CAMBRIDGESHIRE AND PETERBOROUGH HEALTH AND WELLBEING BOARD CORE JOINT SUB-COMMITTEE

Friday, 04 December 2020

10:00

Democratic and Members' Services
Fiona McMillan
Monitoring Officer

Shire Hall
Castle Hill
Cambridge
CB3 0AP

COVID-19

During the Covid-19 pandemic Council and Committee meetings will be held virtually for Committee members and for members of the public who wish to participate. These meetings will held via Zoom and Microsoft Teams (for confidential or exempt items). For more information please contact the clerk for the meeting (details provided below).

AGENDA

Open to Public and Press

The Cambridgeshire and Peterborough Health and Wellbeing Board Core Joint Sub-Committee comprises the following members:

For more information about this meeting, including access arrangements please contact

Councillor Roger Hickford (Chairman) Dr Gary Howsam (Vice-Chairman) Charlotte Black (Appointee) Councillor John Holdich (Appointee) Louis Kamfer (Appointee) Louise Mitchell (Appointee) Val Moore (Appointee) Wendi Ogle-Welbourn (Appointee) Liz Robin (Appointee) Jan Thomas (Appointee)

Clerk Name:	Michelle Rowe
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Agenda Item No:2

CAMBRIDGESHIRE AND PETERBOROUGH HEALTH & WELLBEING BOARD CORE JOINT SUB-COMMITTEE ACTION LOG

Updated: 26/11/20

Meeting date: 11 September 2020					
25.	**INTEGRATED COMMISSIONING BOARD PRIORITIES UPDATE**	Wendi Ogle-Welbourn	To bring a report on recovery and resilience in response to Covid-19 to the next meeting.		
		CCG's Chief Finance Officer	Offered to speak about an example of great work being done by local GP services in Peterborough in support of rough sleepers.		
26.	**CARE HOME SUPPORT PLAN**	Wendi Ogle-Welbourn	Offered to bring a report on the Resilience and Recovery Plan to the next meeting (same action as first action).		
		Head of Commissioning and Partnerships	To look into how PPE masks with visible mouth screen to support communication for those with hearing loss could be promoted.		

Meeting date: 7 November 2019					
13.	**MINUTES – 24TH SEPTEMBER 2019 AND ACTION LOG**	Jan Thomas	The CCG Accountable Officer reported that she would provide the exact figures reflecting the growth in non-elective admissions at Addenbrooke's and Peterborough City Hospital to the Clerk to circulate to the Sub-Committee.		
15.	**BEST START IN LIFE (BSiL) STRATEGY UPDATE**	Liz Robin Wendi Ogle-Welbourn	The Chairman asked officers to prepare a short summary to engage the public and parents.		
		Liz Robin Wendi Ogle-Welbourn	The need to make clear that the BSiL Strategy related to universal provision and areas such as fostering or adoption would be targeted separately.		

Better Care Fund Update

To: Cambridgeshire & Peterborough Health & Wellbeing Board
Core Joint Sub-Committee

Meeting Date: 4 December 2020

From: Will Patten, Director of Commissioning
Cambridgeshire County Council and Peterborough City Council

Purpose: To provide an update to the Health and Wellbeing Board on progress of the local Better Care Fund plans, including the recommended approach to 2020/21 plans.

Recommendation: The Cambridgeshire and Peterborough Health and Wellbeing Board Core Joint Sub-Committee is recommended to:

a) Note and comment on the contents of this report

b) Approve the recommended approach for the Better Care Fund Plan 2020/21

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Member contacts:
Names: Councillor Roger Hickford
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1. Background

1.1 This report is submitted to the Health & Wellbeing Board as an update, in accordance with the statutory requirement of Health & Wellbeing Boards to oversee local Better Care Fund plans.

1.2 This report is for the Cambridgeshire and Peterborough Health and Wellbeing Board Core Joint Sub-Committee to consider under its Terms of Reference.

2. Main Issues

2.1 Better Care Fund Reporting

Since March 2020, during the COVID pandemic, Better Care Fund reporting has been largely suspended. Whilst 2019/20 Quarter 4 reporting to NHS England was resumed and submitted in September 2020 (as reported to the September Health and Wellbeing Board Core Joint Sub-Committee), there has been no reporting for 2020/21 to date.

Currently, there is no indication on the approach to reporting for 2020/21 and further national guidance is awaited on this. However, it is recognised that national reporting metrics have been impacted by COVID. For example, Delayed Transfer of Care (DTOC) reporting has been nationally suspended since March 2020 so data is not available to report on this metric.

2.2 Better Care Fund Planning 2020/21

As yet, there is still no national planning guidance for Better Care Fund planning for 2020-21 and there is no indication currently on timelines for this. However, the published national recommendation is, in light of ongoing COVID pressures, to roll forward 2019/20 plans into 2020/21 to ensure service continuity. This is in line with the approach we recommend locally, as service provision of the Better Care Fund funds has continued into this financial year, to ensure that there has been no break in service provision and this has been maintained during the period of the pandemic.

Better Care Fund allocations have been published for 2020/21. The below table outlines the 2020/21 allocations, compared to 2019/20.

	Peterborough		Cambridgeshire	
	2019/20	2020/21	2019/20	2020/21
CCG Minimum Contribution	£12,270,498	£12,991,510	£38,651,879	£40,770,371
Disabled Facilities Grant	£1,970,984	£1,970,984	£4,467,928	£4,467,929
Improved Better Care Fund	£6,466,276	£7,259,937	£12,401,221	£14,725,277
Winter Pressures Grant	£793,661	-	£2,324,056	-
Total BCF Allocation	**£21,501,419**	**£22,222,431**	**£57,845,084**	**£59,963,577**

As anticipated the allocations for the Disabled Facilities Grant, Improved Better Care Fund (which includes the Winter Pressures Grant allocation) have remained at the same level as last year. In relation to the Better Care Fund CCG Minimum contribution, there has been an increase on last year's allocations of 5.48% for Cambridgeshire and 5.88% for Peterborough.

In line with previous years' national conditions and local plans, we recommend that:

- We continue to spend existing allocations in line with agreed 2019-20 plans. This will enable us to continue with our commissioned arrangements and ensure that we do not have any significant changes to provision whilst we continue to respond to the current pandemic;

- In relation to the CCG minimum contribution uplift, we propose that this uplift is applied proportionately to the CCG and ASC allocations, which is in line with the prior years' national conditions. This will enable both health and social care to address ongoing pressures.

A roll forward of 2019-20 plans into 2020-21 would continue investment of funding in the same areas, as broken down in Appendix 1.

Despite the absence of national planning guidance, the Integrated Commissioning Board has agreed to resume an evaluation of the Better Care Fund to inform 2021/22 planning, though recognises that the evaluation needs to be mindful of the impact of COVID on elements of Better Care Fund provision, including reporting metrics.

3. Consultation

3.1 Not applicable

4. Anticipated Outcomes or Impact

4.1 The report provides an overview of the Better Care Fund progress and 2020-21 planning recommendations. The outcomes associated with this:

- Maximising opportunities for joint commissioning across health and social care, reducing inefficiencies, duplication and ensuring best value
- Delivering joined up and consistent provision of person centred services

5. Implications

Financial Implications

5.1 Delivery assurance through the Board will enable the Council and the CCG to continue to meet NHS England's conditions for receiving BCF monies. The BCF funding is in line with the Council's Medium Term Financial Strategy (MTFS).

Legal Implications

5.2 Not applicable.

Equalities Implications

5.3 Summarise here any equalities implications related to this.

Not applicable.

6. Appendices

6.1 None.

7. Source documents

7.1 Better Care Fund 2020/21 allocations and planning recommendation

Better Care Fund Plan

Appendix 1 - Better Care Fund 2020-21

Breakdown of Investment

Financial Income 2020-21

The below table outlines the confirmed 2020-21 financial allocations for Peterborough and Cambridgeshire:

	Peterborough		Cambridgeshire	
	2019/20	2020/21	2019/20	2020/21
CCG Minimum Contribution	£12,270,498	£12,991,510	£38,651,879	£40,770,371
Disabled Facilities Grant	£1,970,984	£1,970,984	£4,467,928	£4,467,929
Improved Better Care Fund	£6,466,276	£7,259,937	£12,401,221	£14,725,277
Winter Pressures Grant	£793,661	-	£2,324,056	-
Total BCF Allocation	**£21,501,419**	**£22,222,431**	**£57,845,084**	**£59,963,577**

Financial Proposal 2020-21

In the absence of planning guidance and in line with the published national advice. In line with previous years' national conditions and local plans, we recommend that:

- We continue to spend existing allocations in line with agreed 2019-20 plans. This will enable us to continue with our commissioned arrangements and ensure that we do not have any significant changes to provision whilst we continue to respond to the current pandemic;
- In relation to the CCG minimum contribution uplift, we propose that this uplift is applied proportionately to the CCG and ASC allocations, which is in line with the prior years' national conditions. This will enable both health and social care to address ongoing pressures.

A roll forward of 2019-20 plans into 2020-21 would continue investment of funding in the following areas, as broken down in the below tables:

Cambridgeshire Proposal

Better Care Fund Monies

CCG Minimum Contribution	2019/20 Amount	Proposed 2020/21 Amount
CCC - Promoting independence	£1,525,000	£1,525,000
CCC - Intermediate Care and Reablement	£8,600,000	£8,600,000
CCC - Carers Support	£1,500,000	£1,500,000
CCC - VCS Joint Commissioning	£1,950,000	£1,950,000
CCC - Discharge Planning and DTOC	£944,000	£944,000
CCC – Protection of Adult Social Care	£1,255,041	£2,138,135
CCC - Social Care commissioning and protection	£338,000	£338,000
Subtotal - CCC Allocation	***£16,112,041***	***£16,995,135***
CCG - Intermediate Care and Reablement	£3,635,654	£3,635,654
CCG - Carers' Support	£297,758	£297,758
CCG – Carer's Support (Care Network)	£77,117	£77,117
CCG - Neighbourhood Teams	£13,982,107	£13,982,107
CCG – Assistive Technology	£176,392	£176,392
CCG – Discharge to Assess – CPFT	£2,212,500	£2,212,500
CCG – Discharge to Assess – Carers Trust	£150,000	£150,000
CCG – Discharge to Assess – Beaumont	£337,229	£337,229
CCG – Discharge to Assess – Midas	£744,785	£744,785
CCG – Discharge to Assess – Hilton	£399,990	£399,990
CCG – Discharge to Assess - Manor	£222,217	£222,217
CCG – Discharge to Assess – Orchard	£117,640	£117,640
CCG – Discharge to Assess – Ramsey Health	£10,000	£10,000
CCG – Wellbeing Network	£53,275	£53,275
CCG Commissioning and Transformation - Care Home Educators	£123,173	£123,173
CCG – Health uplift		£1,235,434
Subtotal - CCG Allocation	***£22,539,837***	***£23,775,237***
TOTAL CCG Minimum Revenue Contribution	**£38,651,879**	**£40,770,372**
Disabled Facilities Grant	£4,467,928	£4,467,928
TOTAL BETTER CARE FUND BUDGET	**£43,119,807**	**£45,238,300**

Improved Better Care Fund and Winter Monies

There has been no increase to Improved Better Care Fund or Winter Monies allocations in 2020/21. The below table breaks down the proposed investment based on a roll forward of 2019/20 plans.

Improved Better Care Fund		
	2019/20 amount	Proposed 2020/21 Amount
Investment in Adult Social Care and Social Work	£1,058,000	£1,058,000
Costed plan to support delivery of the 3.5% national DTOC target	£2,216,000	£2,216,000
Local Government Financial Settlement monies – protection of ASC in line with original intentions of the national grant	£9,127,000	£9,127,000
Total Improved Better Care Fund	**£12,401,000**	**£12,401,000**

Hancock Winter Monies		
	2019/20 amount	Proposed 2020/21 Amount
Domiciliary Care car capacity	£2,100,000	£2,100,000
Reablement provision - as provider of last resort	£300,000	£300,000
Total Winter Monies	**£2,400,000**	**£2,400,000**

Peterborough Proposal

Better Care Fund Monies

CCG Minimum Contribution	2019/20 Amount	Proposed 2020/21 Amount
PCC - Section 256 (Independent Sector Placements)	£3,522,000	£3,522,000
PCC - Protection of Adult Social Care	£2,283,642	£2,707,455
PCC - 7 Day Services / Reduction of DTOCs (reablement and bed based market)	£250,000	£250,000
PCC - Person Centred Services	£100,000	£100,000
PCC - Ageing Healthily and Prevention	£550,000	£550,000
PCC - Care Act	£407,000	£407,000
PCC - Carer's Support*	£75,000	£75,000
PCC - Wellbeing Network*	£25,000	£25,000
Subtotal - PCC Allocation	***£7,212,642***	***£7,636,455***
CCG - Carer's Support	£75,000	£75,000
CCG - Wellbeing Network	£25,000	£25,000
CCG - Integrated Adults Community Health Services	£4,957,856	£4,957,856
CCG - Health Uplift		£297,199
Subtotal - CCG Allocation	***£5,057,856***	***£5,355,055***
TOTAL CCG Minimum Revenue Contribution	**£12,270,498**	**£12,991,510**
Disabled Facilities Grant	£1,970,984	£1,970,984
TOTAL BETTER CARE FUND BUDGET	**£14,241,482**	**£14,962,494**

Improved Better Care Fund Monies

There has been no increase to Improved Better Care Fund or Winter Monies allocations in 2020/21. The below table breaks down the proposed investment based on a roll forward of 2019/20 plans.

Improved Better Care Fund		
	2019/20 Amount	Proposed 2020/21 Amount
Investment in Adult Social Care and Social Work	£231,000	£261,276
Commitment to joint fund with the STP Falls Prevention	£70,000	£70,000
Costed plan to support delivery of the 3.5% national DTOC target	£820,000	£790,000
Local Government Financial Settlement monies – protection of ASC in line with original intentions of the national grant	£5,345,000	£5,345,000
Total Improved Better Care Fund	**£6,466,000**	**£6,466,276**
Winter Monies		
	2019/20 Amount	Proposed 2020/21 Amount
Nursing Home Capacity	£793,661	£793,661
Total Improved Better Care Fund	**£793,661**	**£793,661**

Optimising Hospital Discharges through the implementation of Discharge to Assess (D2A)

To: Cambridgeshire & Peterborough Health & Wellbeing Board Core Joint Sub-Committee

Meeting Date: 4 December 2020

From: Executive Director

Purpose: To provide an overview of the changes implemented across local health and social care teams from March 2020 to optimise patient outcomes and experience following a hospital admission, and improve the process of discharging patients from hospital to their own home or other appropriate care setting. These changes have been implemented observing the key principles of national Discharge to Assess guidance.

