditional divide between primary care, community services, and hospitals - largely unaltered since the birth of the NHS - is increasingly a barrier to the personalised and coordinated health services patients need.... Over the next five years and beyond the NHS will increasingly need to dissolve these traditional boundaries..... In all cases however one of the most important changes will be to expand and strengthen primary and 'out of hospital' care".

As demand continues to increase, the key to sustaining care for the local people of Cambridgeshire and Peterborough will require action on three fronts:

- An improvement in health and wellbeing services, which focus on helping people make good lifestyle choices;
- Expanding the model of primary care services, and supporting the resilience of general practice;
- Supporting individuals with mental health and long-term conditions

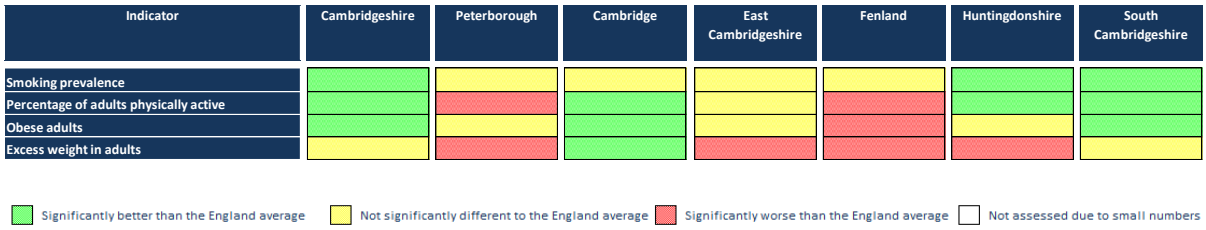
Health and Wellbeing

Poor lifestyle choices have significant future consequences which are preventable. As the obesity rates in Cambridgeshire & Peterborough rise, so will the prevalence of diabetes, leading to illnesses like coronary heart disease and arthritis. This will result in millions of pounds of future spending to pay for preventative illnesses.

We know that poor lifestyle choices are typically made more frequently in deprived populations; as they escalate into illnesses, they magnify the inequalities in the area. For instance, rates of alcohol misuse, smoking and obesity are higher in Peterborough than in Cambridgeshire (Public Health England, Health Profiles; fingertips tool). Hospital admissions related to alcohol in Peterborough were the highest in the East of England (Public Health Outcomes Framework).

[7] https://www.england.nhs.uk/ourwork/futurenhs/ pages 9,16, and 18

Figure 4: Adult's Health and Lifestyle across Cambridgeshire & Peterborough, 2012-2014



Source: Public Health England Profiles

Our vision for health and wellbeing in Cambridgeshire and Peterborough is to support people to stay healthy through effective social care services (e.g. reablement services) and public health programmes (e.g. weight management and stop smoking services) with focused support for patients living with, or at high risk of developing long-term conditions. In all this work we will focus on the parts of the population where deep health inequalities can cascade across generations.

Supporting patients at high risk of, or already living with, long term conditions is particularly important as poor management of these patients' health worsens outcomes and reinforces health inequalities. Patients have also asked for better support to care for themselves, and self-care will become increasingly important in helping keep patients safely at home.

Our colleagues in the councils' public health team have developed for our system a *Cambridgeshire and Peterborough Prevention Strategy* to identify the key opportunities for us to improve the long-term health of the population in a sustainable way. Our prevention plan is based on the best available evidence, including guidance issued by the National Institute of Health and Care Excellence. It identifies key areas on which to focus, including falls prevention, self-management of chronic obstructive pulmonary disease (COPD), and improved diagnosis and management of atrial fibrillation and hypertension, which can lead to cardiac problems. Additional community level prevention strategies, more tailored to diverse needs, will be developed to set out which targeted interventions can help keep people healthy.

There are many examples of good practice across our communities but the quality and availability of services can vary from place to place. For example, the Integrated Community Diabetes Service represents best practice in diabetes management but is currently available only in one of our localities. In future, we will replicate existing pockets of best practice so high quality, proactive care is available to all Cambridgeshire and Peterborough residents, irrespective of where they live.

Primary Care

We believe that the sustainability of primary care is critical for the system to work well, as good quality primary care keeps people healthy and anticipates needs that

may arise, before crises happen. Where primary care struggles, patients can end up in hospital, so demand for hospital services is closely related to the quality of primary care.

Ambulatory care sensitive conditions (ACSCs) provide a good example of this relationship. ACSCs are conditions which, when managed appropriately in primary care, should rarely require patients to be admitted to hospital. However, when their conditions are not proactively managed in primary care, patients can experience crises which force them into hospital. In Cambridgeshire and Peterborough, the number of patients ending up in hospital with ACSCs is higher than in areas with a similar population demographic (NHS Atlas of Variation, 2012/13). This means there is an opportunity to improve how care is provided for these patients, their carers, and the system as a whole.

Our vision for primary care is a holistic, person-centred model which supports wellness, and prevents people from becoming ill and entering a crisis. It ensures care across primary, community, third sector, mental health, hospitals and other settings is coordinated, and provides care which is high-quality and accessible every day.

In order to achieve this vision, there will need to be a radical change to the model of primary care. General Practitioners, many of whom are struggling with a combination of increasing workloads, increasing levels of complexity in patient care, increasing pressure on financial resources and persistent inequalities in access and quality of care, need to be better supported (Improving General Practice: a Call to Action, 2013). New care models must link up social, community, third sector and primary care services, so patients with high needs are effectively supported. Better links between GPs and specialists need to be established to support GPs in providing complex care in the community. Radically new types of primary care models, such as Primary Care Homes (NAPC, 2016) which provide integrated care in settings customised for high-needs patients, need to be explored.

Supporting this structure are new organisational models. Over the past year our GPs have started to work more closely together. Groups of GPs are coming together to develop GP “federations” as well as “super-partnerships” – new organisational forms which will make primary care more resilient in the future as they allow for the sharing of best practice, rotation of staff and reduction of administrative overheads. These groups are at varying levels of maturity, with the Greater Peterborough Partnership having progressed the furthest.

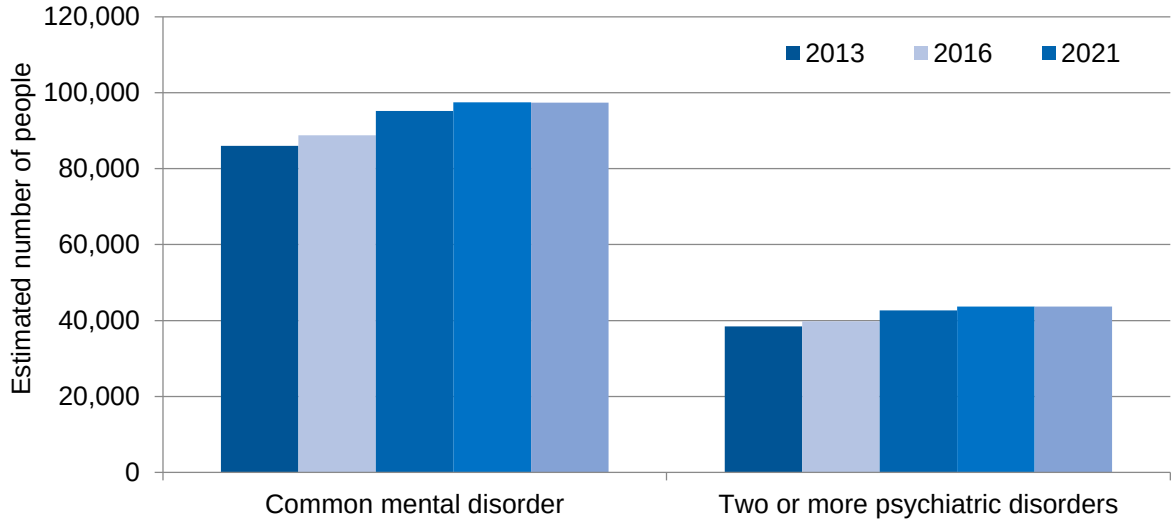
There is still much for us to do to align current services with the vision and create a sustainable, resilient primary care service. Primary care remains at the heart of a sustainable health and care system; where primary care struggles, echoes are felt across the system.

Mental Health and Long-Term Conditions

Patients with long-term conditions such as diabetes or stroke often need high levels of care, as do people with severe and enduring mental health conditions. As our elderly population grows, we will be treating increasing numbers of people with such conditions.

Of the nearly 100,000 people in Cambridgeshire and Peterborough who have multiple long-term conditions, nearly 65% are estimated also to have mental ill health. It is one of the areas with greatest inequality in the system: for instance, research has shown that people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than their peers (Chang et al, 2011; Brown et al 2010). Our physical and mental health services therefore need to address the needs of the whole person (Cambridgeshire and Peterborough Prevention Strategy 2015).

Figure 5: Estimated number of people with mental health disorders, aged 18-64 years, Cambridgeshire and Peterborough



Source : Mid 2012 based population forecasts, Research and Performance Team, Cambridgeshire County Council and Adult Psychiatric Survey 2007, ONS

Our vision for these patients and their carers is a holistic, integrated care service which encourages physical and mental wellness and prevents crisis, coordinating the needs of patients and their carers across community care, social care, third sector services, primary care, mental health and hospital services. Services will be co-designed with patients and their carers so they are empowered to make decisions on how best they should be cared for.

Currently, we find that too many of these people are being cared for in hospitals: this is not what people want, is less effective than proactive care in the community, and uses resources that could be better invested in other parts of the system. For conditions such as COPD and heart failure, patients in Cambridgeshire and

Peterborough are more likely to end up in hospital than in other areas. We also provide suboptimal care for patients with diabetes; and, relative to other parts of the country, we are not achieving key physical and mental health treatment targets as recommended by the National Institute for Health and Care Excellence (NICE) (Right Care Atlas of Variation, 2015) and NHS England (Guidance on new mental health standards 2015/16). If we manage these conditions better in the community, we'll be able to help people remain healthier and reduce hospital stays for them.

Our local people who have long term conditions are those most likely continually to interact with multiple aspects of the system (such as GPs, hospitals, mental health providers, community services). When we provide disjointed services, without any one organisation or person taking responsibility for a patient's care, we find that sometimes our patients 'falls between the gaps' of the various services. Different elements in the health system have been working together on an integrated approach to keeping people healthy in their communities.

We're starting to make some progress on integrated community based care. Across Cambridgeshire and Peterborough, we've deployed sixteen new 'neighbourhood teams' to begin working with people in the community, using a multi-disciplinary approach to support people holistically. A rapid response team, known as the 'Joint Emergency Team' (JET), supports people in crisis in the community, stabilising them at home where possible.

But we know some gaps remain. For instance, there is scope to improve the integration of evidence-based psychological support such as 'Increasing Access to Psychological Therapies' (IAPT) with the neighbourhood teams, since long-term conditions and anxiety or depression often go hand-in-hand (Commissioning for Value, Cambridgeshire & Peterborough, 2016). We also need to do more work to integrate disease-specific services fully, with standard pathways developed for key conditions, such as COPD, dementia, cardiovascular disease and diabetes to help keep people with these conditions healthy and safe in the community.

We also need to do more to tailor the neighbourhood teams' services to different communities' particular needs, and to give particular thought in reaching the most vulnerable communities, such as Gypsies and Travellers. For instance, we know that levels of depression tend to be higher in poorer areas, and in those with risk factors such as unemployment. Importantly, the needs of carers must also be addressed: carers play a critical role in the health and care system, and one of the main reasons patients end up in hospital is because their carers have become unwell.

4.2.2. Urgent and Emergency Care

The picture for urgent and emergency care in Cambridgeshire and Peterborough is similar to the national picture: the pressure on our A&E departments, hospitals and ambulance services is significant and increasing. Unless we can find better ways to address the underlying causes of increasing demand, we predict that attendances

and A&E admissions may rise by up to 17% between 2016/17 and 2020/21. Such rises may tip our fragile urgent and emergency care system over the edge.

The consequence of this pressure is partly responsible for the poor CQC assessment of the quality of the urgent and emergency services at both Addenbrooke's and Hinchingbrooke. It's also partly responsible for our inability to achieve national A&E waiting standards, which require that 95% of patients are seen and treated or discharged within four hours: all three A&Es in Cambridgeshire and Peterborough missed the target in 2014/15.

Our assessment of one main reasons for our quality and access challenges is that a relatively high proportion of patients who attend local A&Es are being admitted: we admit 25.8% of attendances, which is much higher than the England average of 21.3%, and that of our 'peers' (areas with similar demographics), at 21.19% (RightCare Atlas of Variation, 2012/13 figures). Peterborough hospital has particularly high rates of admissions for acute conditions which do not normally require hospital admissions (HSCIC indicator Portal Outcomes Framework, 2012/13).

We've also identified that we're struggling to meet the needs of our local older populations. The majority of beds in our three general acute hospitals are occupied by the elderly: 65% of PSHFT beds, 70% of Addenbrooke's beds and 77% of Hinchingbrooke's beds are occupied by the elderly. A notable area for us to improve is the number of admissions for people who break their hips, where we perform significantly worse than the national average (Public Health Outcomes Framework, 2010/11 – 2013/14). For these patients, better care in the community to help prevent hip fractures, as well as improved support afterwards to help them get home, can make a significant difference to their outcomes.

Another area of opportunity with regards to care for elderly patients is delays in discharge from hospital (or delayed transfers of care). The number of patients experiencing delayed transfers of care, per population, was higher than the national average for both Cambridgeshire and Peterborough last winter[8] (NHS England Statistics). Older people experience delays in being discharged even when they're well enough to go home, as it takes too long to organise the necessary support in their home, in part because the NHS and social care are not as integrated as they need to be. Not only is this costly, but it can be dangerous for elderly people: studies have shown that unnecessarily long stays in hospitals can cause people to become sicker, and more dependent upon health services permanently (NHS Providers, Right Place, Right Time Better Transfers of Care: A Call to Action, 2015).

[8] Calculated as both numbers of delayed transfers of care per population, as well as delayed days per population, for Cambridgeshire and Peterborough, October, November and December 2015

Another group of people, where we're struggling to give them the best quality urgent and emergency care, is people with mental health needs. Our rates of A&E attendances for psychiatric disorders and hospital admissions for self-harm are higher than the national average (Public Health England Community Mental Health Profiles, 2012/13). Moreover, due to gaps in existing mental health provision, local people attending A&E in mental health crisis are more likely to be admitted rather than provided more appropriate community based care better suited to a speedy recovery and ongoing independence. Our local services are not compliant with national guidelines issued by NICE (the National Institute of Health and Care Excellence), which recommends 24-hour crisis teams to support individuals with mental health exacerbations.

Our vision for Urgent & Emergency Care in Cambridgeshire and Peterborough is for highly responsive, effective and personalised services outside the hospital for people with urgent but non-life threatening needs, where people have access to the right advice in the right place, the first time and are supported to effectively self-manage their conditions. For those with serious or life threatening emergency needs, we will ensure patients are treated in centres with the very best facilities and 24/7 access to the leading emergency care expertise (emergency medicine decision makers in A&E, acute medicine and emergency surgery specialists).

We've already started to address the gaps in local urgent and emergency care services. We've been chosen as a 'Vanguard' (a designated national test site) for Urgent and Emergent Care, and we're developing plans to radically upgrade the care we give. For the future, we've identified 5 key innovations:

- An integrated urgent and emergency care service, consisting of three elements:
    - NHS 111, a phone service for patients, providers and carers that provides advice and guidance about a patient's care needs and available local services;
    - Out of Hours telephone-based support for patients and carers;
    - A virtual 'clinical hub' (including GPs and Community Geriatricians) providing expert multi-disciplinary team advice to nurses, social workers and paramedics in real time, allowing them to safely treat more patients in their own homes
- Neighbourhood teams who proactively identify, assess and implement packages of care that support people to stay well/remain independent in the community to avoid admissions to hospital;
- A programme of quality improvement for hospital based emergency care, to assess how best to bring local services in line with national quality guidelines for 7 day care, to reduce length of stay by adopting standardised best

practice emergency care pathways (especially for frailty), and to ensure services have access to the expertise and equipment needed to be safe 24/7;
- A programme to improve the speed with which people are safely discharged from hospital, by enhancing local provision of rehabilitation and reablement services in community hospitals and in people's homes;
- A Mental Health 24/7 crisis response service, to provide immediate support for those experiencing mental health crisis and prevent further crises

Our new model of urgent and emergency care aims to support people more effectively outside hospitals and, where admission is needed, to provide stream-lined responsive care with people going home as soon as it's safe to do so. Urgent and emergency care will also need to be available consistently 7 days of the week, which means we must look carefully at how to make best use of local staff and facilities, in order for care to be safe and sustainable.

4.2.3. Maternity and Neonatal Services

Locally, maternity and neonatal services are provided by Hinchingbrooke, Peterborough and Stamford Hospitals (PSHFT), and the Rosie Hospital at Cambridge University Hospitals. All three are obstetric-led units, with midwifery-led units operating alongside.

We are facing increasing demand for maternity services, with the number of births projected to increase by 8.2% between 2012 and 2021. However, as the birth rate differs across Cambridgeshire and Peterborough, and we are increasingly focussed on enabling women to choose their preferred birth setting, we're not yet clear on the implications for our 3 existing birthing units.

The complexity of deliveries varies by hospital. The caesarean section rates at both Hinchingbrooke and PSHFT are lower than expected when compared to the national level, whereas the proportion at the Rosie is relatively high. At all three, rates are higher than the 'optimal' best practice rate. The number of midwife-led deliveries is highest at Hinchingbrooke and lowest at the Rosie, possibly due to differences in complexity of the women giving birth.

