March 2016

NHS

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.

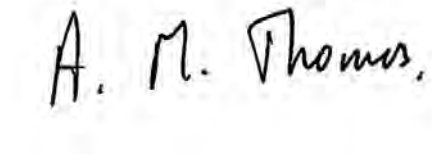
We urge you to join us in making the system serve you better. We look forward to improving it together.

Signed,

Dr Neil Modha
Accountable Officer, Cambridgeshire & Peterborough Clinical Commissioning Group

March 2016

Dr Alexander Gimson
Chair, Clinical Advisory Group



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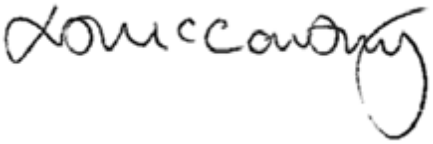
Chief Executive, Cambridgeshire and Peterborough NHS Foundation Trust



Lance McCarthy,
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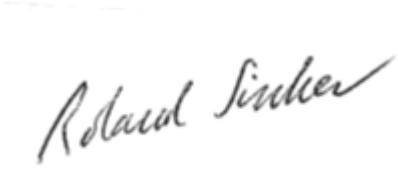

Roland Sinker,
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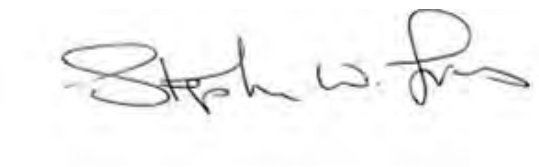

Stephen Graves,
Chief Executive, Peterborough and Stamford NHS Foundation Trust

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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;

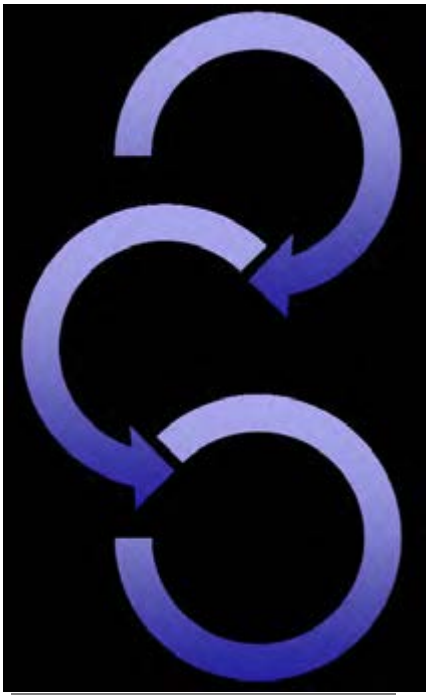
- The Funding and Efficiency gap: The NHS faces a deficit of £21 billion[2] in 2020/21. It must become more efficient to avoid the worst of all scenarios: poor quality services, fewer staff and restrictions on new treatments (NHS England, The Five Year Forward View)

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

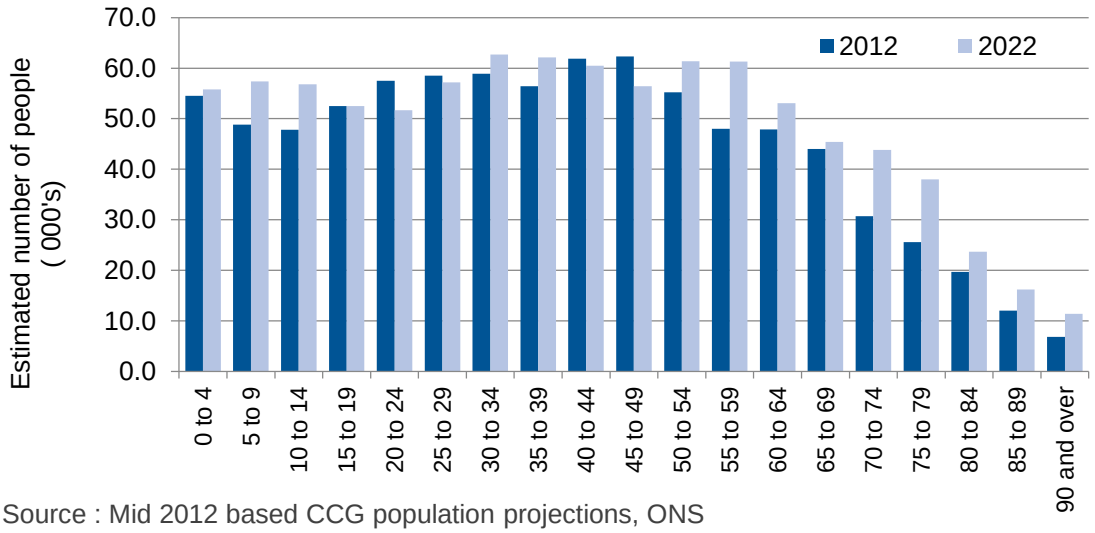
The size and average age of the local population are both increasing, in some cases more than other parts of the country. This means more people are experiencing health problems, and need greater levels of health and care services. In addition, our patients have told us that current services could be 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:

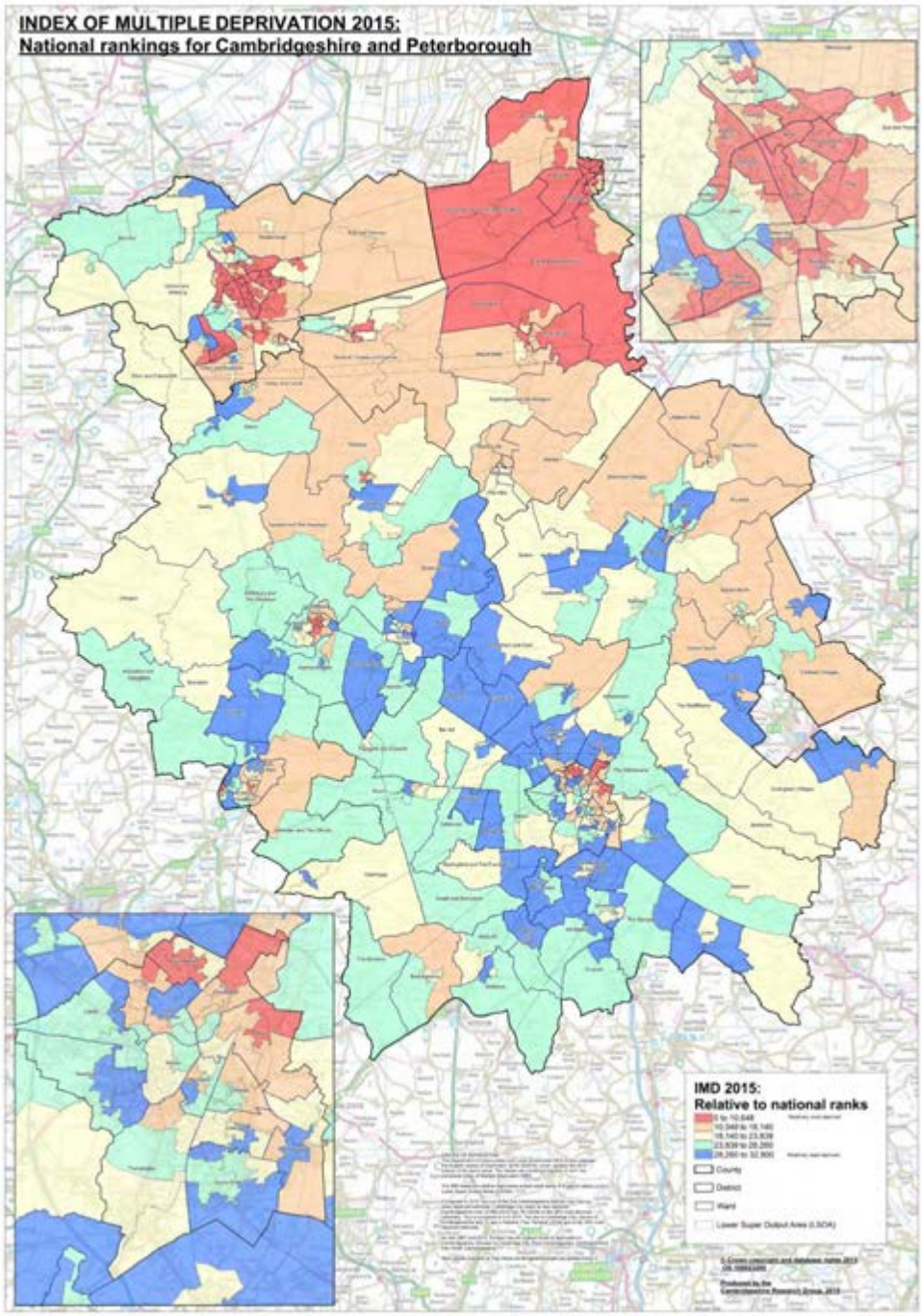
- Patients want to be empowered to stay healthy;
- Patients want easy access to information about their health (they use Google and pharmacies);
- Patients want to be educated to understand how to access the health and care services appropriately;
- Patients would rather use a community facility than 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