Recommendation: The Sub-Committee is asked to note progress in implementing Discharge to Assess principles and processes to support patient discharges from hospital in Cambridgeshire and Peterborough.

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Member contacts:
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Tel: 01223 706398

1. Background

1.1 The Cambridgeshire and Peterborough system has faced some challenges in sustaining good patient flow out of hospitals and delivering national performance standards on Delayed Transfers of Care.

1.2 Discharge to Assess principles and pathways have been reviewed on a number of occasions and despite everyone's best efforts, several challenges remain regarding the pace of complex discharges, such as:

- Insufficient capacity to support home discharges and overreliance on bed-based community services.
- Most patients received health and/or social care assessments in hospital prior to discharge (contrary to D2A principles).
- Referrals for community services were sent from hospital to different services depending on discharge pathway, with "bounce" between some services often taking place and causing unnecessary delays to discharge.

1.3 At the end of March, and in response to the challenges posed by the covid 19 pandemic, national guidance about hospital discharges was issued setting out clear directives regarding the implementation of simplified processes and effective Discharge to Assess pathways.

1.4 In line with the national ask, the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and system partners mobilised very quickly to introduce the following changes:

- Simplified processes in hospitals with all patients referred to community services for discharge when they reach their Medically Fit for Discharge date (MFFD). No assessments take place in hospital with Mental Capacity Assessments being the only exception for safeguarding purposes.
- Established a Single Point of Access in community for all referrals to all health and local authority services supporting discharge.
- Redeployed 60 FTE CPFT staff and 5 FTE complex cases nurses to support D2A pathways, significantly increasing the capacity of intermediate care services in community, and proactively case managing patients following discharge from hospital.
- Increased commissioned capacity using national covid19 funding to include:
    - 346 beds in care homes providing a mixture of residential and nursing beds (including dementia care)
    - An additional 6 home care cars commissioned from the independent sector (2 had been commissioned during winter to cope with seasonal surges in demand and were extended, and a further 4 cars were added to increase pace of discharges from hospital in response to the covid 19 crisis).

1.5 The implementation of true D2A with all assessments taking place in community following discharge, paired up with the funnelling of all referrals through a single point of access and the availability of appropriate community capacity to support D2A pathways, delivered significant results in performance and patient flow.

1.6 This report is for the Cambridgeshire and Peterborough Health and Wellbeing Board Core Joint Sub-Committee to consider under its Terms of Reference.

2. Main Issues

2.1 In the summer the system received further national steer confirming we had to move to a “recovery” phase and start bringing back on line services that where paused in the midst of the pandemic and return to business as usual.

2.2 This provided system partners with an opportunity to discuss the impact and lessons from any changes implemented in the preceding months, to include the implementation of D2A and associated changes highlighted in point 1 of this report. It was agreed then that the system should find a way to sustain the achieved momentum even as the system downgraded the perceived “urgency” to free up acute capacity for critical care as covid19 admissions plateaued and subsequently decreased.

2.3 Further national steer was also received confirming the extension of additional funds linked to the pandemic that could be accessed to support hospital discharges, at least until the end of the March 2021.

2.4 As a result, D2A principles and processes have been consolidated establishing a long term framework that supports prompt patient discharges from hospital through a number of key health and social care pathways:

- **Pathway 0: Home with no support or minimal support / help**

  Patients leaving under this pathway are expected to recuperate with normal access to GP or some arranged follow up support from e.g. a District Nurse. Voluntary sector services and/or social prescribing are also used to support discharge and prevent further admissions to hospital. This should account for at least 50% of all hospital discharges.

- **Pathway 1: Home with Care**

  Patients go home with short term reablement or intermediate care services to help with their recovery. A case manager is allocated to every person on the pathway to actively monitor their progress. The support package will be flexed to match the progress of the individual and during this time assessment for long term need will take place to include any financial assessments if/as required. 45% of people discharged from hospital should leave under this pathway.

- **Pathway 2: Rehabilitation in a community in patient bedded facility**

  A proportion of patients for whom home is not an option will require rehabilitation in a community bedded facility or care home with therapeutic and nursing support to help their recovery. The goal is still to get the patient to their usual place of residence following the period of rehabilitation. A case is allocated to every person on the pathway to actively monitor their progress with assessment of longer-term needs, financial assessments and Continuing Health Care (CHC) eligibility made as soon as the case manager decides that an accurate assessment of future needs is possible. The national benchmark is for 4% of all discharged patients to go through this pathway.

- **Pathway 3: More complex patients with less potential to reable/rehabilitate**

  This pathway is for the small number of people whose needs are such that it is necessary for them to stay in a care home. It also includes patients who can be discharged home with domiciliary care support and who do not meet the clinical

criteria for D2A pathways 1 or 2. As with other pathways a case manager is allocated to every patient until assessments for long term care, including CHC eligibility, are completed and the case management can be handed over to the relevant organisation responsible for supporting the patient long term. This patient cohort is estimated to be the smallest with national guidance anticipating only 1% of hospital discharges to go through this pathway.

2.5 Significant investment has also been agreed in order to retain sufficient capacity in community to support discharges whilst also returning staff previously redeployed to D2A to their substantive roles and minimise risk of impacting negatively on other services at the expense of having sufficient capacity for D2A.

2.6 In September 2020 system partners agreed to invest £3.4m additional funds from the national covid 19 monies to the end of March 2021 to increase capacity levels in community. This funding is largely dedicated to the recruitment of staff such as care workers, therapists, and care coordinators; although a small proportion has also been used to enhance primary care cover of community in patient units at weekends, and additional designated beds in a few selected care homes to be added to the pool of capacity for D2A Pathway 2.

2.7 The challenges of recruiting additional staff particularly around key disciplines such as therapy are very much at the forefront of the local thinking. Therefore whenever possible system partners have opted for the sharing of capacity across organisational boundaries to increase efficiency and effectiveness. This has been one of the local success stories gaining recognition across the region as we have secured 9 therapists and 4 therapy assistants to redeploy from hospitals or other community services into D2A supporting true system working beyond organisational boundaries.

2.8 Furthermore, when additional capacity is required to meet increases in demand due to operational pressures system partners have devised a clear process to request additional funds to spot purchase capacity. Whilst the final decision for the approval of additional spend rests with Cambridgeshire and Peterborough CCG, the decision as to which patients warrant special consideration under this protocol is made by patient facing operational teams that understand the individual needs of the person best.

3. Consultation

3.1 Although all the changes that have taken place under D2A were driven by national mandate and formal consultation with service users or the wider public was not required, all system partners have been keen to ensure the patient / service user voice is taken into account in the commissioning of supporting services short, medium and long term.

3.2 During the first few months of the pandemic, patients discharged under D2A Pathways 1 through 3 were followed up by phone from the hospital Discharge Planning Teams to gather evidence of patient experience and ensure any issues from the patient perspective were promptly identified and followed up.

3.3 The CCG and local authority have also commissioned from Healthwatch Cambridgeshire and Peterborough a survey of a sample of people discharged from hospital. They are aiming to get the report published late November/early December, and we will be using the findings to further shape the future commissioning of relevant services.

4. Anticipated Outcomes or Impact

4.1 By retaining the processes and approach to D2A we will sustain the improvements and benefits we have seen to date, and we will also put the system into a much better footing to respond quickly and effectively to future pressures as we are seeing a second surge of covid19 cases alongside other additional seasonal pressures for the winter season.

The overarching principles that underpin the D2A model are aimed at optimising quality of outcomes of patients and patient experience. These are:

- Home First is an approach which expects people to return home as the preferred option, rather than end up by default in bed-based care.

- A hospital is not the right environment for people to make long-term decisions about their ongoing care and support needs. Home First and D2A enable assessments to be completed in community after reablement or rehabilitation if required.

- We will deliver integrated, timely, personalised care, not care that is most convenient for individual organisations. Flexible, multidisciplinary working involving health, social care and voluntary sector organisations to personalise services around individual need.

- The goal for everyone receiving support should be to maximise their long-term independence.

- It is key for the system to follow best practice in safeguarding, giving due consideration to deprivation of liberty, Mental Capacity Act (2005), and any other concerns that have been identified.

- The whole system response needs to enable local partners to develop creative solutions which meet local demand and capacity. Positive, collaborative system leadership supports the development of a shared vision, trust between partners and a sense of mutual endeavour to solve problems.

4.2 The increased capacity levels in community set out in point 3 of this report are expected to support an increase in the number of daily discharges and achieve 90% of maximum possible daily discharges from hospital.

5. Implications

Financial Implications

5.1 The national funding available to support discharges is only available to the end of March 2021. System partners will need to evaluate in January the full impact of the D2A programme in order to discuss options for the potential sustainability of this work should it be deemed the right way to proceed long term.

Legal Implications

5.2 None anticipated as all practice within D2A adheres to the necessary legal and operational frameworks for social care and health care teams.

Equalities Implications

5.3 A full Equality Impact Assessment has been completed on the D2A work programme with no concerns highlighted.

6. Appendices

6.1 None

7. Source documents guidance

7.1 Source documents

Hospital Discharge Service: Policy and Operating Model (August 2020)

7.2 Location

Hospital Discharge Policy

Best Start in Life Programme Update

To:	Cambridgeshire & Peterborough Health & Wellbeing Board Core Joint Sub-Committee
Meeting Date:	4 December 2020
From:	Wendi Ogle-Welbourn, Executive Director, People & Communities, Cambridgeshire & Peterborough Local Authorities
Purpose:	This report is being presented to update the Core Joint Sub-Committee on progress of the Best Start in Life Programme.
Recommendation:	The Core Joint Sub-Committee is asked to note and comment on the continued development of the Best Start in Life Programme.

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Member contacts:
Names: Councillor Roger Hickford
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Tel: 01223 706398

1. Background

1.1 This report is being presented to the Core Joint Sub-Committee members on progress of the Best Start in Life Programme.

1.2 This report is for the Cambridgeshire and Peterborough Health and Wellbeing Board Core Joint Sub-Committee to consider under its Terms of Reference.

2. Main Issues

2.1 **Best Start in Life Programme**

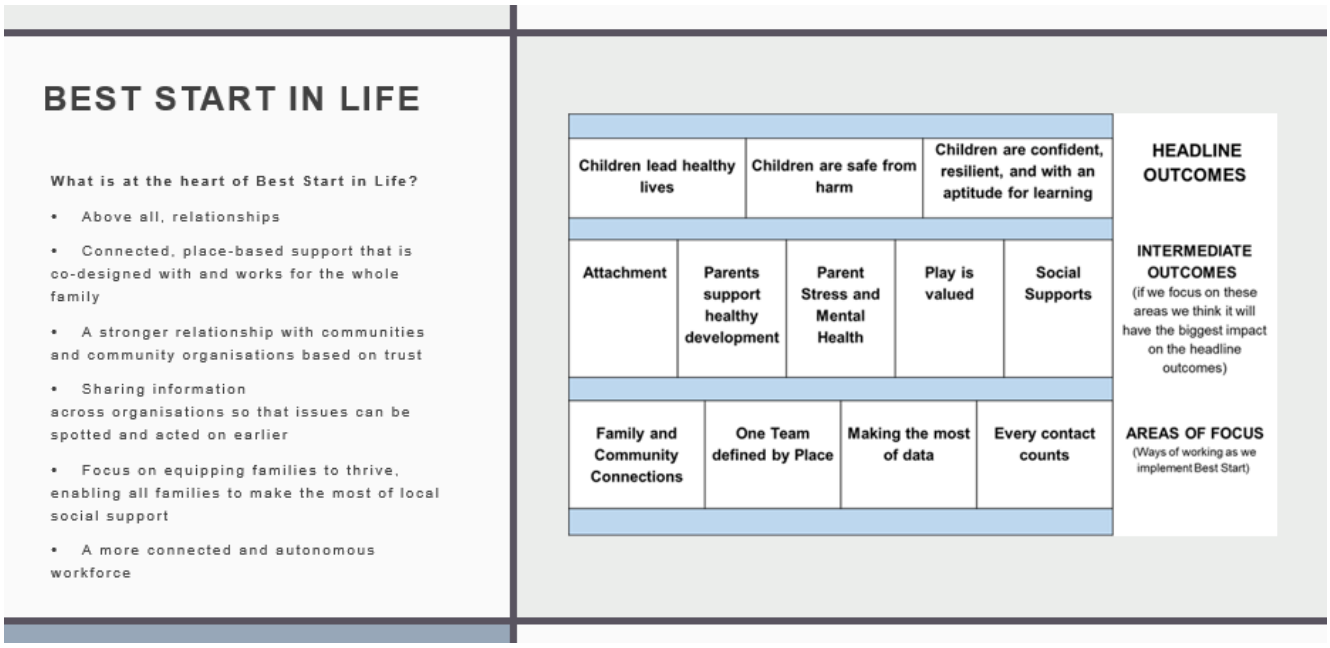
Phase 1 – Development of a Joint Best Start in Life Strategy

Best Start in Life is a 5 year strategy which aims to improve life chances of children (pre-birth to 5 years) in Cambridgeshire and Peterborough by addressing inequalities, narrowing the gap in attainment and improving outcomes for all children, including disadvantaged children and families.

2.2 The Best Start in Life strategy focuses on three key outcomes which represent our ambition for children in Cambridgeshire and Peterborough:

- Children live healthy lives
- Children are safe from harm
- Children are confident and resilient with an aptitude and enthusiasm for learning

2.3 The key aspects of the Best Start in Life programme are outlined in the infographic below:



2.4 **Phase 2 – Develop an integrated delivery model**

Phase 2 focused on the development of a new integrated delivery model which was presented to the Child Health Executive Board in September 2019. Members strongly supported the proposed integrated delivery model concept and recognised all of the hard and effective work that went into its development.

2.5 **Phase 3 – (delayed due to Covid-19) September 2020 – August 2021**

Work has now restarted on the full programme, with the core team meeting fortnightly to oversee the workstreams and includes colleagues from across the partnership. Phase 3 will now focus on piloting the integrated delivery model in 3 areas.