Our maternal outcomes are generally good: infant mortality rates for women giving birth are better than the national average; although outcomes are slightly better for women from Cambridgeshire than Peterborough. While the quality of care of maternity and neonatal care is generally good, with both Hinchingbrooke and PSHFT rated 'good' by the CQC, Addenbrookes is working hard to improve the care at the Rosie, which was rated inadequate by the CQC in the autumn. We think this is primarily due to staffing issues: the Rosie was closed 37 times between July 2013 and April 2015 mainly due to a lack of midwives. Staffing is highly variable across the hospitals: the number of births per midwife varies from 28.0 at Hinchingbrooke, to 30.6 at PSHFT, up to 34.7 at the Rosie.

Our vision for maternity and neonatal services in Cambridgeshire & Peterborough is to deliver maternity and neonatal services through a single, networked model of care that eliminates variation in outcomes and experience and provides consistently high quality care to parents and neonates in Cambridgeshire and Peterborough. The service will be woman-centred, offering parents appropriate information to make an informed choice about their care. Staff will be given the training, tools and experience to work flexibly across provider boundaries, in both acute and community settings.

There are a range of guidelines relating to maternity and neonatal care. The National Institute of Health and Care Excellence guidelines recommend that women have access to choice of four birth settings: home, a free-standing midwife unit, an alongside midwife-led unit (in a hospital), or an obstetric-led unit. Currently, more than 75% of women in the area give birth in obstetric-led units; nationally, this figure is 87%, but surveys tell us that only 25% of women would choose to do so (Trust Maternity Dashboards, 2015/16 YTD, National Maternity Review: Better Births, Improving outcomes of maternity services in England, 2016).

NHS England has also identified 5 ‘big challenges’ for maternity services: more preventative services pre-conception (such as smoking cessation); improved perinatal mental health services; ensuring appropriate capacity for rising birth rates; dealing with increasing complexity of pregnancy; and integration of maternity services into the ‘early years’ agenda for children.

To date, we’ve only made limited progress against these challenges: maternity units are being staffed appropriately for higher complexity of pregnancy, and physical capacity is currently available across the area. However, mental health services for pregnant women have been identified as a priority and integration between maternity and child health is also limited.

In order to improve the quality of care provided, we now need to work together to address the challenges posed nationally by NHS England and the Cumberlege Review (Better Births: Improving the outcomes of maternity services in England, 2016), particularly with respect to aligning workforce capacity, reducing variation, addressing future demand, and ensuring appropriate choice.

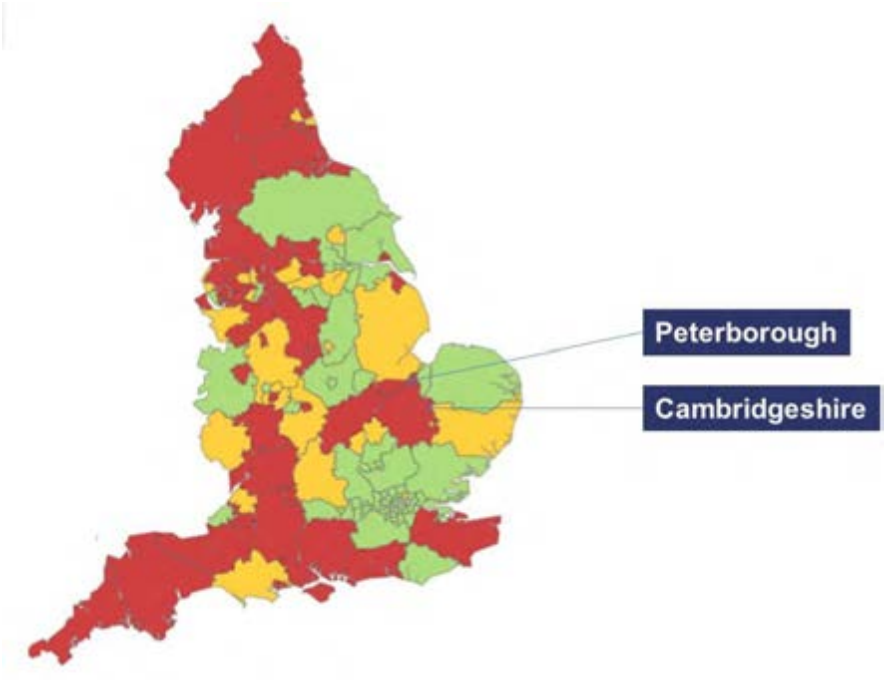
4.2.4. Children and Young People’s Services

We’re proud to say that the quality of Children and Young People’s services in Cambridgeshire and Peterborough is generally good. Recent inspections by the Care Quality Commission rated nearly all the providers ‘good’. However, as with other services, our key challenge relates to staff and bed numbers.

Looking to the future, additional demands will also put pressure on our system which is already near capacity. The population of children & young people in locally is expected to grow by about 9% by 2021; however, young people are already being

moved or being admitted into other units when no beds are available locally. A lack of beds is keenly felt at Cambridge University Hospitals and at Peterborough and Stamford Hospitals (PSHFT), particularly in the winter; Hinchingbrooke has greater levels of beds spare. In the community, children's mental health services provided by CPFT (Cambridgeshire and Peterborough NHS Foundation Trust) are also facing significant demand pressures which are partly responsible for the high levels of admissions for self-harm in children and young people in the area.

Figure 6: Hospital Admission for Self-Harm amongst Children and Adolescents, 2010-11 to 2012/13



Source: Public Health England Fingertips

Variation in levels of demand is significant. Peterborough has relatively high rates of admission for injuries to children and asthma, where as many of Cambridgeshire's admission rates are relatively good compared to national benchmarks. Other variation includes high child attendances at A&E and admissions particularly in Borderline, Peterborough, the Isle of Ely and Wisbech Local Commissioning Group areas. These variations can be at least partially explained by the underlying social determinants of health: we know that children's poverty, family homelessness, poor levels of education and children's obesity levels are significantly higher in Peterborough than in Cambridgeshire. As a result, we need to develop an enhanced primary and community-based model of care that helps to keep local children and young people at home.

Our vision for Children & Young People's services is based on multi-disciplinary, integrated, sustainable and equitable care which supports children in staying at home wherever possible. The vision is underpinned by The Royal College of Paediatrics and Child Health (RCPCH) service standards for hospital services.

We think that by adopting RCPCH guidance we can reduce the strain on our local health and care services. It suggests fewer, larger units, more multidisciplinary teams, clear service standards and a strengthened role for the voices of children and young people. From a staffing perspective, the RCPCH guidance also provides standards on the number and availability of paediatricians and children's nurses in inpatient units. Similar guidance is provided for A&Es which accept children. Currently we do not meet most of those standards.

We've made some progress in meeting RCPCH guidelines for reducing unnecessary admissions to A&E. Telephone advice is generally available from a qualified senior clinician; rapid access is provided by paediatric units; and multi-disciplinary teams tend to be held within organisations. However, there is significant progress yet to be made: links between hospital consultants and primary care are poor; education sessions for primary care professions are irregular; community services do not operate 24/7; key pathways have not been developed or consistently applied.

Similarly, we've already started work to meet national requirements set out in 'Future in Mind' for children's mental health but there remains much to do. In particular, transitions to adult services for children with mental health services are a major problem, and too many children are admitted to hospitals through A&E because of a lack of children's crisis services in the area.

Overall, we know that improved community services are critical to sustainability for better mental and physical health care for children and young people. .

4.2.5. Planned Hospital Care

Planned hospital care, also known as 'elective' care, usually begins with a visit to your GP, and possibly a diagnostic test before being sent to see a hospital doctor. A hospital appointment may involve further tests, to enable the consultant to provide a diagnosis, an opinion, a treatment or a procedure (in which case there may be post-operative care). The pathway ends when the patient is discharged back to their GP. Elective care is primarily provided by Addenbrooke's, Peterborough and Stamford Hospital (PSHFT), Hinchingbrooke and Papworth (for in cardiac and respiratory services only).

Locally, demand for elective services is set to increase dramatically, due both to population growth but especially due to changes in population demographics. Our elderly are high users of elective care services, such as hip and knee replacements. Increases in obesity rates also generate demand, such as for cardiology consultations, and add to the likelihood of complications arising in routine

procedures. Unless we can find better ways to address the underlying causes of increasing demand, estimates for Cambridgeshire and Peterborough suggest an increase of up to 17% between 2016/17 and 2020/21 due to population growth and other non-demographic factors.;

We're not as good as we could be at managing elective demand. Many patients referred for elective services do not always require consultant care; referral rates between GPs in Cambridgeshire and Peterborough vary greatly, not all of it warranted by need.

The need for elective care also varies between localities. Peterborough, for instance, has significantly higher levels of obesity, diabetes, hip fractures and cardiovascular mortality than Cambridgeshire. Elective admission rates (per population) therefore vary within the area, with more deprived areas such as Fenland and Huntingdon having higher rates. We must make sure any changes we make to care in the future seek to reduce these differences in need.

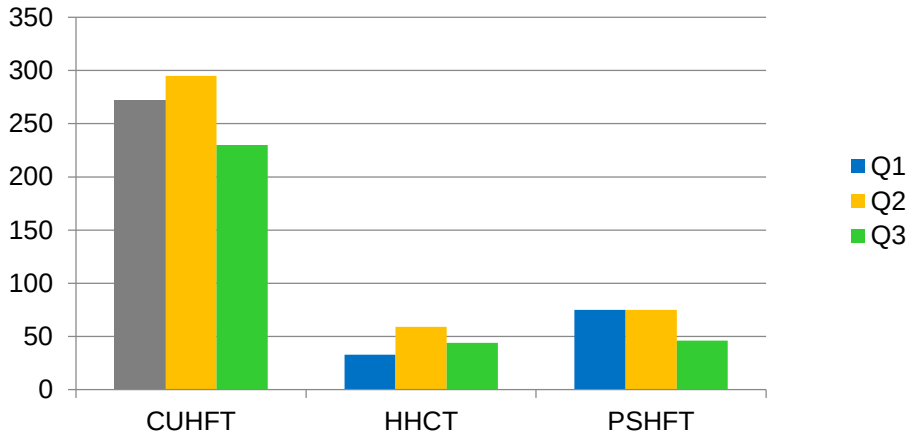
The CQC rated Papworth and Peterborough & Stamford Hospital (PSFHT) as providing 'good' quality of surgical care, whereas Addenbrooke's and Hinchingbrooke were both rated 'requires improvement', primarily due to operational issues, rather than quality of care.

Two sets of national guidance form the basis for evaluating responsiveness within elective services. The first requires that 92% of patients wait no more than 18 weeks between referral and treatment for services, including offering patient choice. This is known as the 18-week RTT. The second is a set of targets for cancer, which sets out maximum timings between referrals to hospital appointments, from diagnoses to treatment, and then to subsequent treatment.

In Cambridgeshire and Peterborough, hospitals are meeting, and often significantly exceeding, nearly all the cancer waiting time targets. With 18-week RTT targets, performance is more variable. There are pockets of good practice, and areas of opportunity; in particular, Addenbrooke's and PSHFT are struggling with their performance in Trauma & Orthopaedics, as well as ENT (ear, nose and throat). Importantly, responsiveness and care are variable across the system: within conditions, between specialties, and across hospitals.

We're aware that there's a strong interdependency between our emergency and elective performance: when emergency services are under pressure, our emergency patients are often placed into beds required for our elective patients; similarly, theatres booked to operate on our elective patients may be required for our emergency patients. This results in cancellations and delays, and poor quality of care for emergency patients (who are not optimally cared for in beds catered to elective services). So progress in improving elective care services depends on separating interdependences with emergency services.

Figure 7: Number of last minute planned operations cancelled for non-clinical (operational) reasons over 2015-16 by Quarter[9]



Our vision for elective services is for high-quality, standardised pathways which meet or exceed national waiting times standards, offering patients choice, and where possible are delivered close to home.

We've already identified a number of opportunities to improve our elective services to reflect best practice better. First, separating interdependencies between elective and emergency pathways can help avoid cancellations, while also improving treatment quality. Secondly, we can reduce inappropriate referrals to hospital with more collaboration between primary and secondary care doctors. Lastly, there is much scope for improving cost-effectiveness of care, through innovative use of alternative care practitioners and technology, all hospitals using similar devices so we can negotiate a better deal with suppliers, and better use of expensive equipment (like operating theatres and diagnostic machines).

Further, while each of our hospitals can better utilise its facilities (e.g. theatres and beds), we can also match treatment capacity and demand better across the system. Addenbrooke's, for instance, is struggling with capacity, as evidenced by their 18-week RTTs for some specialties; Hinchingbrooke, on the other hand, has available capacity. To achieve this, we would need to provide more support for patients in making decisions about what their treatment options are and where they can receive a similarly high standard of treatment.

Therefore, we think we need to create a new model of elective care which better reflects best practice, realigns capacity and demand, and reduces variability in care whilst improving responsiveness. Initially we are focusing on four particular specialties for this work: orthopaedics, ophthalmology, ENT and cardiology. These

[9] Note that the number of operations conducted by these organisations varies significantly, and these are not rates, but actual numbers of operations. CUHFT: Cambridge University Hospitals FT; HHCT: Hinchingbrooke Health Care NHS Trust; PSHFT: Peterborough and Stamford Hospital FT

specialties have been selected by our clinicians as being the areas where we can have most positive impact for patients. We will also consider cancer services, but cancer services across Cambridgeshire and Peterborough are generally of a high standard, so there are likely to be fewer opportunities for improvements.

4.2.6. Draft Design Principles and Evaluation Criteria

As we take all of this work forward, it is important that we establish some common principles to guide the work. Our team of clinical leaders and the Health and Care Executive have therefore developed a draft set of design principles (see Table 2). These reflect important values that they believe should be taken into account by the clinical teams as they develop their models of care and all of their proposals for how services should change.

Table 2: Draft Design Principles

Principle	Definition
High quality care	• Solutions should deliver safe, clinically effective care for all • Services should provide a positive experience for patients • Services should focus on preventative interventions to reduce escalation of need for health and care services, encouraging self care and independence
Integrated care	• Solutions should enable services to be delivered through integrated, holistic disease pathways • This will ensure that patients receive a seamless service and will minimise duplication of processes • Truly integrated care requires partnership working across different groups of care professionals and different organisations and full involvement of patients, carers and the third sector
Right care, right time	• Solutions should enable patients to receive care appropriate to their particular needs • This means providing proactive, timely care that is co-designed with patients and carers and responsive to their particular circumstances
Right place	• Care should be provided in the most appropriate setting • Where possible care should be provided locally (close to home and / or in the community) • Where necessary care should be centralised - this may be required to meet minimum activity thresholds for safety or to ensure compliant rotas
Minimise inequality	• Services should be designed to improve the health outcomes for all and minimise health inequalities • Solutions should not have a disproportionately adverse impact on any specific patient groups
Maximising	• Solutions should deliver efficient and cost effective care by minimising

Principle	Definition
value for the tax payer	the cost of resources used to deliver the intended outcomes • Solutions should seek to optimise the use of existing assets and minimise capital expenditure

It is highly likely that, for some but not all services, there may be more than one option for how the proposed model of care could be implemented. The team of clinical leaders and the Health and Care Executive have therefore developed a draft set of evaluation criteria (see Table 3). Once finalised, these will provide a clear and consistent methodology for how different options are compared with each other.

Table 3: Draft Evaluation Criteria

Criteria	Definition	Sub criteria
Quality	Does the option maintain or improve the quality of care for patients?	• Alignment to national best practice guidelines including clinical standards
		• Impact on patient safety and population health outcomes
		• Impact on patient experience
		• Impact on health inequalities
		• Impact on patient's ability to access services (journey times)
Affordability	Does the option deliver an affordable and financially sustainable solution?	• Options deliver a sustainable income and expenditure position
		• Transition costs including capital expenditure
Sustainability	Will the option enable us to continue to deliver health and care services to the local population for the foreseeable future?	• Ability to recruit and retain sufficient staff with appropriate skills and expertise
		• Extent to which the model provides flexibility for further future increases in demand
Deliverability	Is the option deliverable in a reasonable timeline?	• Stakeholder support
		• Ease and speed of implementation
		• Alignment to local and/or national policies or strategies

We would like your views on the draft design principles and draft evaluation criteria before they are finalised. See page 37 for further details about this.