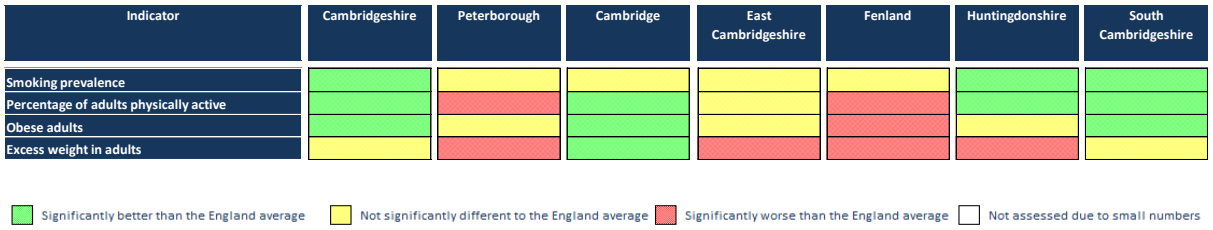
Health and Wellbeing

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.

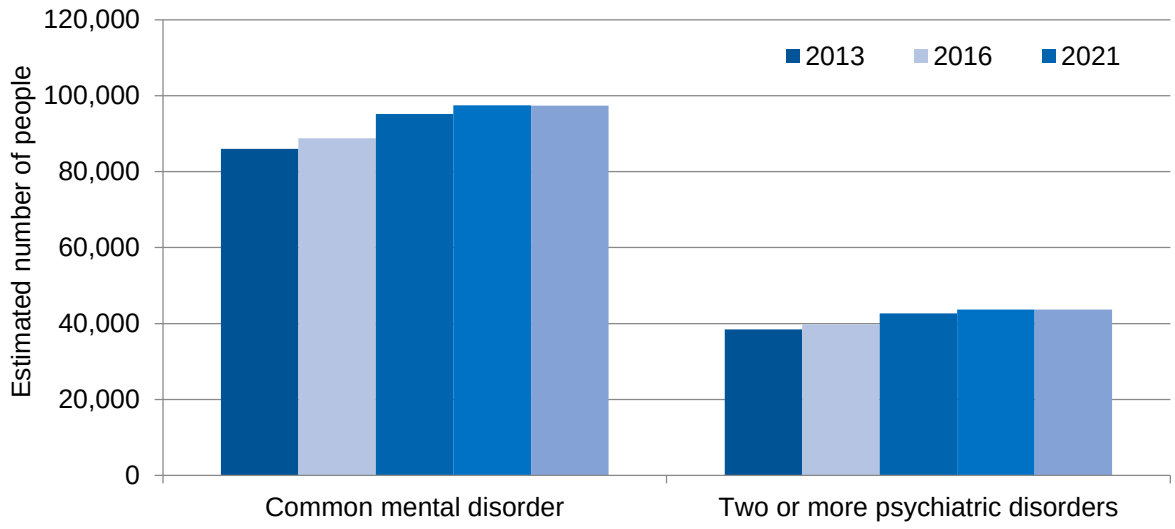
There is still much for us to do to align current services with the vision and create a sustainable, resilient primary care service. Primary care remains at the heart of a sustainable health and care system; where primary care struggles, echoes are felt across the system.