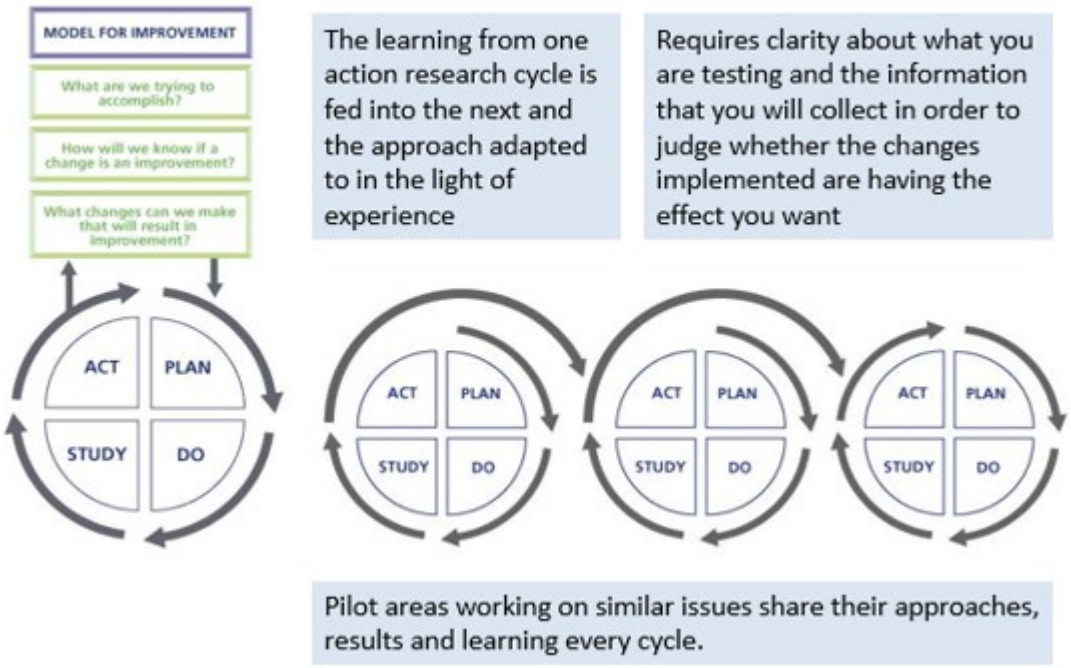
2.6 The BSiL place based workstreams have been established in Cambridge City, Wisbech, and the area of Peterborough around Honeyhill Children's Centre. We are also working with the Primary care network (PCN) in the Thistlemoor area of Peterborough on an additional place based pilot led by primary care colleagues.

2.7 Themes and issues identified in these local conversations are now being looked at alongside hypotheses developed by the steering group to identify the areas to test in the local pilots.

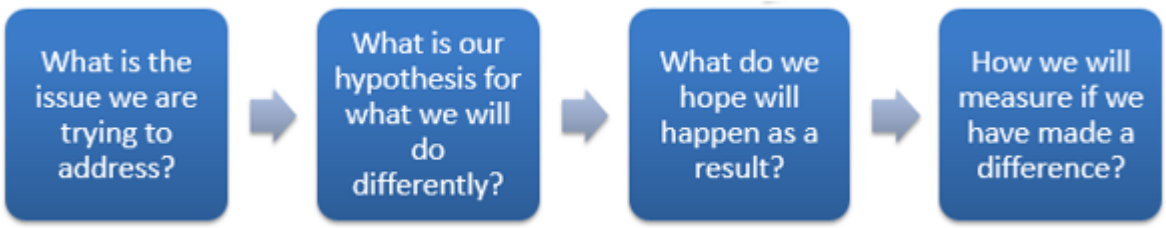
2.8 There are an additional 8 BSiL workstreams looking at overarching themes. These are described in the table below:

Digital Platform	Building a digital platform to provide a single point for families to access online information and where to find support.
Communications and Branding	Creating a communications strategy alongside a visual brand for the Best Start in Life programme. This will prioritise the development of 'Best Start on a Page'
Memorandum of Understanding (MoU) and Best Start Pledge	Finalising the MoU and developing a Best Start pledge for use across wider system partners.
Data Sharing and Pathway improvements	Looking at how data sharing can support integration linked to the place based pilots. Taking system-wide approaches to improving pathways from universal to acute needs.
Outcomes and Evaluation	Ensuring that our learning framework is embedded and we build in effective evaluation into all of our prototypes and pilots.
Building Best Start Culture and Workforce development	Agreeing measures to create the Best Start culture within the workforce, agreeing common approaches and messages, and supporting staff training and development.
Leadership and Governance	Moving the programme forward, ensuring that there are the resources and sign offs required.
Estates and Infrastructure	This workstream will be informed by new ways of working emerging from the prototypes and pilots.

2.9 As we progress with piloting aspects of the BSiL model, we will be using the below learning cycle to make sure that we are collecting the right information from the pilots to confirm that we are having the effect required to improve the outcomes that are identified.



2.10 This can be seen visually in the 4 questions below which will form the basis of the project plans for each activity. It is essential that the evaluation methodology for each BSiL pilot is decided on in advance of the pilot starting.



2.11 As the BSiL programme moves forward we have identified the following opportunities and challenges that we need to build into our next steps planning:

OPPORTUNITIES:

- Building on the partnership work developed during Covid to ensure that the recovery phase is planned with Best Start Priorities at the heart of the recovery plans
- Maternity services are re-starting the roll out of Continuity of Carer, a crucial foundation for the Best Start in Life place based work
- System wide developments including Think Communities and the Cambridge Children's Hospital.
- Sustainability and Transformation Partnerships (STP) Recovery work stream focusing on Children and Maternity.

CHALLENGES:

- Timescales for work are likely to be impacted by how the pandemic evolves. The roadmap will need to be flexible enough to manage this without losing momentum.
- This programme is looking at large scale, system wide change. We need to make sure that sufficient resource is allocated from across the partnership to develop the workstreams.

2.12 We are working with ISOS, an independent research and consulting organisation, to join up the Best Start programme with parallel work that has been looking at the Early Help offer for children aged 5-19 (or up to 25 yrs for those with SEND) and support for vulnerable adolescents, with the ambition to create a single pre-birth to 19 offer for families. The 5-19 service development that is underway within the Healthy Child programme will link into this wider system approach.

3. Consultation

3.1 A significant amount of work has been undertaken to engage the system workforce, partners, providers, agencies as each programme progresses through the phases.

3.2 Overall, with little exception, there has been a strong commitment to the programmes with a genuine desire for cross-organisational collaboration.

4. Anticipated Outcomes or Impact

4.1 The Core Joint Sub-Committee is expected to review the information contained within this report and respond / provide feedback accordingly.

5. Implications

Financial Implications

5.1 There are no significant implications within this category.

Legal Implications

5.2 There are no significant implications within this category.

Equalities Implications

5.3 There are no significant implications within this category.

6. Appendices

6.1 Best Start in Life Strategy 2019-2024

7. Source documents

7.1 None.

Best Start in Life Strategy 2019-2024

Contents

Authors and Acknowledgments

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Acknowledgements

The creation of the Best Start in Life strategy would not have been possible without the dedication and expertise of the strategy group members. As well as playing a key part in shaping the strategy they have helped to refine the document itself.

The input of wider multi-agency stakeholder group members has also been essential and we thank them for their commitment and guidance.

The executive leads, Wendi Ogle-Welbourn (Executive Director: People and Communities for Cambridgeshire & Peterborough Councils) and Dr Liz Robin (Director of Public Health) have provided the leadership and guidance necessary to ensure the success of the strategy development.

The 'Five Themes' which provide a focus for the strategy have been adapted from the Leeds 'Best Start' Plan 2015-19.

Executive Summary

Our Vision

Every child will be given the best start in life supported by families, communities and high quality integrated services.

Best Start in Life is a 5 year strategy which aims to improve life chances of children (pre-birth to 5 years) in Cambridgeshire and Peterborough by addressing inequalities, narrowing the gap in attainment and improving outcomes for all children, including disadvantaged children and families.

Why We Need Strategy

All children have the right to grow up with the best health possible, to be protected from harm and to have access to an education that enables them to fulfil their potential[1].

Whilst on many measures, the health and wellbeing of young children in Cambridgeshire and Peterborough compares well to other similar areas, this is not the case for all children. This creates unacceptable and avoidable inequalities which impacts on their future health and life chances.

For example, whilst the level of 'school readiness' in Cambridgeshire is similar to England as a whole, in Peterborough it is worse and they reside in lowest 10% of all local authorities. However, for children taking free school meals, Cambridgeshire is worse than Peterborough and England and has declined since 2015/16[2].

Many children also face a number of other challenges growing up, including; the effects of smoking in pregnancy, poor oral health, low vaccine uptake, parental mental health problems, domestic abuse and parental substance misuse.

Poor outcomes for children also have a significant social and economic cost. For example, high levels of accident and emergency department attendance and increasing pressures on Children's Social Care create unsustainable levels of demand for services. Public services are part of a wider local system which includes families, communities, local organisations and institutions, the voluntary sector and businesses. We believe it is only through taking a preventative approach and involving this wider system that our vision can be achieved[3].

Cambridgeshire and Peterborough has a huge range of services and innovative programmes available for children and families. However, evidence suggests that the best practice is not always available to all and that services are not always provided in a joined up way which is helpful to families[4]. There is much to be gained by creating a more integrated approach which maximises the benefits of services working together better and involving the public and communities at every stage.

[1] United Nations Convention on the Rights of the Child (UNCRC) 1989
[2] https://fingertips.phe.org.uk/profile/public-health-outcomes-framework
[3] Prevention is better than cure: Our vision to help you live well for longer. Department of Health and Social Care. November 2018
[4] Early Years Social Mobility Pilot Peer Review of Peterborough and Cambridgeshire. Local Government Association. 2018.

What We Are Trying To Achieve

We have an opportunity improve outcomes for children by bringing all the strands of early years provision together, into an integrated strategy and model of delivery.

The Best Start in Life strategy focusses on three key outcomes which represent our ambition for children in Cambridgeshire and Peterborough.

- Children live healthy lives
- Children are safe from harm
- Children are confident and resilient with an aptitude and enthusiasm for learning

The strategy will measure its success through a shared outcomes framework and developing a process for evaluation at an 'intervention' and 'system' level.

How We Will Achieve Our Goals

The core of the Best Start in Life Start strategy consists of;

Five themes[5] for integrated delivery – these describe how we intend to improve outcomes, by focussing on;

1. Healthy pregnancy for parents and children
2. Vulnerable parents - identified early and supported
3. Well prepared parents
4. Good attachment and bonding
5. Supporting child development

See page 32.

Nine building blocks – these form the foundations for creating a long term system wide collaboration which we believe will be required to improve outcomes for children. See page 33.

For example, central to the strategy is an acknowledgement that in order to create the change we want to see, it will require a change in culture and a co-ordinated approach across the whole workforce. This means everyone should know what it means to give children the Best Start in Life and how they can contribute to this vision.

How The Strategy Was Developed

The strategy development was led jointly by Cambridgeshire and Peterborough local authorities, working with a wide range of stakeholders. It is built on knowledge of local need and what the evidence says works in improving outcomes during the early years. Local user research also informed the process.

The strategy reflects the national and local policy context, including: Maternity Transformation - Better Births, The Government's Prevention Vision, the NHS Long Term Plan and the Government's plan for improving social mobility through education, Think Communities and Cambridgeshire and Peterborough's child poverty, healthy weight and SEND strategies.

[5] The 'Five Themes' have been adapted from the Leeds 'Best Start' Plan 2015-19.

Programme Plan

Phases 2 and 3 of the strategy run from May 2019 to March 2020.

Phase 2 (May to September 2019) will further develop the strategy and identify options for the future integrated delivery model.

Phase 3 (October to March 2020) will focus on arrangements for implementing the new model in April 2020, including development of the 'building blocks' which underpin the strategy.

Best Start in Life

Our vision

Every child will be given the best start in life supported by families, communities and high quality integrated services.

3 Key impacts

Children live healthy lives
Children are safe from harm
Children are confident and resilient with an aptitude and enthusiasm for learning

Outcome measures

Smoking and obesity during pregnancy Low birth weight – Infant mortality – Breastfeeding – A&E attendances – Unintentional and deliberate injuries – Dental decay – Excess weight – Immunisations – Rates of looked after children – Children in need plans – Child protection plans – Appropriate referrals to social care – School readiness (good level of development and phonics) – 2-2 ½yr HCP review (ASQ3) – 2 year early education progress check – Uptake of funded education

Integrated Delivery

5 Themes

Healthy pregnancy, parents and children
Vulnerable parents identified early and supported
Well prepared parents
Good attachment and bonding
Supporting child development

9 Building Blocks

A collaborative leadership and governance structure	Place-Based Strategies & Plans	Outcomes & Accountability
Funding & Commissioning	Culture Change & People Development	Integrated Service Delivery
Data, Evidence & Evaluation	Collaborative Physical and Digital Platforms	Communications & Engagement

Introduction

Best Start in Life is a 5-year strategy which aims to improve life chances of children in Cambridgeshire and Peterborough by; addressing inequalities, narrowing the gap in attainment, and improving outcomes for all children including disadvantaged children and families.

Evidence is clear that the early years (pre-birth to 5 years) are a crucial period of change. The experiences of parents, babies and children during this time lay the foundations for their future, and shape their development, educational attainment and life chances.

It is therefore a period of great opportunity, where the combined efforts of parents, communities and services can make a real and lasting difference. The Best Start in Life strategy aims to take this opportunity by being bold and acting to ensure that its vision and outcomes are a shared responsibility and ambition across all partners who provide a service to children and their parents. It sets out new arrangements for providing an integrated early years provision across Cambridgeshire and Peterborough.

A cultural shift is needed in the understanding of the 3 prime areas of development (personal, social and emotional; communication and language; and physical) and how to foster and promote secure and positive parent-child relationships. This means recognising that everyone can play a role, and ensuring that all professionals coming into contact with children or their parents feel a shared purpose and understanding of how they can contribute to giving children the Best Start in Life.

Finally, it is only by engaging and empowering parents and communities that we can ensure that they feel supported, in a positive way when they need it. The strategy will ensure that they know where to go for safe and consistent information, advice and support. Whilst for many, universal preventative approaches will be the right approach, some children and families will need more targeted and specialist support and this should be available close to where they live.

Background

Following a recent Early Years Social Mobility Pilot Peer Review of Peterborough and Cambridgeshire, undertaken by the Local Government Association (LGA), a recommendation was made that the local authorities develop a holistic early years strategy that brings together all the strands of the early years offer,[6] so that children across the county have the best start in life and are 'school ready'.