Summary: We Can Deliver Better Care

- *Integration* is poor, and services are not always designed around the needs of patients, an issue gaining importance as ever more patients have multiple long-term conditions which need to be managed holistically;
- *Capacity and demand* are not well matched across the system. Cambridge University Hospitals and Peterborough & Stamford Trust are both battling capacity constraints for a number of services, whereas Hinchingbrooke has some available capacity which could be better utilised;
- *Recruitment and retention* is a challenge across the area, and by working together to give staff better opportunities and a better work-life balance, we can improve staff satisfaction, thereby lowering dependency on agency workers
- *Health and Wellbeing* opportunities need to be maximised: currently, the system spends the vast majority of its time treating illnesses which can be prevented, or substantially lessened with proactive management and self-care support;
- *Primary care services* are under strain, there is widespread variation in adoption of good practice and in referral rates, and we are a long way from having seamlessly integrated care in the community;
- *People with Mental Health and/or Long-Term Conditions* often receive fragmented, disease-specific services. There is an opportunity to design integrated neighbourhood services which deliver holistic, proactive and coordinated care, meeting both physical and mental health needs;
- *Urgent and Emergency* Care is struggling with demand; the current care model will not be able to sustain high-quality provision of care in the face of inexorable increases in demand. Actions to reduce how many days people spend in hospital due to emergencies, through improved community and primary care preventing admissions and supporting safer discharges, will be essential to allow for the continued sustainability of these services;
- *Maternity and Neonatal Care* is variable; some services are challenged with maintaining safety standards while providing appropriate choice for mothers;
- *Children & Young People's Services* are generally good, but there is a need to increase focus on preventative, community-based approaches in the face of sustainability challenges due physical and workforce capacity constraints;
- *Elective Care* includes some high quality, responsive services, but faces significant rising demand and challenges relating to the knock-on effects of rising emergency care demand
- *Draft Design Principles and Evaluation Criteria* have been developed and we would like your views on them

5. The System's Financial Challenge is Significant and Growing

Our system receives over £1.7 billion[10] each year to pay for NHS services. However, like nearly all health and care systems in the NHS, we are struggling to meet the needs of our local population within our fixed financial budget. In 2015/16 alone, current estimates indicate that we will spend about £150 million more on NHS services than the financial resources we have available – an overspend of about 9%.

While the amount of money that our system receives to pay for NHS services is expected to increase steadily over the next five years (to total more than £2.1 billion by 2020/21), this won't be enough to cover the additional costs of increasing demand for services and rising inflationary costs if the system does not change. The latest projections show that if we do nothing, the total deficit for the system will grow to £480 million by 2020/21. There are many reasons for this, but the main drivers are:

- Rising demand for health and care services due to population growth and 'non-demographic' factors like the prevalence of disease;
- An ageing population with more complex healthcare needs;
- Higher costs from rising inflation

If we don't respond, our organisations will not only incur significant financial losses, but we will also not have enough physical capacity (e.g. hospital beds, operating theatres etc.) to meet the expected levels of demand for hospital care. To build more capacity would require a level of investment in hospital estates that is unlikely to be affordable.

We already have a range of plans in place for 2016/17 to try and reduce the need for expensive hospital care by investing in community, mental health and (in conjunction with the local councils) social care services. Our providers also have plans for 2016/17 to eliminate waste and reduce duplication. In subsequent years, providers are expected to deliver 2% savings each year. The combination of these things is projected to halve the deficit for 2020/21 to £250 million (12% of projected resources). This is the gap we now need to close.

This programme therefore brings the system together with the aim of radically redesigning services in order to create a system which is fit for the future. Each of the Clinical Working Groups within the programme will be learning from the leaders in their field, nationally and internationally, to learn how to improve the efficiency and effectiveness of services. By bringing together patients, clinicians and managers from health and social care services, the teams will be able to identify ways of redesigning services that improve their cost-effectiveness and remove areas of

[10] 2015/16 Cambridgeshire and Peterborough CCG resource allocation plus income received by NHS provider organisations from other sources

duplication or waste. We can rebalance the system to better utilise existing resources by working together more effectively.

We will need to identify mechanisms for the delivery of safe, high-quality care, provided locally where possible, within the financial resources we will have available. Otherwise, as the Five Year Forward View states[11]:

"...the result will be some combination of worse services, fewer staff, deficits, and restrictions on new treatments."

Summary: The System's Financial Challenge is Significant and Growing

- The total healthcare deficit for Cambridgeshire & Peterborough is about £150 million and forecast to grow to about £250 million if the system does not transform itself radically;
- There are significant opportunities to improve the financial position, which will require the system to work together effectively

[11] https://www.england.nhs.uk/ourwork/futurenhs/ page 7

6. The Sustainability and Transformation Programme

6.1. Organisation and Governance

We, the leaders of the NHS organisations and officers from the two local authorities in Cambridgeshire & Peterborough, have come together and established a Sustainability and Transformation Programme (*Fit for the Future*) to develop solutions to the challenges we are facing. This programme is different from previous attempts at transformation: it is focused on the system as a whole, rather than on individual organisations or services. It is designed to be clinically-led and highly collaborative.

The core of the transformation team is a Clinical Advisory Group, supported by 5 clinical work-streams: Urgent and Emergency Care, Maternity and Neonatal, Children & Young People, Elective Care, and Proactive Care and Prevention (including Primary Care). Each of these has a formally appointed clinical chair and involves a range of clinicians (including consultants, nurses and midwives), as well as patient representatives, public health representatives and social care representatives.

Overseeing the Clinical Advisory Group is a Health and Care Executive, comprised of the chief executives of each of the NHS organisations in Cambridgeshire & Peterborough, and the joint Chief Executive of Cambridgeshire County and Peterborough City Councils. We meet on a fortnightly basis, to collaboratively resolve issues facing the system as a whole. Together, we are responsible for the high-quality functioning of the health system, and are leading the programme of change. We are engaging with local Health and Wellbeing Boards and democratic structures.

Finally, the programme is supported by the national regulators: NHS England and NHS Improvement[12]. The national bodies make sure the transformation programme is on track, and encourage us to think beyond our organisational based perspectives.

6.2. The Scope of Work

Over the next 4-6 months we, led by our team of clinical leaders, will be working to identify the core issues, and potential solutions, to the challenges faced by our system. We will look to identify short-term opportunities to improve cost-effectiveness of services, as well as to identify options to create a sustainable Cambridgeshire and Peterborough care model for 2020 and beyond.

In addition to identifying opportunities to improve care delivery, we are also exploring the full range of non-clinical services for collaboration. For instance:

[12] Officially formed on the 1/4/2016 through the merger of Monitor and the Trust Development Authority

- Hinchingbrooke and Peterborough and Stamford Hospitals are currently reviewing a number of opportunities to work more closely. A joint team is currently reviewing potential organisational forms for the two hospitals, as well as finding ways to join up their management teams and back-office functions;
- A team is looking at improving the use of estates across the system, focusing on primary and community estate, as well as Hinchingbrooke hospital. It is undertaking a detailed assessment of health properties, assessing vacant space and ensuring solutions meet future system needs;
- An ambitious ‘health campus’ is being considered for the Hinchingbrooke site, to better utilise existing estate in meeting the needs of Huntingdon residents. Current plans include building staff and student residences, an ‘elderly care village’ with supported housing, and a medi-hotel to support patients receiving elective care. This supports national policy to better use public sector estate, work more collaboratively across the public sector, and support the ‘healthy towns’ initiative (NHS England, Healthy New Towns);
- Papworth Hospital will be moving to the Cambridge Biomedical Campus in 2018 in order to overcome the challenges of the current Papworth hospital site, such as out-of-date buildings and capacity constraints. This will enable Papworth Hospital to provide services to patients from a purpose-built hospital, and work more closely with Addenbrooke’s.

7. Get Involved and Learn More

We are committed to the comprehensive engagement of patients, the public and key stakeholders in all aspects of the programme. Patient and public involvement representatives are already involved in the programme, on the Clinical Advisory Group and on each of the Clinical Working Groups. We want to ensure that the care models being designed by the teams reflect the concerns and needs of the public.

Additionally, we are organising a range of activities, beyond the involvement of clinicians and patients directly in the transformation programme, for local people – residents, patients and staff – to get involved. We are keen to hear everyone's views as we seek to agree a shared understanding of the need for the system to change, and to develop a shared vision for the future.

At the moment, you've got three ways to tell us what you think:

1. There are five Public Involvement Assemblies organised in March – please see our website to find out more – and please contact us if you'd like to join one of these;
2. If you are part of a local interest group and would like us to come and talk to you about this programme, please contact us;
3. Please contact us at any time to provide feedback or request additional information

To contact us, please either send an email to capccgengagement@nhs.net or call us on 01223 725304. To find out more, please see our website: http://www.cambridgeshireandpeterboroughccg.nhs.uk/STP/.

Informed by your feedback and your ideas, the Clinical Working Groups will soon begin designing solutions. We will present their proposals to you in the summer, to discuss and refine together. We will then hold a formal public consultation on any proposed changes starting at the end of this year.

In the meantime, we would very much like your thoughts and feedback on this document so that we can incorporate as many views as possible as we take this work forward. We have set out below a specific list of questions we have, but we would also be grateful for any general comments you would like to give us.

Questions:

1. Do you think the document explains sufficiently the need for the system to change? If not, what more information would you like to see?
2. Do you agree that the system needs to change? If not, why do you think it should stay the same as it is now?
3. What do you think of our overall vision (grey box, pg. 12), and our vision for different types of care (grey boxes on pgs. 17-28)? How might they be improved?
4. What do you think of the draft design principles set out in the document? Are there any changes you would like to suggest? (Table 2, pg. 29)
5. What do you think of the draft evaluation criteria set out in the document? Are there any changes you would like to suggest? (Table 3, page 30)
6. Are there any general comments you would like to make about this programme and what it is aiming to do?

8. Annex

8.1. Glossary of Terms

A&E	Accident and Emergency Department
Ambulatory Care	Care provided on an outpatient basis, including diagnosis, observation, consultation, treatment, intervention, and rehabilitation services
Ambulatory Care Sensitive Conditions	Conditions that when managed appropriately do not require a patient to be admitted to hospital
Acute Care	This is usually provided in a hospital setting. Where people receive specialised support in an emergency or following referral for surgery, complex tests or other things that cannot be done in the community. Acute care usually provides treatment for a short period, until the person is well enough to be supported in the community again.
Atrial Fibrillation	A heart condition that causes an irregular and often abnormally fast heart rate
Clinical Advisory Group	The Clinical Advisory Group is the group of clinical leaders who will lead the Sustainability and Transformation Programme. They will oversee all decisions and recommendations in relation to this programme.
Clinical Working Group	A Clinical Working Group is a collection of local care professionals from different services and providers, who are brought together to define models of care and are unconstrained by current organisational and professional boundaries
Care model	The care model describes how health and care services are currently provided, and how the system operates
Care Quality Commission	Makes sure hospitals, care homes, dental and GP surgeries, and all other care services in England provide people with safe, effective, compassionate and high quality care, and encourages them to make improvements www.cqc.org.uk.
Carer	A carer - can be formal or informal. Some people have both. In this document the term carer is used to mean an informal carer - a family member or friend who is actively engaged in supporting a person by regular contact and helping with the activities of daily living.
CCG	Clinical Commissioning Group - Organisation responsible for planning, organising and purchasing NHS-funded healthcare for residents. A CCG is clinically-led, meaning that decisions about local health services are made by local doctors and health professionals, alongside

	patients.
CCS	Cambridgeshire Community Services NHS Trust
CHD	Coronary Heart Disease
Clinician	Someone who provides healthcare and treatment to patients, such as a doctor, nurse, psychiatrist or psychologist.
Co-morbidity	The existence of one or more additional disorders/illness co-occurring with a primary disease or disorder or additional diseases or disorders occurring as an effect from the primary disease or disorder
Community Care	Network of services provided by local authority social service departments, the NHS and volunteers, designed to keep people independent and able to live in the community rather than in institutional care; for example, older people, people with physical disabilities, learning disabilities or mental health problems. Services are often provided in the home.
COPD / Chronic Obstructive Pulmonary Disease	The name for a collection of lung diseases, including chronic bronchitis, emphysema and chronic obstructive airways disease. People with COPD have trouble breathing in and out, due to long-term damage to the lungs.
CPFT	Cambridgeshire and Peterborough NHS Foundation Trust – provides mental health services, care for older people and adult community services
CQC / Care Quality Commission	Makes sure hospitals, care homes, dental and GP surgeries, and all other care services in England provide people with safe, effective, compassionate and high quality care, and encourages them to make improvements www.cqc.org.uk.
CUHFT	Cambridge University Hospitals NHS Foundation Trust (comprising both Addenbrookes and Rosie Hospitals)
Elective care	Pre-arranged, non-emergency care, including scheduled operations
ENT	Ear Nose and Throat
GP Federation	A group of GP practices that come together to share responsibility for a range of functions
Healthwatch	Healthwatch England is the national consumer champion in health and care. www.healthwatch.co.uk
Health and Care Executive	The Health and Care executive comprises all of the chief executives of all of the NHS organisations in Cambridgeshire & Peterborough, and representatives of the local authorities. This group is responsible for the high-quality functioning of the local health system.

HHCT	Hinchingbrooke Health Care NHS Trust
Hypertension	Abnormally high blood pressure
IAPT	Increasing Access to Psychological Therapies
JET	Joint Emergency Team- a multiprofessional team of nurses, occupational therapists, physiotherapists and social workers that prevent unnecessary hospital admissions
JSNA	Joint Strategic Needs Assessment. JSNAs are local assessments of current and future health and social care needs that could be met by the local authority, CCGs, or the NHS Commissioning Board. They are produced by health and wellbeing boards, and are unique to each local area.
LHE	Local health economy
LTCs	Long Term Conditions
Monitor	The sector regulator for health services in England
NICE	The National Institute for Health and Care Excellence
NHS England	NHS England leads the National Health Service (NHS) in England
Outpatient procedure	Procedure that is carried out without admitting the patient to hospital and is performed in an appointment style clinic
Pathway	Describes the route that a patient will take from their first contact with an NHS member of staff to the completion of their treatment.
Primary Care	The initial contact for many people when they develop a health problem. The term primary care covers GP services, dentists, pharmacists, optometrists and ophthalmic medical practitioners. NHS Direct and NHS walk-in centres are also primary care services.
PSHFT	Peterborough and Stamford Hospitals NHS Foundation Trust
Public Health England	An executive agency of the Department of Health in the United Kingdom that is concerned with improving the health of the population rather than treating the diseases of individual patients
QOF	Quality Outcomes Framework-this is a system for the performance management and payment of general practitioners in the NHS
RCPCH	Royal College of Paediatrics and Child Health
RTT	Referral to Treatment Time- the NHS has a target that 92% of patients wait no more than 18 weeks between referral and treatment for services
Social Care	The range of services that support the most vulnerable people in

	society to carry on in their daily lives. This can encompass being cared for in a care home or being provided with care in one's own home by a domiciliary care worker. The care provided will usually be personal care and will include matters like dressing and washing. It may also include help with functions like bathing, toileting and feeding
STP	Sustainability Transformation Programme- a programme set up to examine how the system might need to change in order to meet those standards
Trust Development Authority	The NHS Trust Development Authority provides support, oversight and governance for all NHS Trusts
Telehealth	Technology to assist users in monitoring of their own health such as equipment to measure blood pressure, blood glucose and weight.
Telecare	Technology and alarm systems for use in the home to help ensure users are safe such as personal alarm systems, pressure mats or door sensors
Urgent and emergency care	Care for people needing medical advice, diagnosis and/or treatment quickly and unexpectedly

8.2. Who We Are

The Cambridgeshire and Peterborough health system serves a population of over 900,000 across Cambridgeshire, Peterborough and parts of Hertfordshire and Northamptonshire.

There are a number of organisations that are responsible for planning and purchasing health and care services on behalf of the population of Cambridgeshire and Peterborough. Most health services are commissioned by Cambridgeshire and

Peterborough CCG; a clinically led organisation made up of GPs, hospital consultant, nurse and lay representatives, responsible for planning, designing and buying health and care services for the population of Cambridgeshire and Peterborough.

NHS England supports Cambridgeshire and Peterborough to make decisions about the services they commission by setting priorities and direction for the NHS. NHS England also commissions the contracts for GPs, pharmacists, and dentists.

Cambridgeshire County Council and Peterborough City Council both provide local government services and help look after the local area to improve the lives of people. This includes making important decisions about the way that care services are provided in Cambridgeshire and Peterborough.

The main providers of health services in Cambridgeshire and Peterborough are:

- **Cambridge University Hospitals NHS Foundation Trust** which encompasses Addenbrooke's and Rosie hospitals;
- **Peterborough and Stamford Hospitals NHS Foundation Trust** which encompasses Peterborough City hospital and Stamford Hospital;
- **Hinchingbrooke Health Care Trust;**
- **Cambridgeshire and Peterborough NHS Foundation Trust** which provides mental health services, care for older people and adult community services;
- **Cambridgeshire Community Services NHS Trust;**
- **Papworth Hospital NHS Foundation Trust** which provides specialist cardiothoracic hospital;
- **East of England Ambulance NHS Trust**

More information on these organisations can be found below:

Cambridge University Hospital NHS Foundation Trust

Cambridge University Hospitals NHS Foundation Trust comprises Addenbrooke's Hospital and the Rosie Hospital in Cambridge. The Trust provides accessible high-quality healthcare for the local people of Cambridge, together with specialist services, dealing with rare or complex conditions, for a regional, national and international population. The Trust is recognised as a centre of excellence and innovation with many of the hospital specialists being leaders in their field.

Peterborough and Stamford Hospitals NHS Foundation Trust

Peterborough and Stamford Hospitals NHS Foundation Trust serves a growing catchment population from across Peterborough, Cambridgeshire, Lincolnshire, Rutland, Leicestershire, Northamptonshire and Norfolk. The Trust's 4,000+ staff deliver acute healthcare services from the 623-bed, state-of-the-art Peterborough City Hospital and from the highly-regarded Stamford Hospital in Lincolnshire, which has 22 inpatient beds.

Hinchingbrooke Health Care NHS Trust

Hinchingbrooke Health Care NHS Trust is a district general hospital providing health care for the people of Huntingdonshire and surrounding areas. More than 160,000 people rely on it and its full range of acute hospital services. Hinchingbrooke is a member of Cambridge University Health Partners supporting excellence in healthcare, research and education for the population of Cambridgeshire and beyond.