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.

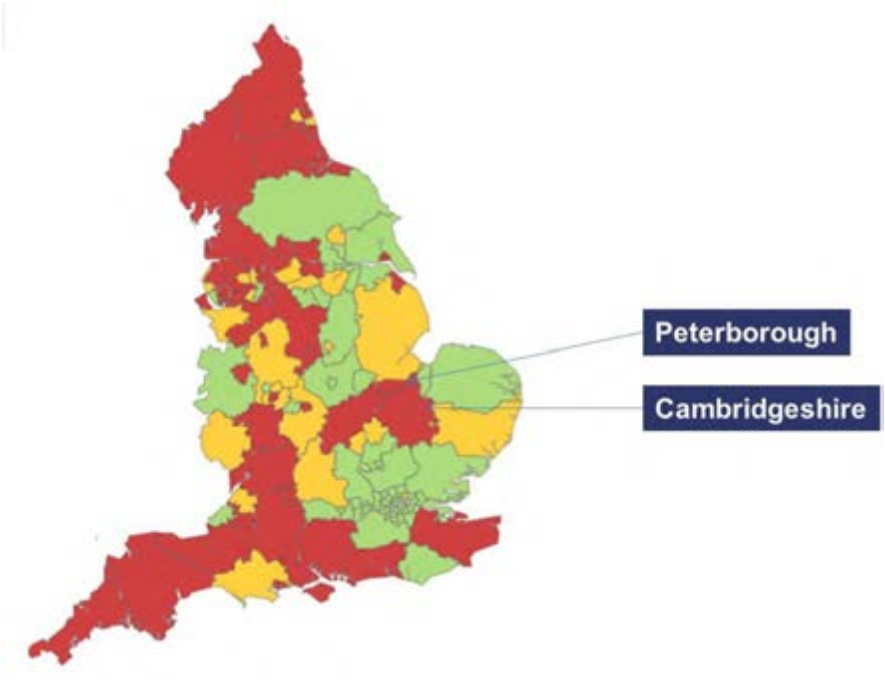
4.2.4. Children and Young People’s Services

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.

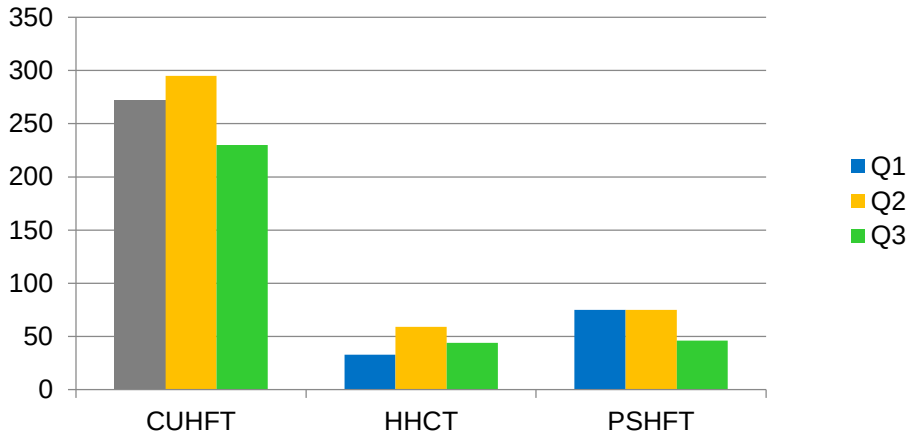
The CQC rated Papworth and Peterborough & Stamford Hospital (PSFHT) as providing 'good' quality of surgical care, whereas Addenbrooke's and Hinchingbrooke were both rated 'requires improvement', primarily due to operational issues, rather than quality of care.

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