The review found a number of areas of innovative and impactful practice. This included the START[7] programme in Peterborough and the Wisbech Literacy Project. It reported that where services work together, there is a positive impact on children and their families. Examples included; co-ordination between Special Educational Needs Co-ordinators (SENCOs) and Portage Home Visitors[8]; working relationships around school clusters.

The review also identified a number of strategic issues and challenges, including;

- a lack of universal understanding about how early years, early help and early support join together to ensure that services are provided to families in a way that is right for them

[6] Including Better Births, Healthy Child Programme, Children's Centres and Early Years Education Settings
[7] A practical guide for parents and professionals on how to prepare children for school. https://www.peterborough.gov.uk/residents/schools-and-education/school-readiness/
[8] Portage is a home visiting educational service for pre-school children with additional support needs and their families.

- recruitment and retention of professional staff and budget reductions
- a lack of clarity around strategic leadership in health which creates issues for accountability and responsibility
- a need to align with the new SEND strategy – in particular early identification and joined up response to needs

The creation of a multi-agency early years strategy is an opportunity to address these issues and bring all the strands of early years provision together to ensure that the children in Peterborough and Cambridgeshire have the Best Start in Life.

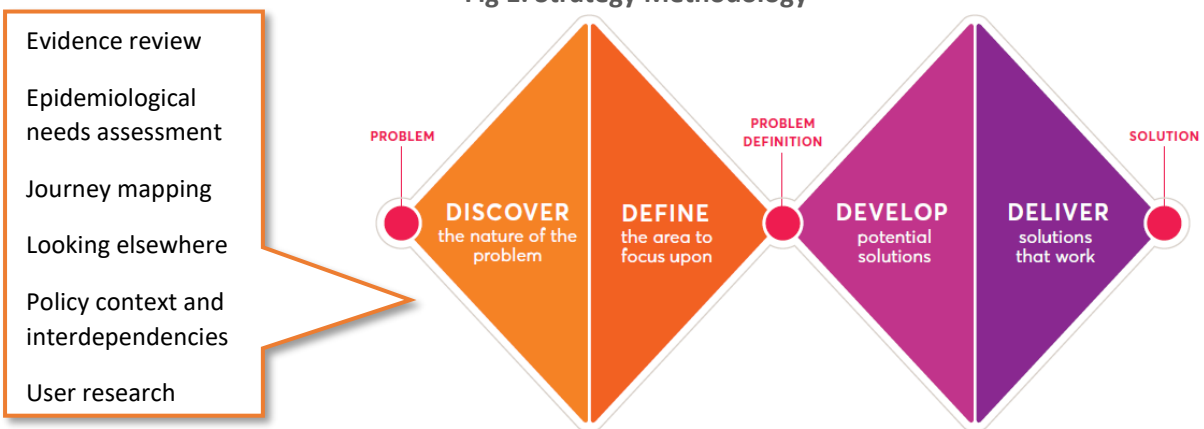
The Child Health Joint Commissioning Unit has worked with the providers of health visiting, school nursing, children's centres, early years education and early help services to review the delivery of early years provision. This work has taken into account national policy and guidance including 'Better Births'[9] and 'Best start in life and beyond'[10] and is set in the context of continuing financial constraints. In November 2018 it established a process for developing a Best Start in Life Strategy bringing together a wide range of stakeholders.

Strategy Development

The process to develop a Best Start in Life Start Strategy began in November 2018. A core strategy group met every two weeks to progress the work. Another, larger stakeholder group has met every 6 weeks. This has served as a reference group and also a forum for exploring or generating ideas, through a workshop format. See Appendix 1 for the groups membership.

The methodology used the four stages of design outlined in Fig 1. Initial phase of the project involved bringing together and synthesising the data, evidence, user research and journey mapping. It also included a look for integrated strategies elsewhere in the country. The elements of the draft strategy were then presented to the stakeholder group for agreement.

Fig 1. Strategy Methodology



[9] Better Births: Improving outcomes of maternity services in England. A Five Year Forward View for maternity care. National Maternity Review.

[10] Best start in life and beyond: Improving public health outcomes for children, young people and families
Guidance to support the commissioning of the Healthy Child Programme 0-19: Health visiting and school nursing services
Commissioning guide 2: Model specification for 0-19 Healthy Child Programme: Health visiting and school nursing services.
Revised March 2018. Public Health England

Best Start in Life Vision

Every child will be given the best start in life supported by families, communities and high quality integrated services.

Key Impact Statements

The Best Start in Life strategy focusses on three key outcomes which represent our ambition for children in Cambridgeshire and Peterborough;

- Children live healthy lives
- Children are safe from harm
- Children are confident and resilient with an aptitude and enthusiasm for learning

Guiding Principles

The strategy aims to give children the best start in life. We will achieve this by;

- Ensuring the opportunity to thrive is available to all children - leaving no one behind
- Recognising the diversity of our population
- Addressing inequalities in outcomes and access to advice and help
- Placing children and families at the centre of all that we do
- Empowering and supporting parents, families and communities to play a role
- Ensuring services work together well and overcome barriers to doing so
- Recognising that every professional has a role to play
- Ensuring the workforce are trained and supported to provide high quality and consistent advice and support
- Using the best available evidence and examples of good practice
- Achieving best value for money and effective use of the resources available
- Being bold in our vision and creative in our approach

Discover and Define

User Research

Best Start in Life Research

Engagement with the public and communities is central to the Best Start in Life strategy development and implementation. The approach adopted to date is ethnographic user research. This is an example of human centred design and allows us to understand and empathise with our users in order to design services to meet their needs.

As part of the Best Start in Life strategy development, a multi-disciplinary team of service specialists and designers went out over 2 weeks to settings, services, public places, health centres and homes to learn about people's lives. We wanted to find out what motivates and drives them, what is important to them, what the hardest aspects of parenting are and how they source help and support.

Below are some insights from the user research programme along with some representative quotes:

- **Parents value social connection and networks with others and they offer each other advice and support in parenthood.** Parents also seek personalised, professional advice and support and seek this during touchpoints with health visitors and also community groups. "I trust the advice from a professional. Families and friends have their own opinions and ways of doing things that is right for them." They also value seeing the same professional again, with whom they build up a relationship and trust. "It was really nice when the Health Visitor recognised me and my baby at the weighing clinic and asked how we were – it made me feel special"
- **It can be hard to ask for help if you are struggling with a new baby and there was a feeling that you have to know what the right questions to ask are**. One mum with post-natal depression said "you have to ask for help, which is the hardest thing because when the health visitor comes you are trying to impress them. No-one says "I'm really struggling" because they are scared of having their baby taken away so you put the brave face on and hide it"
- **Parents like groups led by volunteers and parents because they feel less watched and judged**. "The groups I attend are parent led rather than run by trained professionals, where it can feel like there is a social worker around."
- **There are many community groups that aim to cater for parent's needs and are highly attended and successful**. The most successful focus and succeed in giving parents a warm welcome, creating a non-judgemental environment, making activities available for children, giving parents a chance to relax and socialise with other parents and offering support from professionals. The groups that provide high quality refreshments help make parents feel valued. "Bumps and Babies had a really welcoming atmosphere, it felt safe, friendly, chilled out and calm. They had AMAZING coffee too! Great for bonding time."
- **There is a lack of community provision specifically for fathers**. [When you're the only Dad at a parenting group] "It's quite isolating, you don't feel included and you do feel vulnerable."
- **Most people know what it takes to be healthy (eating well and moving more) but most people know that they don't do the 'right' things all the time**. Getting children out and about walking and playing at the park is seen as important for their wellbeing. "My son is awful with eating the right things - he thinks we are trying to trick him"
- **Pre-schools are very good at helping to prepare children for school**, especially those that are linked to a school where the transition is more seamless. "Pre-school Piglets really helped with

the transition - they talked to the children about what a typical school day looked like, told them about uniform, how the desks would be set up and that they could get used to the environment. They also arranged for the pre-schoolers to join in a lunchtime at the school from Easter time."

- **Parents of children with disabilities or undiagnosed problems find navigating services, entitlement and regular form filling to be a significant 'pain point'**. Parents find the process of explaining their situation and accessing the help and support they need very challenging. "I love being Molly's mummy but I don't like the managerial/administrative side of it. It could be simpler. Molly will need an EHCP and SEND support and I find it so overwhelming I push it away...I don't know where to start with it all."
- **There is a perceived lack of support for children aged 2 to 5 and sometimes parents are not clear about what development milestones they should be** helping their children to achieve and by when. "There is a real lack of advice available from 2-5 years old and that it is assumed you've got it now – it's there if you need it, but you really have to seek it out yourself. It's a shock from the first two years when you have health visitors and regular appointments to just having nothing"

A further programme of user research and engagement is planned for two weeks in July 2019 which will be used to inform the co-produced strategy implementation plan, which will be supported by a communications strategy. The intention is to reach more of the public and professionals who represent the wide diversity across Cambridgeshire and Peterborough.

Cambridgeshire Children's Centre Consultation – July-September 2017.

The Best Start in Life Strategy is concerned with all aspects of early years provision and so public views on the use of children's centres is an important consideration. Questions 1-4 below related to children's centres across the local authority. Questions 5-9 related to specific district related plans and are not included below.

Question 1. Do you support our Children's Centres meeting the needs of a wider age range, from expectant parents to young adults?

You said:

You support us offering services across a broader age range.

There were concerns this would cost more money, and would require staff with different skills.

Question 2. To what degree do you support the proposal to focus services on those families that need them most?

You said:

Many of you agree we should focus our services on those who need us most.

Early Intervention is important to our residents.

We need to ensure our access routes to services is clear

Question 3. To what degree do you support the proposal to focus services on those families that need them most?

You said:

Having health services based with Children's Centre services could make it easier for people to access.

There were concerns this could create a space that was too clinical, and not welcoming.

Question 4. Our Child and Family Services will include the following:

- Maintaining some of our existing Children's Centres
- Delivering services in shared community spaces
- Providing outreach programmes at a local level
- A greater online offer. To what degree do you support this?

You said:

Many of you are attached to the building you currently use, even if they are underutilised.

Some people feel positively about services being delivered in other spaces, and feel it makes sense.

Many respondents have accessed outreach provision already.

Key Challenges

Impact 1: Children live healthy lives[11]

Smoking in pregnancy *has well known detrimental effects for the growth and development of the baby and health of the mother.* On average, smokers also have more complications during pregnancy and labour. Rates are particularly high for mothers attending Queen Elizabeth Hospital and Peterborough City Hospital where 22% and 14% of mothers report smoking respectively at time of delivery. This compares to 11% nationally.

Breastfeeding *has benefits for both child and the mother.* Exclusive breastfeeding is recommended for the first 6 months of life. Breastfeeding prevalence at 6-8 weeks is higher in Cambridgeshire than nationally and slightly higher in Peterborough. Trends are relatively static. However, breastfeeding prevalence increases as levels of relative deprivation decrease.

Low birth weight *is strongly associated with increased risk of infant death and poorer outcomes for the health and development of the child.* It is influenced by a range of factors including the mother's age and general well-being, ethnicity, smoking, nutrition, socio-economic position. Rates are statistically significantly high in most deprived quintile in Peterborough however there are hotspots across the county.

Vaccination *coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases.* This varies across the county and by vaccination type, with potential areas of concern in Cambridge City, where uptake is below 90% for 5 out of the 8 vaccinations reported. Two doses of MMR by 5 years olds are low in Cambridgeshire and Peterborough, but uptake is increasing. There are concerning downward trends in the uptake of most of the vaccinations in Peterborough.

Obesity *remains one of the biggest public health challenges facing the UK and other developed countries. The risk of obesity in adulthood and risk of future obesity-related ill health are greater as children get older.* Whilst levels of excess weight in reception year are similar to or better than the national averages, the picture across the county is variable. A fifth of children in Peterborough and Fenland enter reception with excess weight and overall the proportion of obese pupils doubles during primary school. Prevalence of overweight in reception is higher in some ethnic groups including, Black African and Bangladeshi children compared to the county as a whole.

Tooth decay *is one of the most common preventable childhood diseases and can often be arrested and reversed in its early stages.* Dental health is generally good in Cambridgeshire and the districts, with the proportion of decay in 3 and 5 year olds being significantly better than England. However, dental decay in 5 year olds is significantly worse in Peterborough, with a 32% of children experiencing decay (England = 23%).

A & E attendances *in children aged under five years are often preventable, and commonly caused by accidental injury or by minor illnesses which could have been treated in primary care***.** For children aged 0-4 years, attendance are high in Peterborough compared to England, and lower in Cambridgeshire. There is a strong correlation to deprivation with A&E attendances being significantly high from the most deprived areas of Cambridgeshire and Peterborough.

[11] Data Source: Best Start in Life Start in Life Data Pack Feb 2019. Helen Whyman, Public Health Directorate

Hospital admission rates for unintentional and deliberate injuries in children aged under 5 years are similar to England in Peterborough and better than England in Cambridgeshire, with both areas experiencing downward trends in such admissions. However, within the areas there is a correlation to deprivation, with admission rates higher from the more deprived areas

Impact 2: Children are safe from harm[12]

Nationally, Children's Social Care are experiencing unprecedented levels of demand. Research shows that between 2010-11 and 2017-18, referrals increased by 7% (broadly in line with population growth of 5.2%), while child protection assessments increased by 77%. The most expensive cases, where children are taken into care, have risen by almost triple the rate of population growth (15%) over the same period.

There are also significant local pressures. The number of child protection plans per 10,000 children aged under 18 years, between 2012/13 and 2017/18 have decreased in Peterborough (60 to 51) and *increased significantly in Cambridgeshire* (16 to 35). In Cambridgeshire, this represents an increase from 202 plans to 476 (at March 2018).

The rate of children in care (0-17) has increased in Cambridgeshire between 2011 and 2018, and has the 10th highest rate compared to its 16 statistical neighbours. Whilst the rate remains significantly lower than the national average there has been an increase from 470 to 705 children in care over that time period.

The rate of children in care (0-17) has decreased slightly in Peterborough, between 2011 and 2018, and has the 5th lowest rate compared to its 16 statistical neighbours. ***This remains significantly higher than the national average*** and there has been an increase from 310 to 370 children in care over that time period.

In December 2018,

- 901 children (aged 0-5) in Cambridgeshire were known to Children's Social Care. Of which; 60% were subject to child in need plans (CIN), 23% were subject to child protection plans and 17% were in care.
- 541 children (aged 0-5) in Peterborough were known to Children's Social Care. Of which; 70% were subject to child in need plans (CIN), 19% were subject to child protection plans (CP) and 11% were in care.