Papworth Hospital NHS Foundation Trust

Papworth Hospital includes the country's largest heart and lung transplant centre, the national centre for pulmonary endarterectomy and it is a national centre for a range of other specialist services. Papworth Hospital is a member of Cambridge University Health Partners, a partnership between one of the world's leading Universities and three NHS Foundation Trusts.

Cambridgeshire and Peterborough NHS Foundation Trust

Cambridgeshire and Peterborough NHS Foundation Trust is a health and social care organisation, providing integrated community, mental health and learning disability services, across Cambridgeshire and Peterborough, and children's community services in Peterborough. It is a University of Cambridge Teaching Trust and member of Cambridge University Health Partners, working together with the University of Cambridge Clinical School.

Cambridgeshire Community Services NHS Trust

Cambridgeshire Community Services NHS Trust provides a range of high quality community based services for children and adults across Cambridgeshire, Luton, Norfolk, Peterborough and Suffolk. It is working closely with a range of partners to redesign and deliver integrated services to meet the unique needs of the diverse communities we serve.

The East of England Ambulance NHS Trust

The East of England Ambulance Service NHS Trust (EEAST) covers the six counties in the east of England - Bedfordshire, Hertfordshire, Essex, Norfolk, Suffolk and Cambridgeshire. It provides a range of services, but is best known for the 999 emergency service. Its services are tailored to meet each community's differing environmental and medical needs.

NHS

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

Cambridgeshire County Council

PETERBOROUGH CITY COUNCIL

Agenda Item No: 11

CLINICAL COMMISSIONING GROUP OPERATIONAL PLANNING FOR THE FINANCIAL YEAR 2016-17

To: Health and Wellbeing Board

Date: 17 March 2016

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

1.0 PURPOSE

1.1 The purpose of this report is to brief the Board on:

a) The changing context for planning
b) Progress being made with drafting an Operational Plan for 2016/17

2.0 THE CONTEXT FOR PLANNING

2.1 The additional funding allocated via the Spending Review will support the NHS to implement the Five Year Forward View and deliver financial balance and core access / quality standards. The new planning guidance published in December 2015 signals a major change to planning in the NHS, moving from single-year organisation-based plans to multi-year place-based plans.

2.2 During the transition to multi-year system planning, we are required to produce two separate but connected plans:

- A five year Sustainability and Transformation Plan, place-based and driving the NHS Five Year Forward View
- A one year Operational Plan for 2016/17, organisation-based but consistent with the emerging Sustainability and Transformation Plan

2.3 Each health and care system should come together to create its own ambitious local blueprint for accelerating implementation of the NHS Five Year Forward View. The Sustainability and Transformation Plan will be an umbrella plan comprising a number of different specific delivery plans. Sustainability and Transformation Plans must include all areas of CCG and NHS England commissioned activity and better integration with local authority services.

2.4 Sustainability and Transformation Plans are intended to reflect the work of a health and care system which is active, has strong local leadership and is engaged with its local community. For the first time, central funding will be available to support long term system planning. Sustainability and Transformation Plans will be the single route to acceptance on programmes with transformational funding for 2017/18 onwards. For 2016/17 only, limited available transformational funding will be available through separate processes. The most compelling Sustainability and Transformation Plans will attract the earliest additional

funding from April 2017. First draft plans must be ready for submission to NHS England by the end of June 2016.

2.5 As in previous years, the one year Operational Plan will be produced by the CCG. The final draft plan must be ready for submission to NHS England on 11 April 2016.

2.6 Further detailed guidance on the content and assurance process for Sustainability and Transformation Plans should be available shortly. Where appropriate, the CCG Operational Plan will contribute to the content of the Sustainability and Transformation Plan.

3.0 CURRENT POSITION

3.1 Development of the Sustainability and Transformation Plan and the CCG Operational Plan

3.1.1 Work on producing both plans is underway. As we progress through this transitional phase of planning, it will be critical to ensure that there is good alignment between the longer-term Sustainability and Transformation Plan and the shorter-term, Operational Plan. The team working on the Sustainability and Transformation Plan have established a time-limited working group to oversee this process and to address any issues which may arise.

3.1.2 One of the key requisites for both plans is to ensure that there is a structured and consistent approach to guiding and implementing service transformation within the Cambridgeshire and Peterborough System.

3.1.3 Service transformation will be guided by a Clinical Advisory Group, whose remit includes developing a clinical vision and strategy for Cambridgeshire and Peterborough, providing clinical assurance for all proposals generated by the Clinical Working Groups and developing a set of coherent and sustainable medium term options for service configuration.

3.1.4 The detailed planning and implementation of service transformation programmes will be carried out by several clinical working groups who will cover:

- Urgent and emergency care
- Elective (planned) care
- Proactive care and prevention
- Maternity and neonatal services
- Children and young people

3.1.5 Clinical leaders and management support are being recruited to the clinical working groups where needed. The Board will be kept informed as this work progresses and will have an opportunity to contribute to the longer term plan.

3.2 Operational Plan 2016/17

3.2.1 Plans should demonstrate how we will:

a) Reconcile finance and activity plans and achieve financial balance
b) Contribute to efficiency savings
c) Deliver the national priorities set out in the guidance

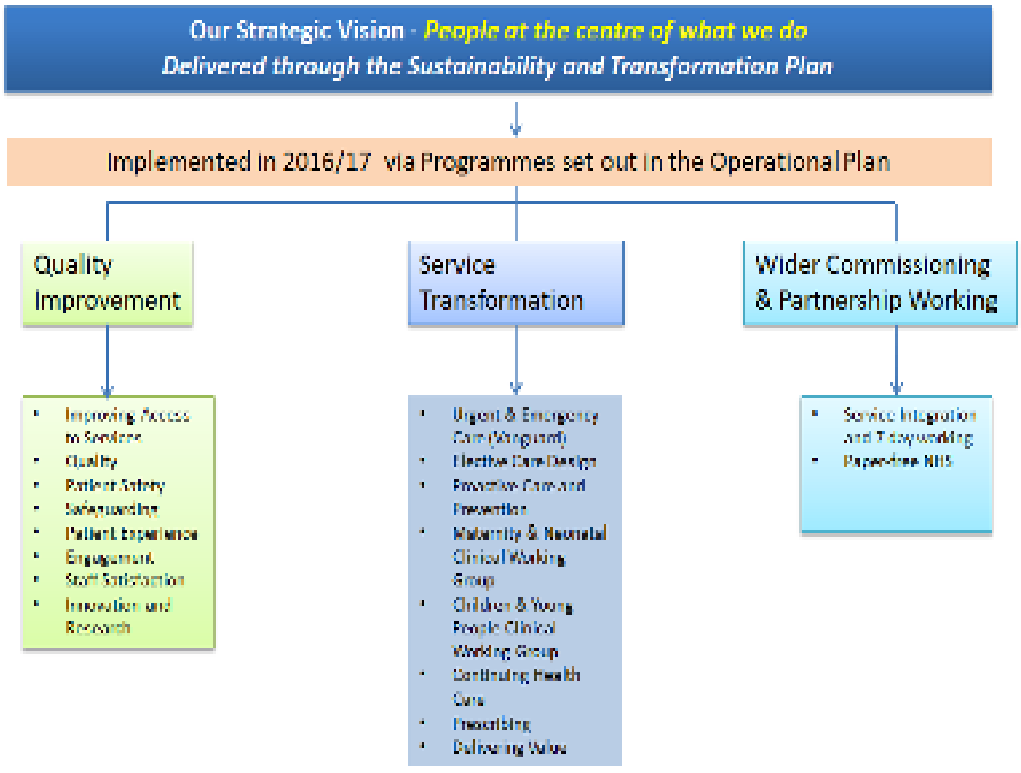
d) Maintain and improve quality and safety for patients
e) Manage risks across local health economy plans
f) Make the links with and support emerging Sustainability and Transformation Plans

3.2.2 The CCG received an increase in resource of 4.7% for 2016/17. A range of business rules are set out in the national planning guidance which CCGs should take account of during the operational planning process, including:

- Achieve a 1% financial surplus – at the very least, CCGs must deliver an in-year break-even position
- Plan to spend 1% of resources non-recurrently. Non-recurrent resources must be uncommitted at the beginning of the financial year and will be released progressively folowing agreement with NHS England
- Hold a contingency of 0.5%
- Continue to invest in mental health services – to match at least the overall expenditure increase
- Agree a joint Better Care Fund Plan with local authorities

3.2.3 The CCG is forecasting a deficit position of £8.4m at the end of the 2015/16 financial year. The first aim will be to return to in-year financial balance in 2016/17. In order to achieve this, the CCG will need to deliver QIPP savings in the region of £44m, which equates to 4.5% of the programme allocation.

3.2.4 We have structured the draft Operational Plan to match, as closely as possible, the way in which service transformation work will be organised in future. In addition, the Operational Plan will cover other areas such as the key operational priorities set by NHS England for 2016/17. Figure 1 below gives an overview of the current structure of the draft Operational Plan.



3.2.5 The content of the draft plan was informed and shaped by the 2016/17 planning intentions which were considered by the Board on 19 November 2015. Since publication of the planning intentions, the working groups have been refining their ideas and proposals for change in conjunction with relevant providers and stakeholders.

3.2.6 Some of the priorities set out in the national planning guidance are more strategic in nature and will require several years to achieve, for example, the requirement to return the System to financial balance. Consequently, they will be more relevant for the Sustainability and Transformation Plan; the planning team will set out how they can be achieved over the longer term.

3.2.7 One of the important areas to be covered by the Operational Plan is the wider commissioning and partnership agenda. The development of the Better Care Fund Plan last year provided good insight into the potential for greater service integration with health and social care working very closely together. Learning from last year, we have established a Programme Integration Team comprising representatives from the CCG, Cambridgeshire County Council and Peterborough City Council. The team's remit is to map all relevant initiatives from our clinical working groups, Better Care Fund project work and contract leads to ensure that we identify where projects and initiatives link with each other and to plan in a fully integrated way for 2016/17 and beyond. This work includes the further development of seven day services. A separate Better Care Fund Plan document is currently being developed; the detail around this will be covered as a standalone update at the Cambridgshire Health and Wellbeing Board.

3.2.8 A first working draft of the Operational Plan was submitted to NHS England for internal assurance review on 8 February 2016. It is a work in progress and its content will change in the light of formal content assurance feedback from NHS England and of the work that is currently on-going to agree service contracts for the new financial year.

3.2.9 NHS England requires submission of a second working draft plan on 2 March 2016 and that draft will undergo further content assurance checks. Final submission of the plan is due on 11 April 2016.

4.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

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

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

5.0 IMPLICATIONS

5.1 There are no known implications arising from this report.

6.0 RECOMMENDATION/DECISION REQUIRED

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

Source Documents	Location
NHS Shared Planning Guidance	https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/
Understanding Today, Designing Tomorrow; Change Document 2015/16 to 2019/20	http://www.cambridgeshireandpeterboroughccg.nhs.uk/five-year-plan.htm

Sarah Shuttlewood, Director of Contracting, Performance and Delivery
16 February 2016

Agenda Item No: 10

PLANNING FOR THE BETTER CARE FUND 2016-17

To: Health and Wellbeing Board

Date: 17th March 2016

From: Adrian Loades, Executive Director – Children, Families and Adults Services

Tracy Dowling, Chief Operating Officer, Cambridgeshire and Peterborough CCG

1.0 PURPOSE

1.1 The purpose of this report is to provide Health and Wellbeing Board members with an update on the Better Care Fund (BCF) planning process for 2016/17 and request input to the Cambridgeshire BCF plan.

2.0 BACKGROUND

2.1 The BCF was created to form a joint budget to help health and social care services to work more closely together in each Health and Wellbeing Board area. The BCF came into effect in April 2015 and in Cambridgeshire the BCF totalled £37.7 million for 2015/16, which was brought into the BCF from existing health and social care budgets. The BCF is designed to support better integration of health and social care to improve services for the most vulnerable people in the community; provide better support for carers and create efficiencies. In the first year of BCF most funding remained in community health and social care budgets, particularly supporting the Clinical Commissioning Group (CCG)'s Older People and Adult Community Services (OPACS) contract; and a smaller amount of funding has been focused on medium term projects that will begin to support our shared outcomes.

2.2 Following significant delays, Better Care Fund Technical Guidance was issued on 23 February 2016. The guidance describes the process for developing and agreeing Better Care Fund plans in each local area, and sets out the changes to the Better Care Fund that are being made in 2016/17. A link to the guidance is provided below. Given the delays in publication of the guidance, the timescales for developing a new plan are short:

23 February	Technical guidance issued
2 March	First submission; part 2 only, including Budget lines and Performance metrics
21 March	Full submission: as above with a narrative plan updating the 2015/16 BCF plan
25 April	Final submission, with Health and Wellbeing Board approval.

2.3 The Council and CCG submitted a BCF return as requested on 2 March as requested; this is attached as appendix A. However as the detail of the plan is still under discussion, no specific finance or performance details were included. Work on the draft BCF Plan is ongoing. Officers have agreed that the week commencing 14 March will be used as a period of intensive work on developing the BCF plan. A draft Plan will be presented to Health and Wellbeing Board members at the meeting, accompanied by a verbal update at the meeting.

3.0 CHANGES TO THE BETTER CARE FUND IN 2016/17

3.1 Broadly speaking, the overall direction for the Better Care Fund remains the same moving into 2016/17. However, there are some significant changes to funding that will affect our planning:

- There is an overall increase in the CCG's minimum revenue contribution to the Better Care Fund, which increases from £34,451k (2015/16) to £35,655k (2016/17)
- There is a significant increase in the Disabled Facilities Grant (capital) awarded by District Councils, which increases from £1,924k (2015/16) to £3,479k (2016/17)
- There is a corresponding drop in Adult Social Care capital, with the County Council's Adult Social Care Capital Grant of £1,294k being removed.

3.2 In addition, there are some changes to the policy approach for 2016/17:

- The performance-related element of the BCF (£836k in 2015/16) mandating a reduction in non-elective admissions has been removed; although the metric remains and a new provision for a 'risk share' arrangement around non-elective admissions has been created.
- Local areas are now required to agree a shared plan for reducing Delayed Transfers of Care (DTOC) from hospital.
- Longer term there is a requirement for local areas to work towards integrated health and social care services by 2020.

3.3 Cambridgeshire's 2015/16 plan emphasised a shift in activity away from acute hospitals and long-term social care towards support that is provided in the community and focused on keeping people independent. It is proposed that this remains the right approach for 2016/17. However, as discussed at the last Health and Wellbeing Board on 12 January 2015, the Council and CCG have agreed that the budget for 2016/17 should allow more transparent monitoring of the BCF. Therefore the plan should be more specific about what will be delivered; how each budget line is spent; and how everything funded will contribute towards the performance metrics described in the BCF plan. It is also expected being more specific as to what services are being funded will create opportunities for the joint commissioning and/or joint transformation of those services with a view to improving outcomes and/or reducing costs.

3.4 Discussions are ongoing about financial allocations in light of significant financial pressures across the local system. The County Council and Clinical Commissioning Group have not yet agreed financial allocations for the BCF in 2016/17 for inclusion in the plan. Both partners are continuing discussions and are seeking to work together to agree a position in time for the next submission on 21 March.

3.5 Health and Wellbeing Board Members will be invited to comment on the draft plan at the meeting before submission on the 21st March; there will be a further opportunity for the Health and Wellbeing Board to comment at an extraordinary meeting of the Board being scheduled for April.

4.0 RECOMMENDATIONS

4.1 Based on the report, the draft plan to be tabled, and the verbal update to be provided at the meeting, the Board is asked to comment on the Better Care Fund plan and approach for 2016/17.

Source Documents	**Location**
Better Care Fund Technical Guidance	https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

Template for BCF submission 1: due on 02 March 2016

Better Care Fund 2016-17 Planning Template

Sheet: 1. Cover Sheet

The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. The selection of your Health and Wellbeing Board (HWB) on this sheet also then ensures that the correct data is prepopulated through the rest of the template.

On the cover sheet please enter the following information:
- The Health and Wellbeing Board;
- The name of the lead contact who has completed the report, with their email address and contact number for use in resolving any queries regarding the return;
- The name of the lead officer who has signed off the report on behalf of the CCGs and Local Authority in the HWB area. Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 6 cells are green should the template be sent to england.bettercaresupport@nhs.net

Health and Well Being Board	**Cambridgeshire**
completed by:	Geoff Hinkins
E-Mail:	geoff.hinkins@cambridgeshire.gov.uk
Contact Number:	01223 699679
Who has signed off the report on behalf of the Health and Well Being Board:	Adrian Loades

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

	No. of questions answered
1. Cover	5
2. Summary and confirmations	0
3. HWB Funding Sources	13
4. HWB Expenditure Plan	
5. HWB Metrics	12
6. National Conditions	9

Template for BCF submission 1: due on 02 March 2016

Sheet: 2. Summary of Health and Well-Being Board 2016/17 Planning Template

Selected Health and Well Being Board:

Cambridgeshire

Data Submission Period:

2016/17

2. Summary and confirmations

This sheet summarises information provided on sheets 2 to 6, and allows for confirmation of the amount of funding identified for supporting social care and any funds ring-fenced as part of risk sharing arrangement. To do this, there are 2 cells where data can be input.

On this tab please enter the following information:
- In cell E37 ,please confirm the amount allocated for ongoing support for adult social care. This may differ from the summary of HWB expenditure on social care which has been calculated from information provided in the 'HWB Expenditure Plan' tab. If this is the case then cell F37 will turn yellow. Please use this to indicate the reason for any variance;
- In cell F47 please indicate the total value of funding held as a contingency as part of local risk share, if one if being put in place. For guidance on instances when this may be appropriate please consult the full BCF Planning Requirements document. Cell F44 shows the HWB share of the national £1bn that is to be used as set out in national condition vii. Cell F45 shows the value of investment in NHS Commissioned Out of Hospital Services, as calculated from the 'HWB Expenditure Plan' tab. Cell F49 will show any potential shortfall in meeting the financial requirements of the condition. The rest of this tab will be populated from the information provided elsewhere within the template, and provides a useful printable summary of the return.

3. HWB Funding Sources

	Gross Contribution
Total Local Authority Contribution	£3,478,866
Total Minimum CCG Contribution	£35,655,499
Total Additional CCG Contribution	£0
Total BCF pooled budget for 2016-17	**£39,134,365**

Specific funding requirements for 2016-17	Select a response to the questions in column B
1. Is there agreement about the use of the Disabled Facilities Grant, and arrangements in place for the transfer of funds to the local housing authority?	No - in development
2. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified?	No - in development
3. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	No - in development
4. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	No - in development

4. HWB Expenditure Plan

Summary of BCF Expenditure

	Expenditure
Acute	£0
Mental Health	£0
Community Health	£0
Continuing Care	£0

Please confirm the amount allocated for the protection of adult social care	If the figure in cell E37 differs to the figure in cell C37, please indicate the reason for the

Primary Care	£0
Social Care	£0
Other	£0
Total	**£0**

Expenditure	variance.

Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool

	Expenditure
Mental Health	#VALUE!
Community Health	#VALUE!
Continuing Care	#VALUE!
Primary Care	#VALUE!
Social Care	#VALUE!
Other	#VALUE!
Total	**#VALUE!**

BCF revenue funding from CCGs ring-fenced for NHS out of hospital commissioned services/risk share

	Fund
Local share of ring-fenced funding	£10,132,282
Total value of NHS commissioned out of hospital services spend from minimum pool	#VALUE!
Total value of funding held as contingency as part of local risk share to ensure value to the NHS	
Balance (+/-)	**#VALUE!**

5. HWB Metrics

5.1 HWB NEA Activity Plan

	Q1	Q2	Q3	Q4	Total
Total HWB Planned Non-Elective Admissions	13,967	13,646	14,867	14,134	56,614
HWB Quarterly Additional Reduction Figure	0	0	0	0	0
HWB NEA Plan (after reduction)	13,967	13,646	14,867	14,134	56,614
Additional NEA reduction delivered through the BCF					£0

5.2 Residential Admissions

		Planned 16/17
Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	0.0

5.3 Reablement

		Planned 16/17
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	Annual %	

5.4 Delayed Transfers of Care

Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+).	Quarterly rate	Q1 (Apr 16 - Jun 16)	Q2 (Jul 16 - Sep 16)	Q3 (Oct 16 - Dec 16)	Q4 (Jan 17 - Mar 17)
		0.0	0.0	0.0	0.0

5.5 Local performance metric (as described in your approved BCF plan / Q1 return)

	Metric Value Planned 16/17
The proportion of adults (aged 18+) receiving long-term social care (per 100,000 of population)	0

5.6 Local defined patient experience metric (as described in your approved BCF plan / Q1 return)

	Metric Value Planned 16/17
Friends and Family Test - Inpatient - % that would recommend NHS service received to friends and family	93

6. National Conditions

National Conditions For The Better Care Fund 2016-17	**Please Select (Yes, No or No - plan in place)**
1) Plans to be jointly agreed	No - in development
2) Maintain provision of social care services (not spending)	No - in development
3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	No - in development
4) Better data sharing between health and social care, based on the NHS number	No - in development
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	No - in development
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	No - in development
7) Agreement to invest in NHS commissioned out-of-hospital services	No - in development
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	No - in development

Template for BCF submission 1: due on 02 March 2016

Sheet: 3. Health and Well-Being Board Funding Sources

Selected Health and Well Being Board:

Cambridgeshire

Data Submission Period:

2016/17

3. HWB Funding Sources

This sheet should be used to set out all funding contributions to the Health and Wellbeing Board's Better Care Fund plan and pooled budget for 2016-17. It will be pre-populated with the minimum CCG contributions to the Fund in 2016/17, as confirmed within the BCF Allocations spreadsheet. https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan

These cannot be changed. The sheet also requests a number of confirmations in regard to the funding that is made available through the BCF for specific purposes.
On this tab please enter the following information:
- Please use rows 16-25 to detail Local Authority funding contributions by selecting the relevant authorities and then entering the values of the contributions in column C. This should include all mandatory transfers made via local authorities, as set out in the BCF Allocations spreadsheet, and any additional local authority contributions. There is a comment box in column E to detail how contributions are made up or to allow contributions from an LA to split by funding source or purpose if helpful. Please note, only contributions assigned to a Local Authority will be included in the 'Total Local Authority Contribution' figure.
- Please use cell C42 to indicate whether any additional CCG contributions are being made. If 'Yes' is selected then rows 45 to 54 will turn yellow and can be used to detail all additional CCG contributions to the fund by selecting the CCG from the drop down boxes in column B and enter the values of the contributions in column C. There is a comment box in column E to detail how contributions are made up or any other useful information relating to the contribution. Please note, only contributions assigned to an additional CCG will be included in the 'Total Additional CCG Contribution' figure. - Cell C57 then calculates the total funding for the Health and Wellbeing Board, with a comparison to the 2015-16 funding levels set out below. - Please use the comment box in cell B61 to add any further narrative around your funding contributions for 2016-17, for example to set out the driver behind any change in the amount being pooled.The final section on this sheet then sets out four specific funding requirements and requests confirmation as to the progress made in agreeing how these are being met locally - by selecting either 'Yes', 'No' or 'No - in development' in response to each question. 'Yes' should be used when the funding requirement has been met. 'No - in development' should be used when the requirement is not currently agreed but a plan is in development to meet this through the development of your BCF plan for 2016-17. 'No' should be used to indicate that there is currently no agreement in place for meeting this funding requirement and this is unlikely to be agreed before the plan is finalised.
- Please use column C to respond to the question from the dropdown options;
- Please detail in the comments box in row D issues and/or actions that are being taken to meet the funding requirement, or any other relevant information.

Local Authority Contribution(s)	Gross Contribution	Comments - please use this box clarify any specific uses or sources of funding
Cambridgeshire	£3,478,866	Capital contribution from Cambridgeshire County Council
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
Total Local Authority Contribution	**£3,478,866**	

CCG Minimum Contribution	Gross Contribution
NHS Cambridgeshire and Peterborough CCG	£35,655,499
Total Minimum CCG Contribution	**£35,655,499**

Are any additional CCG Contributions being made? If yes please detail below;	No

Additional CCG Contribution	Gross Contribution
<Please Select CCG>	
<Please Select CCG>	
<Please Select CCG>	
<Please Select CCG>	
<Please Select CCG>	
<Please Select CCG>	
<Please Select CCG>	
<Please Select CCG>	
<Please Select CCG>	
<Please Select CCG>	
Total Additional CCG Contribution	**£0**

Comments - please use this box clarify any specific uses or sources of funding

Total BCF pooled budget for 2016-17	**£39,134,365**

Funding Contributions Narrative

The final section on this sheet then sets out four specific funding requirements and requests confirmation as to the progress made in agreeing how these are being met locally - by selecting either 'Yes', 'No' or 'No - in development' in response to each question. 'Yes' should be used when the funding requirement has been met. 'No - in development' should be used when the requirement is not currently agreed but a plan is in development to meet this through the development of your BCF plan for 2016-17. 'No' should be used to indicate that there is currently no agreement in place for meeting this funding requirement and this is unlikely to be agreed before the plan is finalised.
- Please use column C to respond to the question from the dropdown options;
- Please detail in the comments box in row D issues and/or actions that are being taken to meet the funding requirement, or any other relevant information.

Specific funding requirements for 2016-17	**Select a response to the questions in column B**	**Please detail in the comments box issues and/or actions that are being taken to meet the condition, or any other relevant information.**
1. Is there agreement about the use of the Disabled Facilities Grant, and arrangements in place for the transfer of funds to the local housing authority?	No - in development	This is under discussion by local partners
2. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified?	No - in development	The Council and CCG have not yet agreed on the allocation of the fund for 2016/17; this is under discussion locally
3. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	No - in development	The Council and CCG have not yet agreed on the allocation of the fund for 2016/17; this is under discussion locally
4. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	No - in development	The Council and CCG have not yet agreed on the allocation of the fund for 2016/17; this is under discussion locally

Selected Health and Well Being Board:

Cambridgeshire

Data Submission Period:

2016/17

4. HWB Expenditure Plan

This sheet should be used to set out the full BCF scheme level spending plan. The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing, which is required
describe a single scheme. In this case please use the scheme name column to indicate this.

On this tab please enter the following information:

- Enter a scheme name in column B;
- Select the scheme type in column C from the dropdown menu (descriptions of each are located in cells B71 - C78); if the scheme type is not adequately described by one of the dropdown options please choose 'other' and give furth
- Select the area of spending the scheme is directed at using from the dropdown menu in column E; if the area of spending is not adequately described by one of the dropdown options please choose 'other' and give further explanatio
- Select the commissioner and provider for the scheme using the dropdown menu in columns G and J, noting that if a scheme has more than one provider or commissioner, you should complete one row for each. For example, if bot

party;

- In Column K please state where the expenditure is being funded from. If this falls across multiple funding streams please enter the scheme across multiple lines;
- Complete column L to give the planned spending on the scheme in 2016/17;
- Please use column M to indicate whether this is a new or existing scheme.
- Please use column N to state the total 15-16 expenditure (if existing scheme) This is the only detailed information on BCF schemes being collected centrally for 2016-17 but it is expected that detailed scheme level plans will continue

Scheme Name	Scheme Type (see table below for descriptions)	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner
2015/16 spending lines are shown below. These categories and associated budgets are currently unde					
Older People and Adults Community Services	Integrated care teams		Community Health		
Carers	Support for carers		Community Health		
14 15 256 Agreement	Reablement services		Social Care		
Protecting Social Care	Reablement services		Social Care		
Re-ablement & intermediate care	Intermediate care services		Community Health		
Joint assessment and lead profesional	Integrated care teams		Community Health		
Information sharing	Other	<Please specify scheme type>	Social Care		
Transformation Team	Other	<Please specify scheme type>	Social Care		
Care Act	Other	<Please specify scheme type>	Social Care		
Local risk share	Other	<Please specify scheme type>	Other		

Scheme Type	Description
Reablement services	The development of support networks to maintain the patient at home independently or through appropriate interventions delivered in the community setting. Improved indepe reduces need for home care packages.
Personalised support/ care at home	Schemes specifically designed to ensure that the patient can be supported at home instead of admission to hospital or to a care home. May promote self management/expert ward' for intensive period or to deliver support over the longer term. Admission avoidance, re-admission avoidance.
Intermediate care services	Community based services 24x7. Step-up and step-down. Requirement for more advanced nursing care. Admissions avoidance, early discharge.
Integrated care teams	Improving outcomes for patients by developing multi-disciplinary health and social care teams based in the community. Co-ordinated and proactive management of individual reduction in hospital admissions.
Improving healthcare services to care homes	Improve the quality of primary and community health services delivered to care home residents. To improve the consistency and quality of healthcare outcomes for care hom workers to improve the delivery of non essential healthcare skills. Admission avoidance, re-admission avoidance.
Support for carers	Supporting people so they can continue in their roles as carers and avoiding hospital admissions. Advice, advocacy, information, assessment, emotional and physical suppor support wellbeing and improve independence. Admission avoidance
7 day working	Seven day working across health and/or social care settings. Reablement and avoids admissions
Assistive Technologies	Supportive technologies for self management and telehealth. Admission avoidance and improves quality of care

ssion 1: due on 02 March 2016

ll-Being Board Expenditure Plan

to demonstrate how the national policy framework is being achieved. Where a scheme has multiple funding sources this can be indicated and split out, but there may still be instances when several lines need to be completed in order to fully

er explanation in column D;
n in column F;
h the CCG and the local authority will contract with a third party to provide a joint service, there would be two lines for the scheme: one for the CCG commissioning from the third party and one for the local authority commissioning from the third

e to be developed locally.

Expenditure						
if Joint % NHS	if Joint % LA	Provider	Source of Funding	2016/17 Expenditure (£)	New or Existing Scheme	Total 15-16 Expenditure (£) (if existing scheme)

endence, avoids admissions,
t patient, establishment of 'home
cases. Improved independence,
e residents. Support Care Home
t, training, access to services to

Template for BCF submission 1: due on 02 March 2016

Sheet: 5. Health and Well-Being Board Better Care Fund Metrics

Selected Health and Well Being Board:
Cambridgeshire

Data Submission Period:
2016/17

5. HWB Metrics

This sheet should be used to set out the Health and Wellbeing Board's performance plans for each of the Better Care Fund metrics in 2016-17. This should build on planned and actual performance on these metrics in 2015-16. The BCF requires plans to be set for 4 nationally defined metrics and 2 locally defined metrics. The non-elective admissions metric section is pre-populated with activity data from CCG Operating Plan submissions for all contributing CCGs, which has then been mapped to the HWB footprint to provide a default HWB level NEA activity plan for 2016-17. There is then the option to adjust this by indicating how many admissions can be avoided through the BCF plan, which are not already built into CCG operating plan assumptions. Where it is decided to plan for an additional reduction in NEA activity through the BCF the option is also provided within the template to set out an associated risk sharing arrangement. Once CCG have made their second operating plan activity uploads via Unify this data will be populated into a second version of this template by the national team and sent back in time for the second BCF submission. At this point Health and Wellbeing Boards will be able to amend, confirm, and comment on non-elective admission targets again based on the new data. The full specification and details around each of the six metrics is included in the BCF Planning Requirements document. Comments and instructions in the sheet should provide the information required to complete the sheet.

Further information on how when reductions in Non-Elective Activity and associated risk sharing arrangements should be considered is set out within the BCF Planning Requirements document.

5.1 HWB NEA Activity Plan

- Please use cell E43 to confirm if you are planning on any additional quarterly reductions (Yes/No)
- If you have answered Yes in cell E43 then in cells G45, I45, K45 and M45 please enter the quarterly additional reduction figures for Q1 to Q4.
- In cell E49 please confirm whether you are putting in place a local risk sharing agreement (Yes/No)
- In cell E54 please confirm or amend the cost of a non elective admission. This is used to calculate a risk share fund, using the quarterly additional reduction figures.
- Please use cell F54 to provide a reason for any adjustments to the cost of NEA for 16/17 (if necessary)

	% CCG registered population that has resident population in Cambridgeshire	% Cambridgeshire resident population that is in CCG registered population	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Total (Q1 - Q4)	
Contributing CCGs			CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**
NHS Bedfordshire CCG	1.1%	0.8%	10,753	121	10,871	123	10,871	123	10,634	120	43,129	487
NHS Cambridgeshire and Peterborough CCG	72.1%	96.6%	18,562	13,389	18,100	13,055	19,766	14,257	18,766	13,536	75,194	54,237
NHS East and North Hertfordshire CCG	0.9%	0.7%	13,914	118	14,067	120	14,067	120	13,757	117	55,805	475
NHS South Lincolnshire CCG	0.4%	0.0%	3,649	13	3,689	13	3,689	13	3,609	13	14,636	53
NHS West Essex CCG	0.2%	0.1%	6,822	16	6,835	16	7,125	17	6,799	16	27,581	65
NHS West Norfolk CCG	1.5%	0.4%	5,404	79	5,759	84	5,669	83	5,492	81	22,324	327
NHS West Suffolk CCG	4.0%	1.4%	5,682	230	5,794	234	6,289	254	6,207	251	23,972	969
Totals		**100%**	**64,786**	**13,967**	**65,115**	**13,646**	**67,476**	**14,867**	**65,264**	**14,134**	**262,641**	**56,614**

Are you planning on any additional quarterly reductions?	No						
If yes, please complete HWB Quarterly Additional Reduction Figures							
HWB Quarterly Additional Reduction Figure							
HWB NEA Plan (after reduction)							
HWB Quarterly Plan Reduction %							

Are you putting in place a local risk sharing agreement on NEA?	Yes
BCF revenue funding from CCGs ring-fenced for NHS out of hospital commissioned services/risk share ***	£10,132,282

Cost of NEA as used during 15/16 ****	£1,490	Please add the reason, for any adjustments to the cost of NEA for 16/17 in the cell below.
Cost of NEA for 16/17 ****	£1,565	The 1,490 figure refers to 2012 / 13 prices. We have included the updated prices for 14/15 costs here.