There is good evidence that the key causes of child maltreatment relate to the individual or combined effects of parental substance misuse, parental mental health problems and domestic abuse[13].

Local analysis suggests that for children aged 0-5 years there are,

- 4,700 living with an adult who has experienced domestic violence and abuse in the last year
- 2,900 living with an adult dependent on alcohol or drugs
- 7,500 living with an adult who has with severe symptoms of mental or psychiatric disorders

[12] Data Source: Best Start in Life Start in Life Data Pack Feb 2019. Helen Whyman, Public Health Directorate
[13] Early Intervention Foundation What Works To Enhance The Effectiveness Of The Healthy Child Programme: An Evidence Update Summary. 2018

- 21,000 living in household where an adult has a moderate or severe mental health problem. This represents a third of children aged 0-5.

Impact 3: Children are confident and resilient with an aptitude and enthusiasm for learning[14]

School readiness is a measure of how prepared a child is to succeed in school cognitively, socially and emotionally. Children are considered 'school ready' if they have reached a good level of development (GLD) at the end of the Early Years Foundation Stage (last term of Reception year, aged 5yrs).

Children are defined as having a good level of development (GLD) if they achieved at least the expected level in the early learning goals in the prime areas of learning (personal, social and emotional development, physical development and communication and language) and in the specific areas of mathematics and literacy.

In Peterborough school readiness is worse than England and despite improving slowly is in the lowest 10% of local authorities in England. In 2017/18, 67% of children were school ready.

In Cambridgeshire school readiness is the same as England but improving slowly. In 2017/18, 71% of children were school ready.

For children eligible for free school meals Cambridgeshire is worse than Peterborough and England and on the decline since 2015/16. In 2017/18, only 47% of these children were school ready.

Funded Pre-School Entitlement. Research shows that attending any pre-school, compared to none, is predictive of higher total GCSE scores, higher grades in GCSE English and maths, and the likelihood of achieving 5 or more GCSEs at grade A*-C.

Funded education uptake in January 2018 is shown in table 1 below. Cambridgeshire and Peterborough have lower proportions of funded early education children recorded as having a special education need compared to England, most notably in Cambridgeshire.

Table 1. Funded Early Education Uptake, Jan 2018[15]

	2 year olds	3 year olds	4 year olds	3 and 4 year olds
Cambridgeshire	68%	95%	95%	95%
Peterborough	69%	88%	95%	91%
England	72%	92%	95%	94%

[14] Data Source: Best Start in Life Start in Life Data Pack Feb 2019. Helen Whyman, Public Health Directorate

[15] Source: Provision for children aged under 5 years of age, January 2018, Department of Education. Children benefitting from funded early education in private, voluntary and independent providers, and in maintained nursery, primary, secondary and special schools.

Evidence Base

The Case for Investment

Producing robust estimates of how the costs of intervening compare with the long-term benefits to society is difficult. However, there is a compelling argument that the costs of intervening early are often likely to pay off to society in overall economic terms and that investing earlier rather than later will lead to cumulative benefits i.e. the skills acquired earlier in childhood will lead to greater additional gains as children get older.[16]

For example, it is estimated that failing to deal adequately with peri-natal health problems comes at a cost of £8.1 billion each year. Social Return on Investment Studies showed a returns of between £1.37 and £9.20 for every £1 invested. [17]

EIF has previously estimated that the costs of late intervention for children and young people add up to £17 billion a year across England and Wales (in 2016/17 prices)[18]. See Fig 2.

Fig 2. EIF estimate of the cost of late intervention

Source: EIF (2016) *The cost of late intervention: EIF analysis 2016.* 2016/17 prices.

Early Years Risk Factors

Studies show that early intervention works best when it is made available to children experiencing particular risks.[19] Risk factors exist at different levels and interact in complex ways, which are not fully understood. Some, such as antenatal development, occur at the level of the individual child whilst others work at the family level, community or societal level. Some risk factors are particularly pervasive, such as childhood poverty. See Appendix 2.

These risk factors are not predictive at an individual level but they can help to identify children who are vulnerable and who may need extra support.

Protective factors also operate at each level and can mitigate these risks. In many cases, risk and protective factors are two sides of the same coin. For example, good parental mental health can

[16] Realising the Potential of Early Interventions. EIF 2018.
[17] https://www.gov.uk/government/publications/health-matters-giving-every-child-the-best-start-in-life/health-matters-giving-every-child-the-best-start-in-life
[18] EIF (2016) The cost of late intervention: EIF analysis 2016. 2016/17 prices.
[19] EIF 2018. Realising the Potential of Early Intervention

underpin consistent and responsive parenting, but where there are problems it can have a wide-ranging impact on family life and child development.

Adverse Childhood Experiences (ACE)

ACE are stressful events occurring during childhood that directly affect a child (e.g. child maltreatment) or affect the environment in which they live (e.g. growing up in a house where there is domestic violence)

Research suggests that a high number of ACEs are associated with poorer outcomes in later life.

According to one study[20], those with 4 or more ACES are:

- 4 times more likely to have had sex while under 16 years old or to have smoked cannabis
- 4 times more likely to have had or caused an unintended pregnancy
- 8 times more likely to have been a victim of violence (12 months) or incarcerated (lifetime)
- 10 times more likely to have been a perpetrator of violence (12 months)

ACE theory is helpful for understanding importance of early years experiences on child development and providing a common language for early years practitioners, however the evidence is not yet advanced enough to be used for identify those at risk at an individual level or setting thresholds for help.

Reducing the Risk of Child Maltreatment

Over half of child protection cases involving an unborn child or infant are based on concerns related to child neglect. For a third of children, the initial concern is emotional abuse[21].

Studies consistently show that children are at a greater risk of maltreatment when[22];

- one or both parents have a mental health problem
- there is ongoing interparental violence in the home
- one or both parents misuse drugs or alcohol

Other factors known to increase the likelihood of child maltreatment include;

- high levels of economic disadvantage
- a low birthweight or premature birth
- higher numbers of children per household
- low levels of social support or single parenthood
- a history of parental maltreatment in childhood.
- children with special educational needs

[20]PHE and Liverpool John Moores University (2016): Adverse childhood experiences (ACE) study in Hertfordshire, Luton and Northamptonshire. http://www.cph.org.uk/publication/adverse-childhood-experiences-aces-in-hertfordshire-luton-and-northamptonshire/

[21] Office for National Statistics. https://www.gov.uk/government/statistics/characteristics-of-children-in-need-2017-to-2018

[22] Early Intervention Foundation What Works To Enhance The Effectiveness Of The Healthy Child Programme: An Evidence Update Summary. 2018

Reducing Child Obesity

Obesity is a complex problem with many drivers, including: behaviour, environment, genetics and culture. Public Health England recommend a number of ways to reduce obesity in children. These include,

- Decreasing pre-schoolers' screen time
- Decreasing consumption of high fat/calorie drinks/foods
- Increasing physical exercise
- Increasing sleep
- Modifying parental attitudes to feeding
- Promoting authoritative parenting
- Involving whole families (parents and children) in interventions that promote both healthier diet and more exercise

The Change for Life promotional campaign includes advice regarding diet and exercise, aimed at children. This includes, 'Sugar Swaps', 'Me Size Meals', '5 a Day' and 'Up & About'[23]. The Chief Medical Officer recommends that mobile under 5s should be physically active for at least 3 hours per day, spread throughout the day[24].

There are also a range of approaches that can be used to change the 'food environment' to promote healthier food and drink choices for parents and children. This includes using planning law to restrict the location and concentration of hot food takeaway outlets. Many local authorities are now working with outlets to encourage and incentivise the provision of healthier ingredients, menus and cooking practices[25].

Schools and early years settings can also play a part in encouraging healthier eating and physical activity.[26]

Improving School Readiness

In terms of what works to improve school readiness, the Department for Education has identified the following[27],

- Good maternal mental health
- Learning activities, including speaking to your baby and reading with your child
- Enhancing physical activity
- Parenting support programmes
- High-quality early education

Through its plan for improving social mobility, and closing the 'word gap', the Government has set a number of challenges which include; ensuring more disadvantaged children are able to experience a language rich early environment; improving the availability and take-up of high quality early years

[23] https://www.nhs.uk/change4life

[24]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213737/dh_128142.pdf

[25] Healthier Catering Guidance for Different Types of Businesses Tips on providing and promoting healthier food and drink for children and families. Public health England. March 2017

[26] Strategies for Encouraging Healthier 'Out of Home' Food Provision. A toolkit for local councils working with small food businesses. Public Health England and Local Government Association. March 2017.

[27] Department of Education, Department of Health (2011) Families in the foundation years evidence pack

provision by disadvantaged children and in challenging areas; improving the quality of early years provision in challenging areas by spreading best practice[28].

Evidence Based Interventions

Given the finite financial resources and the vast array of interventions available, it is more important than ever to be clear about which approaches have been shown to improve child outcomes and which ones have not.

Our evidence review considered 3 main sources of information;

- Early Intervention Foundation (EIF) – part of the What Works Network. The EIF Guidebook contains information on over 100 early intervention programmes that have been shown to improve outcomes for children and young people.
- Public Health England (PHE)
- National Institute for Health and Care Excellence (NICE)

The EIF adopt a widely used framework for categorising interventions according to need[29]. See table 2 below. Appendix 3 provides a summary of the evidence using this framework.

Table 2. Levels of Intervention

Universal	Targeted – selective	Targeted – indicated
Services/interventions which can be made available to all families, including immunisations, developmental reviews and antenatal care	These are offered to children or families based on demographic risks, such as low family income, single parenthood or adolescent parenthood.	Services/interventions for families with a child or parent with a pre-identified issue or diagnosed problem requiring more intensive support.

The evidence base should be considered alongside other factors like cost and existing local resources. Table 3 below shows the 3 interventions for which the EIF have given their highest evidence rating[30]. It clearly show the range of costs involved (5=highest[31]) and the extent to which this is likely to be an important local consideration.

Table 3. Interventions (0-5yrs) with evidence rating > 4. Source: EIF[32]

Programme	Age	Targeting	Evidence Rating	Cost Rating
Family Foundations	Peri-natal	Universal	4	1
Family Nurse Partnership (FNP)	Peri-natal	Targeted Selective	4+	5
The Incredible Years (IY) Preschool	Pre-school	Targeted Indicated	4+	2

[32] https://guidebook.eif.org.uk/

Evaluation and Monitoring

It is important to know whether the services or interventions provided are beneficial for the children and families who most need them and evidence about 'what works' is available to help guide commissioners and planners.

However, this evidence is usually at an intervention rather 'system' level, where a number of agencies, services and interventions are at work. As BSiL has an ambition to create an integrated model for early years it is important to consider how we can generate evidence of impact across the system. This is important for a number of reasons,

1) It is helpful to know which approaches are most promising or which features of the integrated system make the most difference
2) The BSiL strategy extends beyond traditional service delivery, and includes elements such as community engagement and culture change
3) The strategy is committed to building a shared accountability for outcomes across the system

The strategy therefore embeds the principles of evaluation and monitoring at two main levels; System and Service Delivery.

System Level

A draft BSiL Outcomes Framework is detailed in Table 4.

The 'building blocks' of the BSiL strategy includes a commitment to build local accountability through shared outcomes and metrics. As stated previously the strategy aims to explore how measures of impact at system level can be developed.

We aim to measure what is important to citizens and communities. This means thinking beyond traditional measures of user experience for specific services (e.g. children's centres, parenting groups) and working in collaboration with the public to understand what is important to them during the early years.

Service Delivery

It is essential to undertake regular service evaluation. Whilst many interventions may be 'evidence based', it is important to know whether they are producing the expected outcomes locally. For novel or adapted interventions, it provides an additional assurance that the resources are well used and creates an opportunity to share and extend promising new approaches.

The BSiL strategy is an opportunity to explore new evaluation methodologies such as the 'Rapid Cycle Adaptation and Testing[33] or the 10 step framework advocated by the EIF[34]. It is also an opportunity to

[29] Hardiker, P., Exton, K., & Barker, M. (1991). The social policy contexts of prevention in child care. British Journal of Social Work, 341–359

[30] Level 4 evidence rating = long-term positive impact through multiple rigorous evaluations. At least one of these studies must have evidence of improving a child outcome lasting a year or longer

[31] Level 5 cost rating = indicates that a programme has a high cost to set up and deliver, compared with other interventions reviewed by EIF. This is equivalent to an estimated unit cost of more than £2,000.

[32] https://guidebook.eif.org.uk/

[33] https://dartington.org.uk/responding-to-change-by-changing/

[34] 10 steps for evaluation success. Early Intervention Foundation. March 2019

consider how involvement in evaluation and research can be extended to parents and professionals who might not normally get involved.

Table 4. Best Start in Life Start in Life Outcomes Framework - Draft

Key Impact 1: Children Live Healthy Lives
Smoking at time of delivery
Low birth weight of term babies
Infant mortality
Breastfeeding initiation
Breastfeeding at 6-8 wks
A&E attendances - 0-4 years
Hospital admissions caused by unintentional and deliberate injuries in children - 0-4 yrs
Three and five year old children free from dental decay
Excess weight (overweight and obese) at Reception
Obesity at Reception
Immunisation targets met - 1 year olds (3 immunisations)
Immunisation targets met - 2 year olds (4 immunisations)
Immunisation targets met - 5 year olds (3 immunisations)

Key Impact 2: Children Are Safe From Harm
Rates of looked after children
Rates of child protection plans
Rates of child in need plans
Inappropriate referrals to Children's Social Care
Hospital admissions caused by unintentional and deliberate injuries in children - 0-4 yrs

Key Impact 3:Children are confident and resilient with an aptitude and enthusiasm for learning
Two year progress check (early education)
2 – 2 ½ year HCP review (ASQ3)
School Readiness: The percentage of children achieving a good level of development at the end of reception
School Readiness: The percentage of children with free school meal status achieving a good level of development at the end of reception
School Readiness: The percentage of Year 1 pupils achieving the expected level in the phonics screening check
School Readiness: The percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check
Uptake of funded 2,3,4 year old education entitlement

National Policy Context

Sir Michael Marmot's review of health inequalities in 2010[35] stressed,

"what happens in these early years, starting in the womb, has lifelong effects" on a person's health, wellbeing and life chances"

The importance of focusing on the early years of child's life is reflected in a number of recent Government policy documents and parliamentary publications.