Additional NEA reduction delivered through the BCF	£0						£0
HWB Plan Reduction %	0.00%						

* This is taken from the latest CCG NEA plan figures included in the Unify2 planning template, aggregated to quarterly level

** This is calculated as the % contribution of each CCG to the HWB level plan, based on the CCG-HWB mapping (see CCG - HWB Mapping tab)

*** Within the sum subject to the condition on NHS out of hospital commissioned services/risk share, for any local area putting in place a risk share for 2016/17 as part of its BCF planning, we would expect the value of the risk share to be equal to the cost of the non-elective activity that the BCF plan seeks to avoid. Source of data: https://www.england.nhs.uk/wp-content/uploads/2016/02/bcf-allocations-1617.xlsx

**** Please use the following document and amend the cost if necessary in cell E54. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/477919/2014-15_Reference_costs_publication.pdf

5.2 Residential Admissions

- In cell G69 please enter your forecasted level of residential admissions for 2015-16. In cell H69 please enter your planned level of residential admissions for 2016-17. The actual rate for 14-15 and the planned rate for 15-16 are provided for comparison. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

		Actual 14/15*****	Planned 15/16*****	Forecast 15/16	Planned 16/17	Comments
Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	546.3	577.1	0.0	0.0	
	Numerator	621	675			
	Denominator	113,678	116,972	116,972	120,035	

*****Actual 14/15 & Planned 15/16 collected using the following definition - 'Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population'

5.3 Reablement

- Please use cells G82-83 (forecast for 15-16) and H82-83 (planned 16-17) to set out the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services. By entering the denominator figure in cell G83/H83 (the planned total number of older people (65 and over) discharged from hospital into reablement / rehabilitation services) and the numerator figure in cell G82/H82 (the number from within that group still at home after 91 days) the proportion will be calculated for you in cell G81/H81. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

		Actual 14/15	Planned 15/16	Forecast 15/16	Planned 16/17	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	69.8%	86.6%			Targets will be agreed as funding allocations are confirmed
	Numerator	335	525			
	Denominator	480	606			

5.4 Delayed Transfers of Care

- Please use rows 93-95 (columns K-L for Q3-Q4 15-16 forecasts and columns M-P for 16-17 plans) to set out the Delayed Transfers Of Care (delayed days) from hospital per 100,000 population (aged 18+). The denominator figure in row 95 is pre-populated (population - aged 18+). The numerator figure in cells K94-P94 (the Delayed Transfers Of Care (dela commentary in column H to provide any useful information in relation to how you have agreed this figure.

		15-16 plans				15-16 actual (Q1 & Q2) and forecast (Q3 & Q4) figures				16-17 plans		
		Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)	Q1 (Apr 16 - Jun 16)	Q2 (Jul 16 - Sep 16)	Q3 (Oct 16 - Dec 16)
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+).	Quarterly rate	1258.1	1209.2	1209.2	1198.3	1554.7	1511.1	0.0	0.0	0.0	0.0	0.0
	Numerator	6,435	6,185	6,185	6,185	7,952	7,729					
	Denominator	511,489	511,489	511,489	516,152	511,489	511,489	511,489	516,152	516,152	516,152	516,152

5.5 Local performance metric (as described in your approved BCF plan / Q1 return)

- Please use rows 105-107 to update information relating to your locally selected performance metric. The local performance metric set out in cell C105 has been taken from your 2015/16 approved BCF plan and 2015/16 Q1 return - these local metrics can be amended, as required.

		Planned 15/16	Planned 16/17	Comments
The proportion of adults (aged 18+) receiving long-term social care (per 100,000 of population)	Metric Value			Targets will be agreed as funding allocations are confirmed
	Numerator			
	Denominator			

5.6 Local defined patient experience metric (as described in your approved BCF plan / Q1 return)

- You may also use rows 117-119 to update information relating to your locally selected patient experience metric. The local patient experience metric set out in cell C117 has been taken from your 2015/16 approved BCF plan and 2015/16 Q1 return - these local metrics can be amended, as required.

		Planned 15/16	Planned 16/17	Comments
Friends and Family Test - Inpatient - % that would recommend NHS service received to friends and family	Metric Value	93.0	93.0	Target is still being finalised, but this is indicative of level of target being considered
	Numerator			
	Denominator			

ayed days) from hospital) needs entering. The rate will be calculated for you in cells K93-O93. Please add a

Q4 (Jan 17 - Mar 17)	Comments
0.0	This is in progress. There are diffferential targets within different SRG areas within the CCG -
520,502	

Template for BCF submission 1: due on 02 March 2016

Sheet: 6. National Conditions

Selected Health and Well Being Board:

Cambridgeshire

Data Submission Period:

2016/17

6. National Conditions

This sheet requires the Health & Wellbeing Board to confirm whether the eight national conditions detailed in the Better Care Fund Planning Guidance are on track to be met through the delivery of your plan in 2016-17. The conditions are set out in full in the BCF Policy Framework and further guidance is provided in the BCF Planning Requirements document. Please answer as at the time of completion. On this tab please enter the following information:

- For each national condition please use column C to indicate whether the condition is being met. The sheet sets out the eight conditions and requires the Health & Wellbeing Board to confirm either 'Yes', 'No' or 'No - in development' for each one. 'Yes' should be used when the condition is already being fully met, or will be by 31st March 2016. 'No - in development' should be used when a condition is not currently being met but a plan is in development to meet this through the delivery of your BCF plan in 2016-17. 'No' should be used to indicate that there is currently no plan agreed for meeting this condition by 31st March 2017.
- Please use column C to indicate when it is expected that the condition will be met / agreed if it is not being currently.
- Please detail in the comments box issues and/or actions that are being taken to meet the condition, or any other relevant information.

National Conditions For The Better Care Fund 2016-17	Does your BCF plan for 2016-17 set out a clear plan to meet this condition?	Please detail in the comments box issues and/or actions that are being taken to meet the condition, or any other relevant information.
1) Plans to be jointly agreed	No - in development	The Council and CCG have not yet agreed on the allocation of the fund in 2016/17; this is under discussion locally
2) Maintain provision of social care services (not spending)	No - in development	
3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	No - in development	
4) Better data sharing between health and social care, based on the NHS number	No - in development	
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	No - in development	
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	No - in development	
7) Agreement to invest in NHS commissioned out-of-hospital services	No - in development	
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	No - in development	

Agenda Item No: 9

CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD DEVELOPMENT DAY – FEEDBACK FROM WORKING GROUP'S DISCUSSIONS

To: Health and Wellbeing Board

Date: 17th March 2016

From: Adrian Lyne, Policy and Projects Officer

1.0 PURPOSE

1.1 To outline the work undertaken so far by the working group established by the Cambridgeshire Health and Wellbeing Board (HWB).

1.2 To consult members of the Cambridgeshire HWB on initial proposals to make changes to the board's membership.

2.0 BACKGROUND

2.1 A development session for members of the Cambridgeshire HWB was held on 29 October 2015. The development session was based around the Local Government Association (LGA) report, 'Making it better together: A call to action on the future of health and wellbeing boards'.

2.2 A report outlining the main topics of discussion at this development session was presented to the HWB on 19 November 2015. At the meeting, it was agreed to establish a time-limited working group to further develop some of the main ideas raised at the development session. A small number of HWB members volunteered to join this working group, hereafter referred to as the 'HWB Working Group'.

3.0 PROCESS SO FAR

3.1 The HWB Working Group met for the first time on 25 January 2016 and discussed what were considered to be the key points raised at the HWB's development session in October 2015.

3.2 A summary of these discussions was circulated to the wider membership of the Cambridgeshire HWB for initial comments, feedback and direction. As a consequence, the HWB Working Group met for a second time on 22 February 2016 to further refine its thinking based on this feedback.

4.0 PROPOSALS SO FAR

4.1 Members of the Cambridgeshire HWB will be consulted at its 17 March meeting on the following main themes considered by the HWB Working Group:

a) Membership of the Cambridgeshire HWB – balance between local authority and health representation on the HWB
b) Vice-chair, or co-chair arrangements
c) Relationship with Peterborough HWB
d) Priorities for the Cambridgeshire HWB
e) Engagement with providers
f) Links with other boards and groups in the health and care system, including Local Health Partnerships

4.2 Other considerations will include:

- Style of the HWB and ways of working
- Duplication across the health and care system
- Longer-term plans for HWBs

4.3 Further detail around each of these areas is included the slides attached as an appendix to this paper and will be presented to the Cambridgeshire HWB at the 17 March meeting.

5.0 NEXT STEPS

5.1 The table below outlines the proposed next steps:

Date	Group / board	Purpose
17 March 2016	Cambridgeshire Health and Wellbeing Board	Consultation on HWB Working Group's initial proposals.
5 April 2016	Cambridgeshire County Council's Constitution and Ethics Committee	To discuss any potential proposed changes to the HWB's membership.
N/A – engagement via email	District Forum	Consultation and discussion on any potential proposed changes to District Councils' representation on the HWB.
13 April	Cambridgeshire Public Services Board	Consultation with wider system on any potential proposed changes to the HWB.
21 April (reserve date - TBC)	Cambridgeshire Health and Wellbeing Board (reserve date)	Following this process of engagement, any firm proposals to make changes to the HWB will be brought back to the HWB for formal approval.

6.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

6.1 The themes of this paper relate to Priority 6 of the Cambridgeshire Health and Wellbeing Strategy: to work together effectively.

7.0 IMPLICATIONS

7.1 There are no significant implications.

8.0 RECOMMENDATION

8.1 The Health and Wellbeing Board is asked to:

- Comment on the initial proposals developed by the HWB Working Group
- Agree recommendations that should be presented to Cambridgeshire Public Services Board

Source Documents	Location
Local Government Association (LGA), 'Making it better together: A call to action on the future of health and wellbeing boards'.	http://www.local.gov.uk/documents/L15-254+Making+it+better+togeth+A+call+to+action+on+the+future+wellbeing+boards/311885a4-5597-46bc2732d6a2
19 November 2015 Cambridgeshire Health and Wellbeing Board - update on Health and Wellbeing Board Development Day	http://www2.cambridgeshire.gov.uk/utes/Committees/AgendaItem.aspx=12358

Cambridgeshire Health and Wellbeing Board Working Group

Summary of discussions and potential (draft) changes to the Cambridgeshire Health and Wellbeing Board

Thursday 17 March 2016

Main questions considered

*Do we need more of a **balance on the HWB between elected councillors and health?***

*Would a **CCG co-chair or vice-chair** help the HWB feel more like an equal partnership?*

*Should we have a **single HWB for Cambridgeshire and Peterborough?***

What should the HWB's main purpose and priorities be?

*How can the HWB engage better with **providers?***

*How can the HWB engage better with **other key boards and groups, especially Local Health Partnerships?***

Overview of Working Group's view (1)

Do we need more of a balance on the HWB between elected councillors and health?

- Yes!
- Reduce from 5 County Councillors and 5 District Councillors to **5 elected Councillors (County and District) in total**
- 5 representatives for providers (mix of influential non-executive directors and executives)

CCG co-chair or vice-chair?

- Yes!

Joint Cambs and Peterborough Board?

- Long-term – maybe
- Short-term – no, but board-to-board meetings?

Overview of Working Group's view (2)

Overall purpose and priorities of HWB

- Joining up the system – a positive force for system leadership, but not the 'system leader'
- Accountability remains with constituent organisations
- Health and care outcomes, addressing inequalities

Better engagement with providers?

- Invite providers to join HWB
- Timely – LGA and NHS Providers report issued in Feb stressing importance of HWB engagement with providers

Engagement with other boards, especially LHPs

- Links with Local Health Partnerships need strengthening – LHPs and Integrated Care Boards?
- Reduction in District Councillors – risks losing local knowledge
- District Forum to be consulted further before discussion with CPSB

Purpose and membership: back to basics

Extract from King's Fund document outlining core purpose, functions and minimum membership of HWBs

The boards will bring together those who buy services across the NHS, public health, social care and children's services, elected representatives and representatives from Healthwatch to plan the right services for their area. They will look at all health and care needs together, rather than creating artificial divisions between services.
(Department of Health 2011)

Core membership:
- local authority director of adult social care
- local authority director of children's services
- director of public health
- elected member (at least one)
- clinical commissioning group
- Healthwatch

Functions:
1. Fulfil duty to promote integrated working
2. Produce a joint strategic needs assessment
3. Develop a joint health and wellbeing strategy

King's Fund, 2013

Other considerations

Devolution

- Changes to the Cambs HWB should happen in the short-term
- May need a longer-term plan too

Style and ways of working

- HWB feels like a Cambs County Council committee, scrutiny
- Changes to style may flow from changes to membership – induction for new members

Duplication across health and care system

- Robust agenda planning following changes to membership

Potential alternative Cambs Health and Wellbeing Board

- 5 local elected representatives (combination of county and district councillors, with a geographical and ideally political spread)
- 2 representatives of NHS Cambridgeshire and Peterborough Clinical Commissioning Group (2 GPs? Or 1 GP, 1 senior officer?)
- 5 provider representatives (3 non-execs and 2 execs – 1 rep for each main provider in Cambridgeshire)
- Healthwatch Cambridgeshire representative
- Executive Director for Children, Families and Adults
- Director of Public Health for Cambridgeshire and Peterborough
- NHS England representative
- Chief Finance Officer
- Voluntary sector representative (co-opted)

Recommendations

Comments and feedback on proposals to:

a) Reduce from 5 County Councillors and 5 District Councillors to **5 elected Councillors (County and District) in total**

b) Invite 5 representatives for providers (mix of influential non-executive directors and executives)

c) Co-chair or vice-chair arrangements with CCG

d) Board-to-board meetings with Peterborough, explore joint programmes of work

e) Strengthen links with Local Health Partnerships – Integrated Care Boards?

OLDER PEOPLE'S AND ADULT COMMUNITY SERVICES (OPACS) CONTRACT UPDATE

Review of procurement, operation and termination of the OPACS contract published

To: Health and Wellbeing Board

Date: 17 March 2016

From: **Report of Jessica Bawden, Director, Corporate Affairs, Cambridgeshire and Peterborough Clinical Commissioning Group**

Contact Officer(s) – Cambridgeshire and Peterborough CCG Engagement Team
Contact Details – 01223 725304, capccg.engagement@nhs.net

1. PURPOSE

1.1 The purpose of this report is to update the Health and Wellbeing Boardon the independent internal investigation on the termination of the Older People's and Adult Community Services (OPACS) contract held between Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and UnitingCare LLP.

2. BACKGROUND

2.1 The CCG commissioned an internal review following the termination of the OPACS contract. The Review was conducted by West Midlands Ambulance Service who are the CCG's internal auditors, it is an independent report, published by West Midlands Ambulance Service.

2.2 The Review looked at the circumstances that led to the termination of the older people's and adult community services (OPACS) contract. The CCG asked West Midlands Ambulance Service to identify learning points for the CCG and wider NHS. The objective of the review was to document and evaluate the CCG's systems, processes and controls used during the procurement and management of the contract with UnitingCare in order to identify any systemic weaknesses that may have contributed to termination of the contract and to identify learning points for future procurements.

2.3 The Review was conducted by reviewing documents and processes held by the CCG, as well as by interviewing members of the CCG Executive Team, Governing Body and Chair. The Review also takes into account the views of local Healthwatch.

3. KEY ISSUES

3.1 The review report was published by the CCG at 12 noon on 10 March.

3.2 The Review finds that the procurement process and financial evaluation undertaken by the CCG was robust, but that there are lessons to be learned for the CCG and for all organisations involved.

3.3 The Review concludes that the main reason for the early termination of the contract was a mismatch in the expectations of the CCG and the Lead Provider over the cost/value of the contract.

3.4 The Review makes a number of recommendations, based on its findings, for areas which should be strengthened for future procurements. These findings apply to the CCG, its advisers and other organisations involved in the procurement and evaluation. The report is intended to provide learning for the wider NHS.

4. APPENDICES

4.1 **Appendix 1 – Press release Review of OPACS contract published**
4.2 **Annex 1 – Internal Audit OPACS report**

Source Documents	Location
None – review attached as an annex.	

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Lockton House
Clarendon Road
Cambridge
CB2 8FH

Tel No: 01223 725317
Website: www.cambridgeshireandpeterboroughccg.nhs.uk

MEDIA RELEASE

10 March 2016

Review of procurement, operation and termination of the OPACS contract published

Today, the independent internal investigation on the termination of the Older People's and Adult Community Services (OPACS) contract held between Cambridgeshire and Peterborough Clinical Commissioning Group and UnitingCare LLP has been published.

The Review finds that the procurement process and financial evaluation undertaken by the CCG was robust, but that there are lessons to be learned for the CCG and for all organisations involved.

The Review concludes that the main reason for the early termination of the contract was a mismatch in the expectations of the CCG and the Lead Provider over the cost/value of the contract.

The Review makes a number of recommendations, based on its findings, for areas which should be strengthened for future procurements. These findings apply to the CCG, its advisers and other organisations involved in the procurement and evaluation. The report is intended to provide learning for the wider NHS.

Dr Neil Modha, Chief Clinical Officer at Cambridgeshire and Peterborough Clinical Commissioning Group said,

“We welcome the Review and would like to thank West Midlands Ambulance Service for undertaking the investigation.

“We are glad to see that the Review has acknowledged that the procurement process and financial evaluation undertaken by the CCG for this innovative contract was of a high standard. We have carefully considered the lessons and recommendations the Review makes. It has identified a number of lessons to be learned, by us and by the wider NHS.

“We will reflect on the findings of this Review, as well as the NHS England review when it is published, and will build the learning into our Procurement Policy.

“The innovative new model of care, which was based on seeing improvements to people’s health outcomes, and the type of organisation that was chosen to deliver services were different from the traditional NHS models. This meant that there were areas that needed additional questions to be asked or types of reassurance to be sought which were new to the CCG. However, we accept the report’s view that there was a mismatch between the CCG and UnitingCare’s assumptions relating to the finances.