The Government's Prevention Vision[36] includes within it an aspiration to give every child the best start in life, including.

- Encouraging healthier pregnancies (reducing smoking before or during pregnancy)
- Working to improve language acquisition and reading skills in the early years, including by supporting parents to help their children's language development at home
- Helping families by taking a whole family approach. This involves coordinating support for those that need it across a range of important areas, including: mental and physical health, housing, debt and employment, reducing parental conflict
- Improving dental health in children
- Protecting and improving children's mental health
- Encouraging healthier food and drink choices

This will be supported by the work of a **new Early Years and Family Support Ministerial Group** announced in July 2018[37]. This was preceded some years previously by the launch of **The 1001 Critical Days Manifesto**[38], a cross party manifesto setting out a vision for the provision of services in the UK for the early years period.

The NHS Long Term Plan includes a focus on providing children with a 'strong start in life', including

- implementing recommendations from the **National Maternity Review: Better Births,** implemented through Local Maternity Systems
- improving access to and quality of perinatal mental health care (up to 24mths)
- prioritising improvements in childhood immunisation
- reducing unnecessary A&E attendance
- new clinical networks for long-term conditions

The National Maternity Review (2016) in its report - **Better Births**[39] – set out the vision to improve the outcomes of maternity services in England so that they are personal and safe. It included a recommendation to create 'Community Hubs' where maternity services, particularly ante- and postnatally, are provided alongside other family-orientated health and social services

[35] Professor Sir Michael Marmot, Fair Society, Healthy Lives. The Marmot Review. 2010.
[36] Prevention is better than cure: Our vision to help you live well for longer. Department of Health and Social Care. November 2018
[37] Office of the Leader of the House of Commons, Cabinet Office and Rt Hon. Andrea Leadsom MP, Leader of the commons to chair ministerial group on family support from conception to the age of two, 27 July 2018
[38] The 1001 Critical Days. The Importance of the Conception to Age Two Period. A cross-party manifesto. Andrea Leadsom, Frank Field, Paul Burstow, Caroline Lucas. 2013.
[39] Better Births. Improving outcomes of maternity services in England. A Five Year Forward View for maternity care. National Maternity Review. NHS England. 2016

provided by statutory and voluntary agencies. They may be located in children's centres, GP surgeries, or midwife-led units.

They have two key purposes:

- To act as "one stop shops" for many services. This means different teams operating out of the same facility
- To provide a fast and effective referral service to the right expert if a woman and her baby need more specialised services.

The recently published **Health and Social Care Committee report, 'First 1000 days of life'** sets out the case for investment in the early years and strong national leadership. It suggests the need for a compelling, long-term strategic vision for giving every child the best start in life nationally as well as locally. In terms of local delivery it advocates 'proportionate universalism' [40], underpinned by,

- focus on prevention and early intervention
- co-design of services with the local community
- engaging with and supporting marginalised communities
- multi-agency working
- delivering evidence-based interventions

It also makes some recommendations regarding the Healthy Child Programme (including an additional mandated visit at 3-3 ½ years), workforce, funding and information sharing.

The Governments report '**Unlocking Talent, Fulfilling Potential. A plan for improving social mobility through education**' [41] sets out a number of ambitions for children and young people in order to "*level up opportunity across the country*" and "*leave no community behind*". This includes,

- Closing the 'word gap' in the early years
- Closing the attainment gap in school while continuing to raise standards for all

The Healthy Child Programme[42] for the early life stages focuses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting. Since 2015 local authorities have been mandated to provide five 'health visitor reviews' to all families within their area, during set periods in a child's development.

Troubled Families is a programme of targeted intervention for families with multiple problems, including crime, anti-social behaviour, truancy, unemployment, mental health problems and domestic abuse. It began in 2012 and is known locally as the 'Think Family Approach' in Cambridgeshire and 'Connecting Families' in Peterborough.

[40] An approach to reducing health inequalities with a balance of universal and targeted services, whereby those services are delivered in proportion to the level of need (Marmot Review 2010)
[41] Unlocking Talent, Fulfilling Potential. A plan for improving social mobility through education. Department for Education. December 2017.
[42] Healthy Child Programme Pregnancy and the first five years of life. Department of Health. 2009

Local Policy Context

Think Communities is Cambridgeshire and Peterborough's approach for creating a shared vision, approach and priorities for building community resilience across the county and reducing demand for statutory services. It is a 'place based' approach which has a strong emphasis on community involvement and creating the right conditions for long term system change i.e. one in which people, communities and services can work together effectively.

The **LGA Early Years Social Mobility Peer Review for Cambridgeshire and Peterborough** last year recommended that the local authorities develop a holistic early years strategy that brings together all the strands of the early years offer so that children across the county have the best start in life and are 'school ready'.

The new **Special Educational Needs and Disabilities (SEND) Strategy 2019-24** sets out the vision, principles and priorities to ensure that we are working together effectively to identify and meet the needs of Cambridgeshire and Peterborough's children and young people with Special Educational Needs and / or Disabilities (SEND) from birth to the age of 25. It has identified 3 priority areas for action.

1) **SEND is everybody's business** - embedding the vision of the SEND Strategy into the practice of everyone who works with children and families in ways that strengthen families
2) **Identify and respond to needs early** - a holistic and joined up early identification of and graduated response to needs
3) **Deliver in the right place at the right time** - improving outcomes for children and young people through making best use of resources, ensuring a graduated response and high quality local support and provision

The Fenland and East Cambridgeshire Opportunity Area (OA) was launched by the Government in January 2017 as one of 12 OAs across England. The aim is to raise education standards locally, providing every child and young person in the area with the chance to reach their full potential.

The first of it 4 priorities is to "Accelerate the progress of disadvantaged children and young people in the acquisition and development of communication, language and reading". Activity includes the launch of an Early Years Improvement Fund and a phonics project to upskill school staff.

Cambridgeshire County Council's Communities and Partnership Programme have developed a **strategy for tackling poverty and improving social mobility.** Amongst its 4 priorities are,

- Priority Two: Improving early literacy, education standards and raising skills
- Priority Three: Strengthening families and communities

Peterborough City Council's **Child Poverty Strategy (2016-21)**. It acknowledges the pervasive effect of poverty on children's life chances, the need to close the attainment gap and develop greater resilience within families. Amongst its 5 priorities, it acknowledges the need to address barriers to work through supporting families with complex needs, improving school attainment and aspirations, supporting children with special educational needs and disabilities (SEND).

Early Help Strategies for both Cambridgeshire and Peterborough set out how 'early help' services are organised across the county. They describe a number of themes, which emerge for the data and provide a focus for how services and interventions are delivered. These include,

- Reducing parental conflict
- Domestic abuse
- Emotional health and well being
- Exploitation
- Challenging / concerning behaviours and parenting support
- Neglect

The current **Healthy Weight Strategies** for Cambridgeshire (2016-19) and Peterborough (2019-2022, draft) emphasise the importance of a joined up 'whole system approach', formed of three main components across the life course, namely;

- the physical environment (e.g. minimise local promotion of unhealthy foods)
- work and educational settings (e.g. policies that support healthy eating and physical activity in pre-school settings)
- information and skills (e.g. equipping professionals to help others)

This is tied to the ambitions of the Government's Childhood Obesity Plan[43].

[43] https://www.gov.uk/government/publications/childhood-obesity-a-plan-for-action

Current Service Delivery

The Healthy Child Programme (0-5)

The Healthy Child programme (HCP) follows a 'progressive universalism' approach, with all families receiving basic elements of the programme and additional services being provided to those with specific needs and risks. Elements of the service include, screening tests, developmental reviews, and information and guidance to support parenting and healthy choices.

The HCP uses the 4-5-6 model. See Appendix 4. This means,

- **4** – levels: Community, Universal, Universal Plus (single service response) and Universal Partnership Plus (multi-agency response for children with complex needs)
- **5** – universal, mandated checks (after 28 weeks into pregnancy; 1 day to 2 weeks after birth; 6 to 8 weeks after birth; 9 to 15 months after birth; and 2 to 2.5 years after birth)
- **6** – high impact areas (parenthood and early weeks; maternal mental health; breastfeeding; healthy weight; minor illness and accidents; healthy 2 year olds getting ready for school.

The service is primarily delivered by health visitors and nursery nurses employed by Cambridgeshire Community Services (CCS) and Cambridgeshire and Peterborough Foundation Trust (CPFT).

The Family Nurse Partnership (FNP)

The FNP is delivered as part of the HCP. It is an in-depth, structured, home visiting programme which aims to improve pregnancy outcomes by supporting mothers-to-be to make informed choices about healthy pregnancy behaviours. This was originally offered to first time parents under the age of 19 at time of conception. However, in 2016, the National FNP Unit introduced the option to modify the eligibility criteria according to local circumstances.

Currently, in Cambridgeshire and Peterborough first time mothers[44] aged 19 years or under who meet the 'fixed' or 'high risk' criteria[45] are eligible for FNP and assigned a Family Nurse as the core offer, with the aim of enrolling women as early as possible in pregnancy, ideally before 16 weeks and by the 28th week of pregnancy. See Appendix 4 for more detail.

For those teenagers not meeting the criteria for FNP, the local commissioned HCP now includes an Enhanced Teenage Parent Pathway, led by FNP, working with the wider locality teams. This includes additional antenatal visits and at least monthly contact for the baby's first year of life. One hundred place are available.

Early Help

Ofsted consider early help to be required for;

"Those children and young people at risk of harm (but who have not yet reached the "significant harm" threshold and for whom a preventative service would reduce the likelihood of that risk or harm escalating) identified by local authorities youth offending teams, probation trusts, police, adult social

[44] Also available to other mothers who did not receive FNP with their first child.
[45] Fixed criteria include very young women (<16yrs) and children in need. High risk criteria include – mental health problems, ever a child in care, no or low educational qualifications (GCSEs)

care, schools, primary, mental and acute health services, children's centres and all local safeguarding Children Board partners including the voluntary sector where services are provided or commissioned"

Cambridgeshire Early Help Delivery Model

Requests for Early Help are received by the Early Help Hub which forms part of the Integrated Front Door, working alongside Multi-Agency Safeguarding Hub (MASH).

Requests will either be sent direct to the Early Help Hub through an Early Help Assessment[46], from the MASH or assessment teams if the threshold of Children's Social Care has not been met. The Early Help Assessment is shared when appropriate [and where there is consent] with other professionals who are working in a co-ordinated way to support the family.

Cambridgeshire Early Help Teams

Early Help teams are multidisciplinary[47] and integrated with Children's Social Care. They support children, young people and families across the 0-19 age range.

They are aligned with District & City Council boundaries. Each team is managed by a District Manager who reports to either the Head of Service North, or Head of Service South.

The 7 teams are:

- East Cambridgeshire
- South Cambridgeshire
- Cambridge City
- March, Chatteris & Whittlesey
- Wisbech
- Huntingdon & St Ives
- Ramsey, Sawtry, Yaxley and St Neots

Peterborough Early Help Delivery Model

Early Help in Peterborough is based on a commissioning model. The Local Authority Early Help Service supports practitioners and professionals in the field to take on the role of Lead Professional, complete Early Help Assessments and co-ordinate services around the family.

Interventions and services to support families are, in the main, commissioned and delivered by external partners, many of whom are third sector organisations. Examples include, supporting young people not in employment, education or training (NEET), youth workers, Healthy Child Programme, Mind, YMCA, NSPCC, Little Miracles (supporting children with additional needs, disabilities and life limiting conditions), CHUMS (emotional health and well-being), Project for Schools (mental health nurses working in primary schools) and Carers Trust.

[46] Early Help Assessment (EHA) as a holistic assessment that captures the family's strengths and unmet needs. They are completed by any professional or partner agency who comes into direct contact with families, and who has identified more than one unmet need that would benefit from a multi-agency support approach.
[47] Early Help Teams - Family workers, Young People's Services, Child and Family Centre delivery, Educational Inclusion Officers, Senior Transition Advisors, transition advisors and Youth Offending Service.

For those children requiring additional, more targeted support, this is accessed through an 'Early Help Panel'. Three outcomes are then available,

- Early Support Pathway (for children with complex health, education, or care needs)
- Multi-Agency Support Group (families requiring more targeted and co-ordinated support)
- Primary Behaviour Panel (for children whose behaviour is putting their school placement at risk)

The Early Help Service maintains a role in monitoring the progress of children through the pathway, at 1 and 6 months.

Children's Centres

Children's centres form part of the Government's agenda to improve outcomes for children, providing a place where families with children under 5 years can access a range of services. Their function and the responsibilities of local authorities are covered by statutory guidance[48].

The purpose of children's centre services is to improve outcomes for young children and their families, with a particular focus on the most disadvantaged families, in order to reduce inequalities in child development and school readiness. This is supported by improving,

- parenting aspirations, self-esteem and parenting skill
- child and family health and life chances

Child and Family Centres - Cambridgeshire

The provision of children's centres was redesigned in April 2018 following a public and staff consultation in 2017. There are 10 Child and Family Centres (some split over 2 sites) across the five districts, plus additional 'Child and Family Zones' (facilities where there is a shared building use). See Table 5 below.

All are managed 'in house' with the exception of South Fenland (March, Chatteris & Whittlesey) where services are delivered by Ormiston. A memorandum of agreement is in place with two nurseries, at Huntingdon Town and the Fields.

Child and Family Centres offer a range of groups, activities and one to one support delivered by Child and Family Centre Workers and Family Workers. The latter provide specific support to children and families known to Children's Social Care.

Centre activity varies across the area, and is provided based on local needs and available resources. However examples include,

- Parent/carer drop-ins
- 'Stay and play' groups
- Targeted parenting groups, school transitions
- Baby Rhyme Time, Messy Play
- Voluntary led toddler groups
- Creative families – talking together project
- Multi-agency early years conferences and safeguarding meetings

[48]Sure Start children's centres statutory guidance. For local authorities, commissioners of local health services and Jobcentre Plus April 2013

The Centres also provide a base for Healthy Child Programme activity (e.g. breastfeeding support, weigh-ins, drop-in clinics, peri-natal mental health support) and midwifery (e.g. antenatal clinics and antenatal classes).