“We are proud of the achievements that have already been delivered for older people’s and adult community services, for example establishing Joint Emergency and Neighbourhood Teams who can see patients quickly and support them in the community. This is the model we want to build on and we are working closely with our partners in the NHS, Local Authorities, Healthwatch and patient groups to ensure that we have a good quality, sustainable model of care moving forward. We are also working with Healthwatch organisations to contribute their community learning event in May.

“We hope that today’s Review will provide useful learning for the wider NHS, and other organisations conducting complex, high value procurements.”

Tracy Dowling, Chief Operating Officer at Cambridgeshire and Peterborough Clinical Commissioning Group said,

“Since the ending of the contract on 3 December 2015 we have been working constructively with our partners in the NHS, Local Authorities, Healthwatch and patient groups on the model for the future.

“We are committed to the model of an integrated and outcomes-based approach as we believe this delivers benefits for patients and the health system. Conversations with our partners have reiterated their support for an integrated model of care. We continue to work with our partners and staff to ensure we are able to deliver a good quality service to our patients within the resources available to us.”

Ends

Media bids

There are limited interview slots between 2.15pm and 5pm on Thursday 10 March 2016. Interviews will be with Dr Neil Modha, Chief Clinical Officer.

Notes to Editors

1. The Review was conducted by West Midlands Ambulance Service who are the CCG’s internal auditors.
2. The Review was commissioned by Cambridgeshire and Peterborough Clinical Commissioning Group.
3. The Review is an independent report, published by West Midlands Ambulance Service.
4. The Review looked at the circumstances that led to the termination of the older people’s and adult community services (OPACS) contract.
5. The CCG asked West Midlands Ambulance Service to identify learning points for the CCG and wider NHS.
6. The objective of the review was to document and evaluate the CCG’s systems, processes and controls used during the procurement and management of the contract with UnitingCare in order to identify any systemic weaknesses that may have contributed to termination of the contract and to identify learning points for future procurements.
7. The Review was conducted by reviewing documents and processes held by the CCG, as well as by interviewing members of the CCG Executive Team, Governing Body and Chair. The Review also takes into account the views of local Healthwatch.
8. The Review sets out a number of contributory factors which provide opportunities for learning for future procurements. These are:

    - The timing of regulatory approval of bidders’ business case and associated conditions prior to approval (Section 3.3.2)
    - Rigorous application of controls within the procurement including re-assessment of all bidders where the nature of the bidders had changed during the process (Section 3.1.6);

- No re-assessment of the particular risks proposed by the change in legal entity of the successful bidder to a Limited Liability Partnership (LLP) and not being aware of the details of the ownership agreement between the partners; Cambridge and Peterborough NHS Foundation Trust (CPFT) and Cambridge University Hospital NHS Foundation Trust (CUH) (Section 3.1.5);
- The failure to obtain Parent Company Guarantees from CPFT and CUH prior to the signing of the contract despite the engagement of external procurement and legal advisers (Section 3.1.10);
- The design of the evaluation process leading to a lack of knowledge of the of the legal entity and nature of the bidder at the time of evaluation by some of the work streams (Section 3.1.9);
- The CCG was not able to triangulate the bid with income assumptions contained within the business plan submitted by the Foundation trusts to the regulator (Monitor) (Section 3.2.4);
- Need to identify flags of concern in particular lack of access to the bidders business case, the inconsistency of the first invoice with the contract sum (Section 3.2.3);
- Ensuring early flagging of the seriousness of concerns with NHS England (Section 3.3.7); and
- Enhancements to the reporting to the Governing Body (Section 3.4.1).

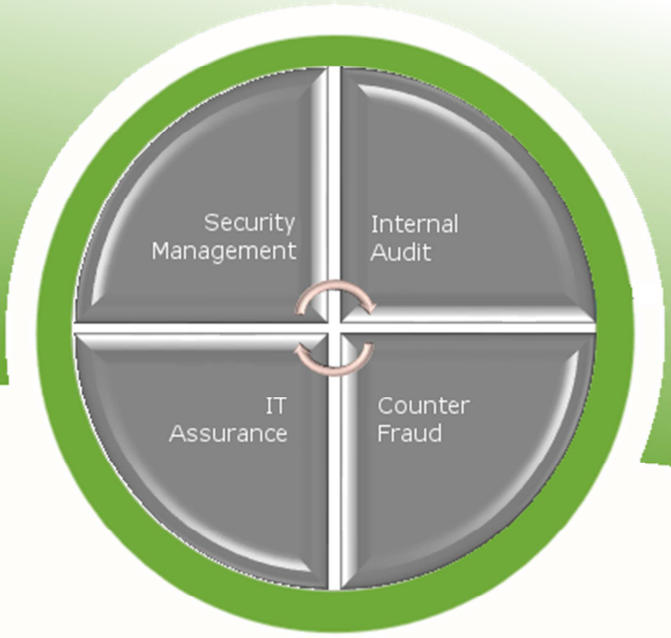
The full report will be published on the CCG's website at 12pm at http://www.cambridgeshireandpeterboroughccg.nhs.uk/pages/older-peoples-programme.htm

About Cambridgeshire and Peterborough CCG

Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) is a clinically led organisation with 106 GP practices as members across Cambridgeshire, Peterborough and parts of Hertfordshire and Northamptonshire. We are the third largest CCG in England and responsible for ensuring that high quality NHS services are provided to our 929,926 patient population.

The CCG is organised into eight local groups (known as Local Commissioning Groups or LCGs). The eight LCGs are part of the wider Clinical Commissioning Group.

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group



Review of Procurement, Operation and Termination of the Older People & Adult Community Services Contract (OPACS)

Internal Audit Final Report: CPCCG15/23

Internal Audit Service

West Midlands Ambulance Service provides Internal Audit services to Cambridgeshire and Peterborough CCG. This report has been prepared following a request from the CCG for an independent internal investigation into the circumstances that led up to the termination of the OPACS contract in December 2015 with the aim of identifying learning points for any future procurement process. No responsibility to any third party is accepted as the report has not been prepared, and is not intended, for any other purpose.

Consultation & Distribution

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Contents

Executive Summary

Aim and Headline Context

As the Internal Audit provider to Cambridgeshire and Peterborough CCG we have been asked to undertake an independent internal review of the circumstances that ultimately led to the termination of the Older Peoples and Adult Community Services (OPACS) contract. Internal Audit is an independent, objective assurance and consulting function and as such is well placed to provide an objective assessment to the CCG of processes deployed in the procurement of the contract and subsequent contract management.

The objective of the review is to document and evaluate CCGs systems, processes and controls deployed in the procurement and management of the subsequent contract in order to identify any systemic weaknesses that may have contributed to termination of the contract and importantly identify learning points for future procurements. The review focussed on the processes and mechanisms deployed by the CCG and the review of evidence was restricted to that held by the CCG or available in the public domain and interviews with Senior Executives Lay Chair and Lay Members of the Governing Body. It did not encompass review of any further evidence held by any of the contract bidders or other parties such as NHS England or Monitor.

The OPACS procurement was a significant undertaking for the CCG incorporating:

- extensive consultation with stakeholders,
- the design of a new clinical outcomes framework,
- the undertaking of a competitive procurement exercise, to design a new service model to deliver the outcomes, and the subsequent letting of a contract to new Lead Provider of Services.

This procurement was designed to achieve better clinical outcomes, services designed to meet patient needs in a sustainable manner.

Much of the work undertaken was ground breaking and as such carried inherent risk but the termination of the contract soon after its inception is an indication that there were mismatched expectations of the financial investment required to deliver the service delivery model.

Summary of Issues and Lessons to be Learned

Fundamentally the main reason for the early termination of the contract was a mismatch in the expectations of the CCG and the Lead Provider over the cost/value of the contract. Although significant efforts were made during 2015 to bridge this gap these were ultimately unsuccessful. Internal Audit has assessed the financial evaluation process employed as part of the ISFS evaluation and found that the CCG did have in place controls designed to ensure bids were within the estimated annual contract values and the values over the expected five years of the contract however other aspects of the process have been identified as contributory factors to the eventual early termination of the contract.

In considering contributory factors there are a number of issues arising from our review which provide opportunities for learning and application to future procurements. These are:

- The timing of regulatory approval of bidders Business case and associated conditions prior to approval (Section 3.3.2)

- Rigorous application of controls within the procurement including re-assessment of all bidders where the nature of the bidders had changed during the process (Section 3.1.6);
- No re-assessment of the particular risks proposed by the change in legal entity of the successful bidder to a Limited Liability Partnership (LLP) and not being aware of the details of the ownership agreement between the partners; Cambridge and Peterborough NHS Foundation Trust (CPFT) and Cambridge University Hospital NHS Foundation Trust (CUH Section 3.1.5);
- The failure to obtain Parent Company Guarantees from CPFT and CUH prior to the signing of the contract despite the engagement of external procurement and legal advisers (Section 3.1.10)
- The design of the evaluation process leading to a lack of knowledge of the of the legal entity and nature of the bidder at the time of evaluation by some of the work streams (Section 3.1.9);
- The CCG was not able to triangulate the bid with income assumptions contained within the business plan submitted by the Foundation trusts to the regulator (Monitor) (Section 3.2.4);
- Need to identify flags of concern in particular lack of access to the bidders business case, the inconsistency of the first invoice with the contract sum (Section 3.2.3) ;
- Ensuring early flagging of the seriousness of concerns with NHS England (Section 3.3.7)
- Enhancements to the reporting to the Governing Body (Section 3.4.1)

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1. Objective & Scope

1.1. Internal Audit has been asked to undertake an independent internal review of the circumstances that ultimately led to the termination of the Older Peoples and Adult Community Services (OPACS) contract. The objective of the review was to document and evaluate the CCG's systems, processes and controls deployed in the procurement and management of the subsequent contract in order to identify any systemic weaknesses that may have contributed to termination of the contract and importantly identify learning points for future procurements. The review focussed on the processes and mechanisms deployed by the CCG and the review of evidence was restricted to that held by the CCG or available in the public domain. It did not encompass review of any further evidence held by any of the contract bidders or other parties such as NHS England or Monitor.

1.2. As part of the review a series of interviews was undertaken with representatives of the CCG Executive team and Chair as well as a selection of lay members of the CCG Governing Body. Internal Audit also contacted Healthwatch Cambridgeshire representatives to obtain their perspective of the process.

2. Significance

2.1. The OPACS procurement was a significant undertaking for the CCG incorporating:

- Extensive consultation with stakeholders;
- The design of a new clinical outcomes framework;
- The design of a new service model to deliver the outcomes, via a competitive procurement exercise;
- The involvement and use of external technical advisers (Strategic Projects Team, Financial advisers Deloitte LLP and Legal advisers Wragge, Lawrence Graham &Co); and
- The subsequent letting of a contract to a new Lead Provider of Services.

2.2. This procurement was designed to achieve better clinical outcomes, services designed to meet patient needs in a sustainable manner. Much of the work undertaken was ground breaking and as such carried inherent risk but the termination of the contract soon after its inception is an indication that there were mismatched expectations of the financial investment required to deliver the service delivery model.

2.3. A competitive dialogue procurement process ran from July 2013; OJEU advert and Pre-qualification Questionnaire (PQQ) submission through to contract award to Uniting Healthcare LLP in November 2014 and contract commencement 1 April 2015. The contract was terminated in December 2015.

3. Our Findings

3.1. Project Control Framework and Procurement Process

3.1.1. The Project Control Framework established by the CCG was commensurate with the complexity and extent of the procurement. Key features included:

- The use of a two stage competitive dialogue procurement process (external advisers were the Strategic Project Team (SPT);
- A Governance framework designed to provide information and assurances to enable the Governing Body to reach informed decisions;
- A Programme Management Board responsible for operational oversight of the project including the maintenance of risk registers and action logs
- Technical Groups and Local Project Groups responsible for the delivery of individual tasks and projects and reporting to the Programme Management Board
- Use of external procurement, legal and financial advisers throughout the procurement process and particularly in evaluating outline and final business solutions from bidders.
- Use of Dept. of Health and NHS England Gateway reviews at key stages of the Older people programme, procurement and development of the Outcomes framework.

3.1.2. At an early stage of our investigations it was clear that the principal reasons for the termination of the contract were financial rather that service quality related, for this reason this report concentrates on the procurement process, and subsequent contract management rather than the development of the outcomes framework and service model.

3.1.3. The financial principles underlying the procurement and contract aims were:

- aligning improved patient outcomes with financial incentives;
- delivering recurrent financial balance in a sustainable way;
- sharing financial risk across the commissioner – provider system; and
- creating the conditions for investment and delivering a return on investment.

3.1.4. To assist in the delivery of these aims the contract period was to be for a minimum of five years with an option to extend for a further 2 (much longer than a traditional NHS healthcare services contract, financial reward was to be linked to outcomes and the bidders were asked to tender within a

budget envelop established by the CCG (which took into account cost improvement expectations).

3.1.5. The competitive procurement process commenced on 3rd July 2013 with the publication of a Contract Notice on the Official Journal of the European Union (OJEU) and Supply2Health. The notice invited expressions of interest from parties wishing to submit a Pre-Qualification Questionnaire (PQQ) to deliver integrated care pathways for older people and a range of community services for adults. The PQQ sought responses from those parties who expressed an interest testing their capacity, capability, economic and financial standing and eligibility to take part in the procurement process. Twelve completed PQQs were received and evaluated.

The assessment of capacity, capability, economic and financial standing and eligibility was applied at PQQ stage; the ultimately successful bidder was a different legal entity to that which completed the PQQ and these checks were not applied to that entity.

3.1.6. The evaluation of the submitted PQQs included assessment against Financial, Legal, Clinical Service and Workforce criteria described in the PQQ, Bidders were ranked and the seven highest ranking Bidders for each Lot were selected to proceed to the next stage of the process, the Invitation to Submit Outline Solutions (ISOS) which ran until the deadline of 6th January 2014. These were subjected to further evaluation. As part of the ISOS submission suppliers were required to re-submit their PQQs where there had been a change. The eventual winner did not re-submit their PQQ despite the delivery vehicle now being described as a Limited Liability Partnership within their ISOS submission. It is understood that this is because the bidder considered that this did not represent a change as this had been previously reported to the CCG. The legal evaluation at this stage does however consider that the legal entity had changed from that which submitted the PQQ. The LLP was not registered/formed until 31 October 2014 after preferred bidder status had been announced.

It is unclear why the eventual winning bidder was not asked to re-submit their PQQ given the legal evaluation at ISOS stage, the implementation of such a step may have triggered a more formal risk assessment of the proposal and risks associated with contracting with a LLP.

3.1.7. After evaluation of the ISOS submissions four suppliers were asked to prepare and submit the final solutions (ISFS stage) with a closing date of 28th July 2014. One bidder withdrew. The three submitted bids were then subjected to further extensive evaluation. The evaluation process was

complex and designed to achieve an objective evaluation of each of the bids. Features included:

- The breaking down of the evaluation into specialist work streams including Corporate Governance, Workforce, Estates, Finance etc;
- The use of moderators to ensure consistency of evaluation; and
- The Use of external specialist support for key technical areas including procurement, financial and legal evaluation.

3.1.8. The evaluation process was designed to ensure objectivity and fairness to all bidders. Many managers interviewed as part of our investigation expressed the opinion that one of the key drivers in the design of the procurement process generally and the evaluation process in particular was to ensure even handedness and because of the high profile nature of the procurement to avoid the possibility of challenge and potential judicial review. Indeed the final Dept. of Health "Gateway" review and report (November 2014) issued post identification of preferred bidder, commented that the "*procurement process, so far, has clearly been undertaken professionally. It is a mark of success for such a high profile, high value procurement that it has reached this stage, maintaining competitive tension, whilst also receiving no challenges to the process"*.

3.1.9. The outcomes of the work stream evaluations were consolidated in a work stream evaluation report, prepared by the Strategic Projects Team, detailing outcomes of evaluation against each of the three ISFS bidders with indications of their respective strengths and weaknesses. From discussions with CCG Executive members involved in various evaluation work streams it is understood that not all were aware of the nature of the proposed LLP delivery vehicle. This is reflected in our review of the work stream evaluation reports which included: for example, the workforce evaluation report which comments "*was thoughtful and reflected well on the potential challenges facing the new provider. ….identity and culture was already visible for the evaluator, together with a clear picture of what they are going to provide to support the incoming workforce."*

The Corporate governance evaluation includes *"There was very strong narrative around risk management processes, and clear structure in place. This was demonstrated by assurance and, transparency and ownership at Board level, and at every level of the organisation".*

Both of these observations read as if Uniting Care to be the employer of the incoming workforce and had many levels within the organisation whereas in reality Uniting Care employed directly 20 to 30 staff (none of which were engaged in direct healthcare provision).

The different legal entity was not noted by the Strategic Projects Team in the main narrative of their contract evaluation report see paragraph 3.1.10.

Internal Audit therefore concludes there is a need to ensure clarity over the structure and nature of the bidders to better inform the evaluation and any change in the legal entity of the bidder needs to be fully reflected in the evaluation.

3.1.10 The legal evaluation was undertaken by the CCG's legal advisers and their report on the successful bidder identified the different legal entity of the bidder (compared to PQQ submission) and also identified the need for "performance guarantees to be in place from member organisations. The report goes on to record that this was raised with the bidder and accepted by them. Finally the legal evaluation records…" that this would need to be a condition attached to any decision to award them preferred bidder status ….." The legal evaluation report was included in the Strategic Projects Team "Invitation to Submit Final Solutions Evaluation report as Annex E submitted to the Governing Body in September 2014. The recommendations to proceed to appoint the preferred and reserve bidders contained in that report are not caveated with the need to obtain performance guarantees. The preferred bidder letters (drafted by the Strategic Projects Team) did not include any reference to the need for a Parent Company or Performance Guarantees nor was there any mention included in the "Preferred bidder contract issues log". It is of note that the Strategic Projects Team was appointed as procurement advisers for the ISOS and ISFS stages of the procurement following a competitive tendering exercise. The specification relating to that contract clearly states (page 22) that one of the responsibilities of the procurement adviser is to "Draft the 'provisional' recommended and reserve bidder letters that protects the C&PCCG's interests and commits the bidder to the commercial agreement." It may be argued that the absence of any reference to the need for Parent/Performance Company Guarantees did not fully protect the interests of C&PCCG.

The CCG assumed that because of the legal adviser's evaluation and agreement with the bidders, as well as the fact that the drafting of the contract was their responsibility that they would undertake the drafting of the Parent/Performance Company Guarantee.

Internal Audit understands that the CCG has sought independent legal advice to determine the circumstances surrounding the failure to draft and agree a "Parent Company Guarantee".

The failure to capture the need for performance guarantees from the partners of the preferred bidder is a weakness in the process and whilst it may not have prevented the termination of the contract it did increase the CCG risk profile in the event of contract failure.

The evaluation process failed to ensure that any issues requiring attention were resolved prior to awarding of preferred bidder status and this was exacerbated by the format of the evaluation report.

The preferred bidder letter did not require Parent/Performance Company Guarantees to be in place.

3.2. Contract Values and Payments

3.2.1. The fundamental reason for the termination of the contract in December 2015 was an inability to reconcile the CCG and Provider position in relation to contract value despite attempts to bridge the gap between the two positions. The value of the signed contract was clear £725 million over the five year period (£152 million in year one 2015/16) The CCG did acknowledge within the procurement process that the contract value would require adjustment for 2014/15 outturn (up or down) this was communicated to the preferred bidder in January 2015. From subsequent correspondence it is clear that the Provider believed there was opportunity to negotiate on other aspects of the contract value, post award.

3.2.2. At the outset of the process the CCG approach to the financial value of the contract was to seek solutions within a cost envelop that had been derived from examination of current cost of delivery but also included expectations of cost improvements to be achieved over the contract term. Bids were received from a variety of organisational types including consortia of NHS Organisations partnered with private sector organisations to straight private sector bids and from the eventual winner initially a consortia of two NHS Foundation Trusts but ultimately a Limited Liability Partnership owned (members) by the two Foundation Trusts.

3.2.3. As part of the Foundation Trust regulatory framework organisations need to seek approval of the regulator via the submission of a business case for any “significant transactions”. This applied to one of the partners of the Uniting Care Partners LLP. There was no requirement within the evaluation process for bidders to confirm whether there are any regulatory requirements to be satisfied prior to the signing of contracts. This would have highlighted to the CCG any preconditions required to be satisfied by any bidding organisation. Internal Audit understands that the CCG requested sight of the CPFT business case at a later stage but that this was declined. Whilst commercial sensitivities are understandable, at the very least the business case income assumptions should have been triangulated with the bid price. No further attempts were made to triangulate the bid value with the levels of income expected in the business plan

despite there being contact between the CCG and Regulator late in 2014/15. There was a further flag indicating a mismatch in financial assumptions on the receipt of the first quarterly invoice (April 2015) which was in excess of the CCGs expectations.

3.2.4. The final Dept. Health Gateway report (November 2014) included discussion of feedback from stakeholders concerning the risks associated with the delivery of the service. It states *"Several stakeholders expressed concern about the overall financial viability of the programme within the financial envelope. The Review Team understands that this will be addressed by a business case that is currently being prepared. Although the procurement has not required a formal business case, the two partners (CUHFT and CPFT) who form the UCP are required by Monitor to submit a Full Business Case and Long Term Financial Plans."*

No recommendations were made in this report around the need to ensure the business case was fully in line with the accepted bid.

The evaluation process would be enhanced if at PQQ stage bidding organisations were asked to confirm any regulatory pre-requisites and the timescale for satisfying them.

In order to enhance assurance, use of triangulation opportunities to ensure the bidder income expectations are in line with the accepted bid should be made.

3.2.5. The financial evaluation formed 25% of the overall evaluation of the ISFS bids. It fell into three parts: the first to pass the "Financial Hurdle", the second was qualitative based on answers provided to 7 questions; the third was quantitative and based on the bid value in comparison to the CCG expected contract value. The two assessments were then combined to arrive at an overall assessment. Internal Audit notes that there was no minimum value threshold applied to the quantitative assessment but also that there was no competitive advantage of submitting a price more than 3.5% below the CCG estimated contract value. It is of note that the successful bidder scored the maximum number of points for the quantitative element of the financial evaluation but lowest in comparison to the other bids in the qualitative assessment of the financial evaluation. The combined effect was to place them highest in the overall financial assessment.

The financial hurdle consisted of three elements these were that the bids must:

- Have an expected annual contract value (EACV) which in each year is not greater than the CCG's budget plus transformational funding (as defined in the ISFS);

- Have a Net Present Value (NPV) over the 5 year contractual period which is not greater than the NPV of the CCG's budget plus the transformational funding; and

- Not assume any additional funding from the CCG over and above the budget plus the transformational funding.

All three bidders were assessed as having passed the financial hurdle.

3.2.6. In an effort to ensure the financial evaluation was able to compare bids on a like for like basis clarification questions were raised with bidders where bids appeared to caveating the bid value e.g." *Please confirm that they would deliver their solutions within the submitted EACV (and the transformational funding of £5m in the first two years) without assuming the receipt of any additional funding (whether from the CCG, for example but not limited to exceptional funding, EDS, LES/DES, readmissions or MRET or otherwise e.g. the Better Care Fund."* The successful bidder responded "Yes" to this clarification question.

3.2.7. The contract payment schedule recognized the need to provide the successful bidder with some degree of working capital support including the payment of the first two quarters payments of 2015/16 quarterly in advance plus the payment of £5 million transformation monies for each of the first two years of the contract. The original contract start date of 1 January 2015 was put back to 1 April 2015 (agreed in response to public consultation, July 2014). The CCG made payments in 2014/15 (in advance of the commencement date) of some £4.3 million in recognition of the bidder's need to mobilize. The OPACS Contract provided for repayment of the £4.3m Support Monies by reducing the Annual Contract Value by the £4.3m under a repayment profile and timescale to be agreed between the Parties. The value of the bid excluding any additional sums (£5m transformation funds et al.) was £726 million over the five year period with the contract value for 2015/16 some £152 million. This contract was signed in November 2014. There was recognition by both sides that the contract sum would need to be amended to take account of the activity outturn for 2014/15 once the value of this rebasing could be quantified (June 2015).

3.2.8. The final Dept. of Health Gateway report (received post preferred bidder letters November 2014) commented on the professionalism of the procurement process undertaken and was particularly complimentary concerning the process delivery in terms of maintaining competitive tension and avoiding any challenge to the process.

There is good evidence that the procurement process and in particular the financial evaluation at ISFS stage was designed and implemented In terms of ensuring financial bids were evaluated consistently and designed to ensure service delivery would be accomplished within the CCG budget.

3.3. Post Contract Negotiations

3.3.1 The mismatch between CCG and Uniting Care over contract value and the expected contract income are at the heart of the reason for the contract termination. Although the signed contract value is not in dispute (£726 million over the 5 year contract term), there is evidence of disagreement over the extent to which the contract value might be varied post award, this despite the clarifications given and the financial hurdle test contained in the ISFS evaluation process. In an effort to determine how this mismatch arose and to identify the efforts made to resolve the differences Internal Audit has reviewed:

- The bid documentation and associated bid clarification questions and answers made at the time of the ISFS submissions ;
- Correspondence between the CCG and UCP during the period between the signing of the contract in November 2014 and the eventual commencement on 1 April 2015 including agreement to a local variation of the contract
- Correspondence between the two parties in the period from the commencement of the contract and the termination in December 2015
- Evidence of the operation of the escalation and mediation process involving both NHS England and Monitor.

3.3.2 As has been discussed in section 3.2.3 one of the owners/members of Uniting Care LLP was required to obtain Monitor approval of its business case submission and consideration of this took place post signing of the contract but prior to commencement (November 2014 to end of March 2015). Whilst the CCG did not have access to the detail of the Business Case it was in discussion with Monitor on certain aspects including specific questions on contract wording. Internal audit understands that, as represented by UCP, a condition of approving the business case agreement of a local variation between the contract parties was required. In terms of impact on the subsequent negotiations around contract value Internal Audit highlights the following attributes of this local variation:

- Recognition of the need for re-basing of the contract value as a result of outturn in 2014/15 and other funding changes

- Acknowledgement that in respect of any items that UCP have not been able to accurately quantify due to shortfalls in information from the UCP due diligence process, and which may arise for a period of up to 6 months post service commencement, the parties may agree a contract variation.

This local variation was agreed by the CCG. Internal Audit has reviewed correspondence between Senior Executives and Lay Chair of the CCG that preceded agreement and it is clear that the risks associated with agreement were well rehearsed at that time. The decision to accept (although never formally ratified) was considered on balance to be the best course of action. This urgent decision was communicated to the Governing Body at development session in April 2015. The CCG Lay Chair believes it is important to note that the wording of the variation set out the process by which the contract "**may"** have been amended (rather than "**shall"** have been amended). It did not commit the CCG to agreement.

The acceptance of the local variation wording did satisfy the Monitor condition and incorporated the CCG acknowledgement that the contract would require amendment as a result of rebasing but also opened the possibility of further negotiations around contract value if raised within 6 months of the contract commencement. Although Internal Audit acknowledges that this variation was never formally ratified and that the variation committed the CCG to agreement of variation is disputed.

It should also be noted that the timing of the request for this change put additional pressure on the CCG to accept to ensure the ultimate success of the contract.

3.3.3 In May 2015 (one month after contract commencement) Uniting Care Partnership (UCP) presented to the CCG as part of general contract discussion, a request for additional funding totaling £34.3 million as summarised below:

Acuity	£6 million
Delays resulting in lost savings (Acute and CPFT)	£9.4 million
VAT	£4.9 million
2014/15 Outturn adjustments MRET	£6.6 million
Other activity adjustments	£5.3 million
Technical adjustments	£2.1 million

This triggered a series of meetings between the two parties where the CCG disputed the relevance of some of the claimed monies (Acuity, VAT and

lost savings primarily) and on the 5th August the CCG wrote formally to Uniting Care offering an uplift in the contract value (£9.3 million) to reflect the 2014/15 outturn but linked explicitly to the original bid price. Other non-recurrent sums were also offered (£3.4 million e.g. System Resilience Funds for specified projects) and in addition the CCG offered additional cash support including; delay in repayment of the 2014/15 previously advanced (£4.3 million), payment in 2015/16 of the 2016/17 transformation monies (£5 million).

3.3.4 This offer was rejected by Uniting Care on 21 August based on their position that UCP faced a £34.5 million financial challenge in 2015/16. Of which it was acknowledged that £10.9 million might not be incurred or was subject to other mitigation. Of the remaining £23.6m: £8.4m was non-recurrent after 2015/16 (as it related to delays in savings); leaving £15.2m as recurrent with up to £9.9m of this relating to information shortfalls and to be resolved in a system wide financially neutral way.

3.3.5 UCP issued a proposed contract variation to the CCG dated 20th August which re-iterated the UCPs position re. Acuity, VAT, delays resulting in loss of savings, their calculations relating to the 2014/15 outturn and additionally £9.9 million in connection with information shortfalls in the UCP due diligence process. This variation was rejected by the CCG on the basis that it was not necessary as the contract provided for resolution of such matters already.

3.3.6 Further meetings of CCG and UCP Senior Management were held in order to resolve the issues, and agreement reached on an open book exercise which took place in September 2015. The starting position for this used the offer from the CCG of 5th August and compared this to the amounts requested in the draft contract variation (20th August); this showed a gap of £23.4 million. Meetings by this point included Chairs of the CCG CPFT and UCP (the Chair of UCP is also Deputy Chair of CUH) - which became a local oversight Group for a recovery plan process. The recovery plan resulted in reduction of the gap to c10m for 2015/16, but it should be noted that there were financial risks associated with delivery of recovery measures for all parties.

3.3.7 As part of the on-going dialogue with NHS England the CCG included within its assessment of achievability of financial surplus for 2015/16 an analysis of risks. Internal Audit notes that in the assurance report relating to Q4 2014/15, presented in June 2015, that the size of the risk identified as a result of “final settlement with UCP” as £3 million. There is no mention of the larger sum claimed by UCP as the size of their financial challenge in 2015/16.

The CCG flagged the risks associated with the situation to NHS England with a formal briefing provided on the 14th October 2015. The Local Oversight Group agreed on 17th November 2015 that most of the Recovery Plan had been completed and that the residual gap needed to be escalated

to NHS England and Monitor. A meeting of all parties took place with NHS England Regional Director and Monitor Director on 23rd November. No additional bridging funding mechanisms were identified and the parties were advised to prepare for withdrawal from the contractual arrangements ensuring as little disruption to the health system as possible. The contract was terminated on 3rd December 2015.

From the information reviewed Internal Audit recommends that earlier formal notification and briefing of the issues to NHS England should have been made. Whilst this may not have altered the eventual outcome it would have signalled the seriousness of the situation and acknowledge the wider reputational damage that would have resulted from the failure of the contract.

3.4 Reporting and Escalation to the Governing Body

3.4.1 In order to determine the adequacy of reporting and escalation processes Internal Audit undertook a review of both Public and Private Governing body papers, agendas and minutes. Our examination confirms extensive reporting and discussion at Governing Body and Clinical Management Executive Team (CMET). There is good evidence of the raising of concerns regarding financial risk associated with the contract throughout 2015 and there is also evidence of requests for decisions regarding continued financial support and assistance with cash flow September and October 2015. There are some aspects of the procurement and contract management that we would have expected to be evidenced in Governing Body papers including:

- The change in role of the contractor from a Lead Provider to an integrator role and the CCG being in a position of co-commissioning (although this was flagged in a report to CMET 29 October 2014);
- Discussion of risks associated with the establishment of the LLP as the delivery vehicle from the preferred bidder; and
- Anything summarizing the issues or actions stemming from the contract evaluation report prepared by the SPT (particularly the need for performance guarantees which were within an annex of that report.);
- Specific reporting and agreement of the levels of cash support particularly the payment of sums to the contractor in 2014/15.

Whilst the Governing body papers clearly show engagement with the process there are gaps in the detail of reporting which may have impacted the Governing body's full understanding of the issues and risks as noted above.

4. Acknowledgements

Internal Audit would like to acknowledge the support given by Senior Officers and Lay Members of the CCG throughout the conduct of this review.

5. CCG Governing Body Response

The CCG welcomes the internal investigation undertaken by WMAS internal audit services and would like to thank the auditors for their thorough, balanced and considered approach, informed by and based upon the CCG's information and documentation and other evidence that is publicly available.

The CCG Governing Body has reviewed the report and carefully considered the lessons and recommendations set out in the report, which it accepts. There are clearly lessons to be learned and in light of this the CCG will in particular be reviewing how it conducts complex, high value procurements in the future, and our related procurement policy. The CCG will reflect on this report and the NHS England review that is due to be published shortly.

The ground-breaking, challenging and innovative nature of the integrated Older People's and Adult Community Services ('OPACS') procurement meant that the CCG relied heavily on external specialist advice, including legal and procurement advice. The CCG notes that the report suggests that further investigation may be required as to the advice and support that the CCG received from its external advisers in order to better understand the extent to which this may have contributed to the early termination of the OPACS Contract, lessons to be learned from this and consequently how best to mitigate the risks of such issues arising in the future. This applies particularly to how the fundamental change to the legal entity in the form of the UnitingCare Partnership, a Limited Liability Partnership, during the procurement, and to the Parent Company Guarantees that should have been in place as a condition precedent to the signing of contracts in consequence of that fundamental change.

The CCG is pleased to note that there is good evidence the procurement process and financial evaluation was designed to ensure that bids were evaluated to ensure service delivery within the CCG's budget. While the signed contract value was not disputed, the continued negotiations running in parallel with the mobilisation of new services and staff transfer clearly resulted in greater

risk than would have occurred had the negotiations been concluded prior to commencement.

In addition, as the Audit Report observes, the fact that the CCG did not see the CPFT (UC) business case approved by Monitor meant that the CCG did not know that there was a fundamental mismatch between the financial assumptions that were in excess of the CCG's expectations and the UnitingCare bid. The CCG's evaluation process did not highlight the need for the regulatory requirements to be shared. That is an important learning point for the CCG and for the wider NHS conducting similar procurements. The delay in regulatory approval for the business case until the end of March 2015 also put additional pressures on the mobilisation of services and the contract variation negotiations.

The CCG hopes that this report alongside the NHS England review, due to be published shortly, will help other commissioners undertaking large scale and complex procurements.

The CCG remains committed to delivering an integrated, outcomes based service for older people and adults being cared for in the community. We welcome the support we have had from stakeholders to this model and we continue to work with partners, stakeholders and staff to ensure we are able to deliver a good quality service to our patients within the resources available to us.