Table 5. Cambridgeshire - Child and Family Centre Offer		
	Child and Family Centres	Child and Family Zones
Fenland	Wisbech (Wisbech Town and Wisbech South)	
	March, Chatteris	Whittlesey
East Cambridgeshire	Ely, Littleport	Soham
Cambridge City	Chesterton/North Cambridge (split Site), Abbey Child and Family Centre (The Fields)	Trumpington, Peacock Centre
South Cambridgeshire	Cambourne	Waterbeach, Sawston, Melbourn, Northstow
Huntingdon	Eaton Socon/Eynesbury (split Site), Huntingdon Nursery/ Huntingdon Youth Centre (split site)	Sawtry, Ramsey, St Ives

Children's Centres – Peterborough

There are four children's centre 'hubs' in Peterborough, with a further three linked sites. They are commissioned externally and provided by Barnardos and Spurgeons. See Table 6. The centres provide a range of services and activity, similar to that provided in Cambridgeshire.

Table 6. Peterborough – Children Centres	
Central (Barnardos)	East Children's Centre – Dogsthorpe
	First Steps Children's Centre – Welland, Dogsthorpe
	linked sites at Fulbridge School and Gladstone Primary School
North (Spurgeons)	Honeyhill Centre – Paston
	linked site at Watergall School
South (Spurgeons)	Orton Children's Centre - based at Orton Malbourne, Herlington

Early Years Services - Education

Local authorities are required to secure sufficient early years education and childcare provision[49]. This includes an entitlement of 570 hours of free early education entitlement per year for eligible 2 year olds to be taken over no fewer than 38 weeks, equating on average to 15 hours/week [50]. This is also available universally to working parents of 3 and 4 year olds. If both parents are working, most[51] are also entitled to an additional 570 hours per year.

The majority of early education and childcare provision is operated by private, voluntary or independent (PVI) groups. The maintained (council run) sector accounts for a small proportion of

[49] Childcare Act 2006

[50] Eligibility criteria include parental receipt of benefits, children with a statement of special educational needs, children with an education, health and care plan, children in receipt of disability living allowance, children looked after by a local authority.

[51] Where both parents earn a weekly minimum equivalent to 16hrs at national minimum wage or national living wage and less than £100,000.

groups based settings in Peterborough and Cambridgeshire. Childminders are also a vital element within the overall childcare mix in the county.

Delivering services to meet the needs of families requires a partnership approach between the Councils and the PVI sector. Direct delivery by the council is only considered where there is no alternative, an approach encouraged by the Government.

The Early Years Services in Cambridgeshire and Peterborough have a role in supporting early years settings and monitoring the quality of their provision. This is achieved through a range of activity, including training and site visits.

The Early Years Services also co-ordinate or contribute to a range of projects and programme across the county which support early education. This includes,

- Speech, language and communication needs (SLCN). 1 year PHE/DfE led training for health visitors in SLCN
- I CAN and EasyPeasy – home learning environment. 1 year programme starting March 2019
- Talking Together in Cambridgeshire –language and literacy project in deprived communities
- East Cambs and Fenland Opportunity Area Phonics Project
- Cambridgeshire Early Years Service on behalf of the East Cambs and Fenland Opportunity Area. Targeted - 60 practitioners developing phonics skills and confidence through champions and cascade training to others. (October 2018 –June 2019)
- Early Talk Boost - targeted intervention for practitioners in Cambridgeshire settings to work with children with language delay.

Maternity Provision and Better Births

The Better Births agenda is being taken forward locally by Local Maternity System, which brings together the user voice (including Maternity Voice Partnerships and Healthwatch), the voluntary sector, commissioners and providers of statutory maternity services.

Within Cambridgeshire and Peterborough CCG this is overseen by the Senior Responsible Officer and the Maternity Transformation - Better Births Programme Manager.

Through partnership with local authority children's commissioners, three community hub launches have taken plan these are based in children's centres. This work stream also includes the development of 'Pathways to Parenting', a universal antenatal parenting programme which is in pilot form and due to roll out geographically across Cambridgeshire and Peterborough.

Best Start in Life Strategy Proposal

Five Key Themes

The Best Start in Life Start strategy proposes that 5 key themes provide the framework for a new integrated model for early years. Within each theme, detail is provided regarding the areas of focus. This will be delivered through a mix of universal and targeted approaches, and use a variety of methods (face to face, digital, telephone). Wherever possible, a standardised approach will be used, however it may need to be modified locally to be effective.

Healthy pregnancy, parents and children

- Healthy weight – diet and physical activity (incl. mother and baby nutrition)
- High quality maternity services – Better Births & maternity community hubs
- Reduce unplanned teenage pregnancies and support teenage parents
- Improve breast feeding rates
- Increase smoking cessation in pregnancy
- Improve oral health and immunisation uptake
- Reduce childhood accidents

Vulnerable parents will be identified early and supported

- Perinatal mental health support – extended to mild/emerging problems, including infant mental health pathway (identify attachment difficulties early offer support)
- Support parents to reduce use of alcohol, drugs and tobacco
- Support parents to reduce levels of domestic violence/parental conflict

Well prepared parents

- High quality education on sex and relationships
- Antenatal education programmes and postnatal programmes – universal and targeted (e.g. Pathway to Parenting, Baby Steps, FNP)
- Evidence based parenting programmes – universal and targeted
- Promote awareness of specific risks - safe sleeping and accidents
- Parents with an understanding of; their role in child development and learning; how to access services

Postive attachment and bonding

- Perinatal mental health support – extended to mild/emerging problems, including infant mental health pathway (identify attachment difficulties early and offer support)
- Promote positive parent- child interaction (e.g. Five to Thrive - Respond · Cuddle · Relax · Play · Talk, Big Little Moments)

Supporting child development

- Raise awareness of parents about 3 prime areas of development - personal, social and emotional; communication and language; and physical
- Promote early play and communication opportunities
- Promote positive ways to help of help children thrive – through interaction, social contact, first hand experiences e.g. 50 Things to do before you're 5
- Early identification and assessment of need (ASQ, integrated review) - including children with SEND

Building Blocks

As outlined in *Building Collaborative Places: Infrastructure for System* Change, the move to an integrated approach to supporting children pre-birth to five requires the deliberate creation of shared infrastructure as well as the right conditions to 'connect people and organisations and help align the incentives driving individual organisations, creating a gravitational pull that is towards collaboration for shared outcomes.[52] This view places public services (including local authorities, health bodies, and police) within a wider local system which includes people, families, communities, local organisations and institutions, the voluntary sector and businesses – clearly indicating that the public sector alone cannot solve complex social problems.

Drawing from systems change research and more mature early years integration efforts, we propose that our work to implement the Best Start in Life Strategy also include the establishment of key 'building blocks' to support system wide collaboration, as articulated by Collaborate CIC and Lankelly Chase in their 2017 report:

- **Place Based Plans:** These plans set out the social and economic vision for place as a shared challenge among local partners and citizens, and core operating principles for local public services. These plans will be co-produced with families and young children, with particular care and attention to reflecting the cultural and linguistic diversity of our communities. In Cambridgeshire and Peterborough, this work should consider and wherever possible, align with other local programmes of place-based change, including Think Communities and the new primary care networks.[53]
- **Leadership and Governance:** In order to deliver the Best Start in Life strategy, a collaborative system leadership forum which includes community representatives as well as public and voluntary sector representatives and share a commitment to create the necessary conditions to enable collaborative problem solving and embed new shared operating principles.
- **Outcomes and accountability:** Identifying shared outcomes to support children's health, safety and school readiness. Outcomes which reflect the social and economic challenges and aspirations of our places and hold the entire system to account. In this context, organisational outcomes are aligned with place-based outcomes, measuring what is important to citizens and communities and avoiding targets which 'miss the point.'
- **Funding and commissioning:** Considering opportunities for collaborative funding arrangements which support achievement of shared outcome and help reduce duplication and waste, developed in collaboration with service users and flexible to accommodate ongoing learning.
- **Culture change and people development:** Culture change and organisational development programmes designed to develop the capacity of our workforce to work across organisational boundaries. The purposeful creation of a shared culture across our early years workforce where individuals can clearly see their role in giving our youngest children a best start in life. The development of shared knowledge and practice tied to the key areas of focus of the Best Start in Life strategy and its underpinning principles.

[52] Building Collaborative Places: Infrastructure for System Change. Collaborate and Lankelly Chase February 2017
[53] Primary care networks will be based on GP registered lists, typically serving natural communities of around 30,000 to 50,000.

- **Integrated delivery:** Collaborative service models bringing education, early help and community health together in meaningful ways where it makes sense to do so, supporting working relationships built on trust. This will include the iterative design and delivery of interventions, developed with input frontline staff and families and a focus on effective prevention and targeted early intervention. Staff work across organisational boundaries to provide a more coherent approach.
- **Data, evidence and evaluation:** Shared data, both quantitative and qualitative (reflecting the lived experience of children, parents and professionals) used effectively to understand and address root causes of issues and demand. A collaborative 'test and learn' approach that allows for a flexible response to early years interventions.
- **Collaborative digital and physical platforms**: Physical and virtual spaces that bring together people and organisations, enabling them to connect, develop networks and share information. This could include a dedicated website which provides or signposts parents and service providers to trusted information and delivers digital interventions. Enhancing existing public sector co-location, supporting collaboration and the design of joint solutions by cross-sector teams.
- **Communications and engagement:** Clear and consistent information and insight shared fluidly throughout the system: vertically (top-down and bottom-up) and horizontally (across sectors), enabling real-time collaboration and adaptive delivery. Providing families with easy access to reliable, consistent and up-to-date ideas, advice and services. A fundamental commitment to partnership with parents (volunteering, local delivery, service design).

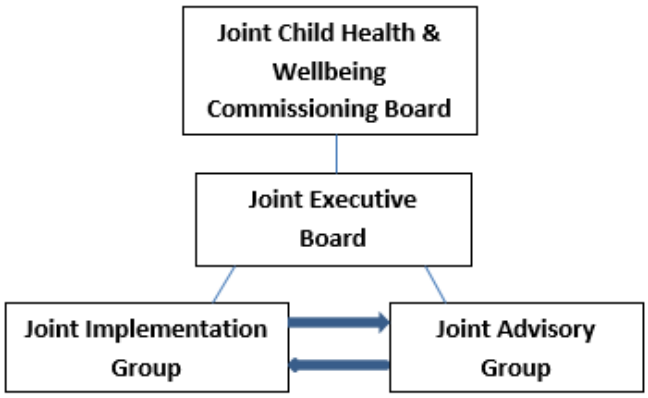
Next Steps

Phases 2 and 3 of the strategy run from May 2019 to March 2020.

Phase 2 (May to September 2019) will further develop the strategy and identify options for the future integrated delivery model.

Phase 3 (October to March 2020) will focus on arrangements for implementing the new model in April 2020, including development of the 'building blocks' which underpin the strategy.

A new governance structure will be used, with a direct reporting line through to the Joint Child Health and Wellbeing Commissioning Board. The indicative schedule until September 2019 is outlined below.



(Formerly, the 'Strategy Group')

(Formerly, the 'Stakeholder Group)

Timeline – May – September 2019

May		**June**		**July**
w/c 6th	w/c 27th	w/c 10th	w/c 24th	w/c 8th
Understanding system conditions	Evidence about what matters/local priorities Consolidating insights from families and communities	System/service and asset mapping	System, service and asset mapping 1-day Summit	Opportunities for evidence informed practice, improvement and innovation
July	**August**		**September**	
w/c 22th	w/c 5th	w/c 19th	w/c 2nd	w/c 16th
Workforce and System Leadership	Theory of change for Integrated Delivery Model	Local theory of change to reflect geographical prioritisation	1-day summit	Refine integrated delivery model and finalise work plan for Oct 19 – March 20

Appendix 1 – Best Start in Life Group Membership

Strategy/Implementation Group

Chair	John Peberdy, Director of Children's Services, Cambridgeshire Community Services
Public Health Lead/Co-ordinator	Ben Brown, Specialty Registrar Public Health (PCC and CCC)
Transformation Team Lead/Co-ordinator	Gwendolyn Casazza (CCC) Rebecca Pentelow (CCC) Emily Sanderson (CCC)
Early Years leads	Karen Hingston (PCC) Annette Brooker (CCC)
Early Help leads	Lisa Riddle/Sarah Tabbitt (CCC) Karen Moody (PCC)
Health Visiting leads	Andrea Graves/ Verity Trynka-Watson (CCS)
Children's Commissioning Lead	Pam Setterfield (PCC and CCC)
Commissioning Team Manager- Healthy Child Programme	Helen Freeman, Public Health (PCC and CCC)
Speech and Language Therapy, Nutrition and Dietetics.	Alison Hanson, Cambridgeshire Community Services
Children and Family Centre Providers	Kat Band, Assistant Director of Children Services at Barnardos
LGSS Digital	Kat Sexton
Communications	Jo Dickson (CCC)
Project planning and management	Tess Campbell, Public Health (PCC and CCC) Helen Gregg, Partnership Manager, People & Communities Directorate

Stakeholder Group

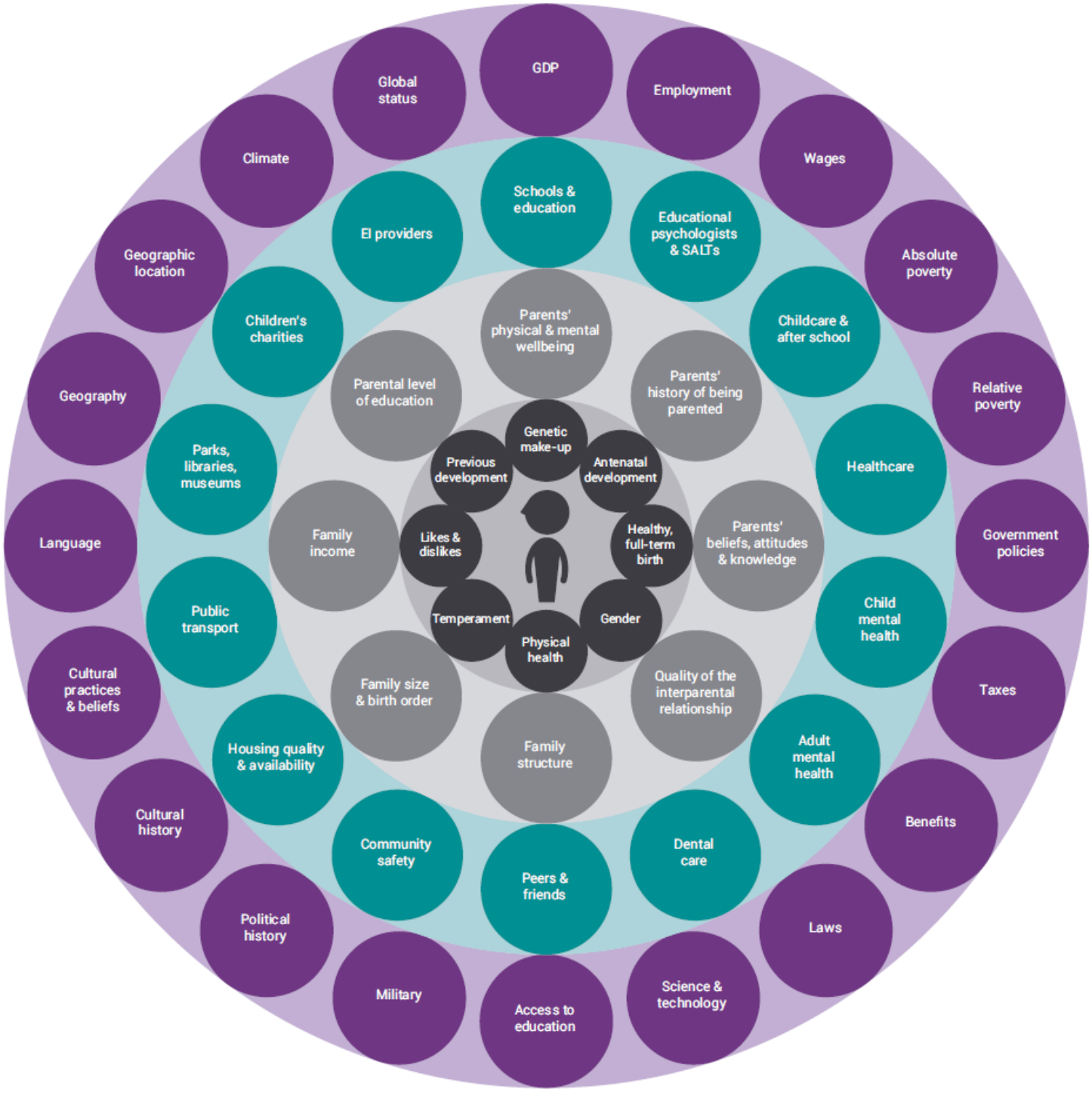
Co-Chairs	Dr Liz Robin, Director of Public Health (PCC and CCC) Wendi Ogle-Welbourn, Executive Director People and Communities (PCC and CCC)
Public Health Consultant	Dr Raj Lakshman, (PCC and CCC)
Public Health Lead/co-ordinator	Ben Brown, Specialty Registrar Public Health (PCC and CCC)
Transformation Team lead/co-ordinator	Gwendolyn Casazza (CCC)
Early Years leads	Karen Hingston (PCC) Annette Brooker (CCC)

Early Years Providers	Jayne Chapman (Harlequin Childcare) Caroline Maryon (PACEY Project Manager)
SEND leads	Marian Cullen and Jo Middleditch (CCC) Sheelagh Sullivan (PCC)
Children's Commissioning Lead	Pam Setterfield (PCC)
Commissioning Team Manager- Healthy Child Programme	Helen Freeman, Public Health (PCC and CCC)
Children's Social Care Assistant Directors	Sarah-Jane Smedmor (CCC) Nicola Curley (PCC)
Education leads	Clare Hawking (Early Years Lead, Virtual School, CCC)
Early Help leads	Lisa Riddle/Sarah Tabbitt (CCC) Karen Moody (PCC)
Children Centre Providers	Kat Band, Barnardos Lynn McNish, Barnardos Amanda Newman, Ormiston Jason Wilson, Spurgeons
Healthy Child Programme	John Peberdy (CCS) Andrea Graves (CCS) Verity Trynka-Watson (CCS)
Speech and Language Therapy, Nutrition and Dietetics	Alison Hanson (CCS)
Primary Care Leads	Dr Becky Jones
Clinical Commissioning Group	Liz Phillips, Better Births Programme Manager (CCG) Ruth Kern - Perinatal Mental Health – (CCG) Sarah Hamilton, Designated Nurse Safeguarding Children (CCG) Karlene Allen, Children's Commissioner(CCG)
Support Cambridgeshire	Julie Farrow
Stakeholder group planning	Helen Gregg, Partnership Manager, CCC/PCC

Corresponding Stakeholder Group Members

Communications lead	Joanne Dickson, Communications & Marketing Manager, CCC
Finance leads	Martin Wade (CCC) Fiona Chapman (PCC)
Information and intelligence lead	Helen Whyman

Appendix 2 – Childhood Risk Factors



Appendix 3 – Summary of Evidence

Universal

Family support via children's centres, key workers, outreach to families **(Marmot Review)**

Teenage pregnancy prevention– (prevention, choice, support)

Transition to parenthood – Family Foundations -reduces parental stress & attachment related behaviours when offered to couples expecting their first child **(EIF)**

Universal screening for mental health problems during pregnancy **(EIF,NICE)** and for mothers if combined with treatment **(EIF)**

Healthy Child Programme 0-5 (4-5-6 model) **(PHE)**

Identifying risks @ 5 key HCP contacts **(NICE)**

SIDS advice re sleeping position **(EIF)**

Individual breastfeeding advice – pre/post natal **(EIF)**
UNICEF Baby Friendly Initiative **(PHE)**
PHE's Start4Life campaign **(PHE)**

Home safety equipment schemes – increase parental knowledge **(EIF)**
Oral health promotion -best evidence and fluoridation of public water supplies **(PHE)**

Obesity – multi-component and holistic approach **(PHE)**

Early cognitive and language development (e.g. Let's play in tandem, Raising early achievement in literacy) **(EIF)**

Speech and language skill assessed @ 2-2 ½ year review **(NICE)**

Pre-school attendance **(DfE)**

Targeted – selective

Attachment programmes (e.g. FNP, Family Foundations, Infant–Parent Psychotherapy, Child First) **(EIF)**

Pre and post-natal care programmes (e.g. Nurse – Family Partnerships) **(GLA)**

FNP for reducing IPV among first time teenage mothers **(EIF)**

Home safety equipment schemes - increase parents' knowledge of home safety **(EIF)**

Preventing unintentional injuries in the home – targeting, working in partnership, co-ordinated delivery, assessments and follow-up **(NICE)**

Providing and fitting free or low-cost home safety equipment (incl. thermostatic mixing valves) **(PHE)**

Healthy Start – UK Gov't voucher scheme **(PHE)**

Oral health – targeted provision of toothbrushes/ toothpaste, supervised tooth brushing in targeted childhood settings, tooth varnishing and healthy food and drink policies in childhood settings **(PHE)**

Take up of funded education/universal entitlement 15hrs @ 2 yrs

Pre-school programmes (e.g. Perry Preschool Programme) **(GLA)**

Home visiting interventions - children's language development in the early years (FNP, Child First, Parents as First Teachers) **(EIF)**

Transition programmes (home/nursery to school) – (targeted, flexible) **(PHE)**

Targeted – indicated

Behaviour programmes (e.g. Incredible Years, Triple P) **(EIF)**

Incentive-based programmes to encourage smoking abstinence during pregnancy **(EIF)**

CO monitoring and opt out systems –smoking in pregnancy **(PHE)**

Post-natal treatment for mental health problems **(NICE)**

Methadone treatment for mothers (buprenorphine during pregnancy) **(EIF)**

LBW – (Kangaroo Mother Care, Infant Massage, H-Hope, MITP) **(EIF)**

Sleep advice – infants ≥4mths **(EIF)**

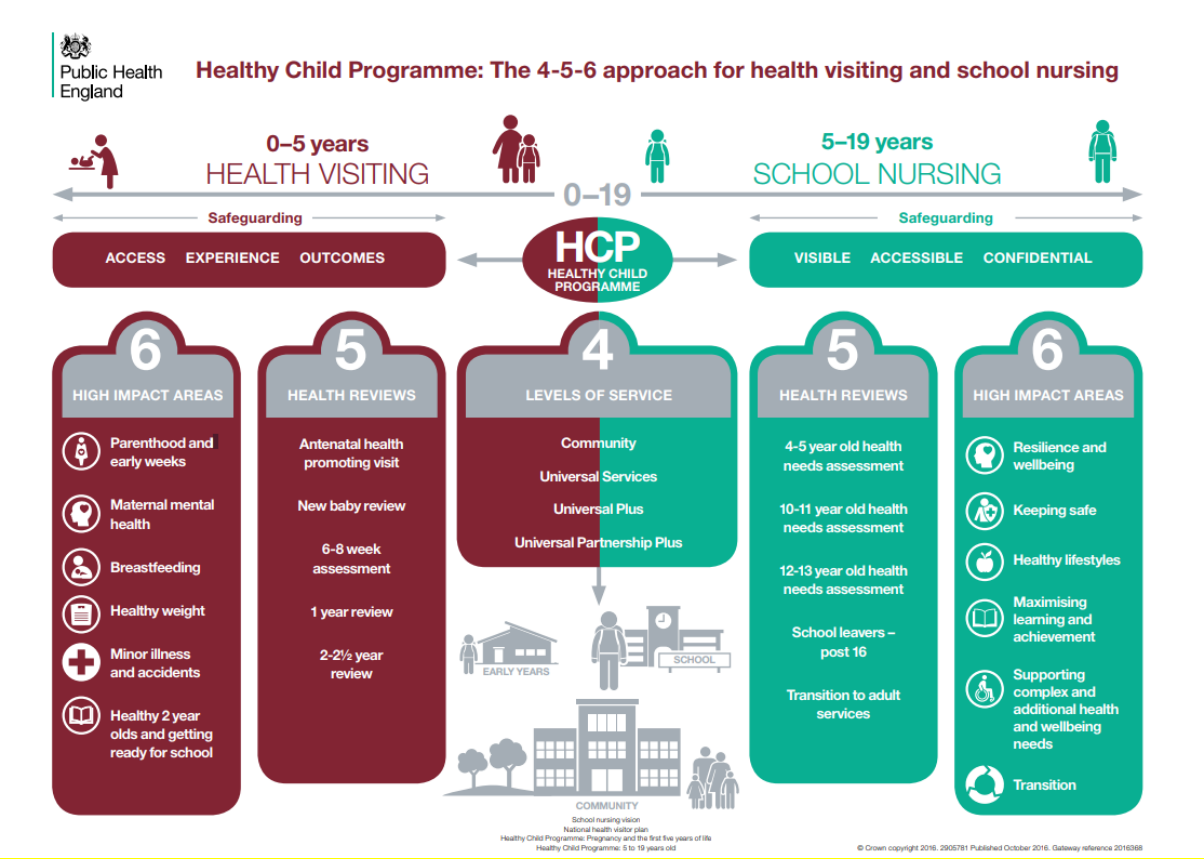
Psychosocial support integrated into routine antenatal care – for reducing revictimisation rates among women reporting IPV Home visiting in highly vulnerable families has the best evidence of reducing child maltreatment during infancy (FNP, Child First, Infant-Parent Psychotherapy) **(EIF)**

Identification, assessment and treatment of attachment difficulties (edge of care, LAC, adopted) **(NICE)**

Joint protocols for parental drug/alcohol use
HIPPY for 3-5yr olds (home instruction or pre-schoolers) **(PHE)**

Families and Schools Together (FAST) for ages 3-11 **(PHE)**

Appendix 4 – Healthy Child Programme



Family Nurse Partnership (FNP) and Enhanced Teenage Parents Pathway

Fixed criteria (all to receive FNP):

- Very young women – all first time mothers aged 16 years or under
- Currently in the care system as a Child in Care (CIC), Child in Need (CIN), on Child Protection Plan (CPP) or recent care leavers.

'High-risk' criteria (any 4 or more of the following risk factors in first-time teenage mothers)

- Not living with their own mother or baby's father/partner
- No or low educational qualifications, i.e. no GCSEs or equivalent, low grade GCSEs
- Currently not in education, employment or training (NEET)
- Has mental health problems
- Ever a 'child in care' ; or lived apart from parents for more than three months when under the age of 18
- Current smoker (and doesn't plan to give up during pregnancy)
- Living in disadvantaged area
- History/risk of abuse

FORWARD AGENDA PLAN - CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD, CORE AND WHOLE SYSTEM JOINT SUB-COMMITTEES AND LOCAL OUTBREAK ENGAGEMENT BOARD

Agenda Item No: 6

Updated 25.11.2020

MEETING DATE	ITEM	REPORT AUTHOR	ORGANISATION
January 2021 Date **TBC**	**Cambridgeshire and Peterborough Local Outbreak Engagement Board**		
	Apologies for absence and declarations of interest	Oral	
	Minutes of the meeting on 4th December 2020	Oral	
	Cambridgeshire and Peterborough Health Protection Board Report	Liz Robin	
	Communication Plan		
	Public Questions		
February 2021 Date	**Cambridgeshire and Peterborough Local Outbreak Engagement Board**		
	Apologies for absence and declarations of interest	Oral	
	Minutes of the meeting on X January 2020	Oral	
	Cambridgeshire and Peterborough Health Protection Board Report	Liz Robin	
	Communication Plan		
	Public Questions		

FORWARD AGENDA PLAN - CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD, CORE AND WHOLE SYSTEM JOINT SUB-COMMITTEES AND LOCAL OUTBREAK ENGAGEMENT BOARD

10-11am – 2nd March 2021	**Health and Wellbeing Board Core Joint Sub-Committee**		**CCC - Democratic Services**
	Apologies for absence and declarations of interest	Oral	
	Minutes of the Meeting on X February 2020	Oral	
	Action Log	Michelle Rowe	
	Joint Commissioning and Integration Workstream		
	Service Transformation and Business Workstream		
	Outcomes for Residents Workstream		
	Agenda Plan	Michelle Rowe	
11am-12noon – 2nd March 2021	**Cambridgeshire and Peterborough Local Outbreak Engagement Board**		
	Apologies for absence and declarations of interest	Oral	
	Minutes of the meeting on X February 2020	Oral	
	Cambridgeshire and Peterborough Health Protection Board Report	Liz Robin	
	Communication Plan		
	Public Questions		

FORWARD AGENDA PLAN - CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD, CORE AND WHOLE SYSTEM JOINT SUB-COMMITTEES AND LOCAL OUTBREAK ENGAGEMENT BOARD

11am-12noon – 6th April 2021	**Cambridgeshire and Peterborough Local Outbreak Engagement Board**		
	Apologies for absence and declarations of interest	Oral	
	Minutes of the meeting on 2nd March 2020	Oral	
	Cambridgeshire and Peterborough Health Protection Board Report	Liz Robin	
	Communication Plan		
	Public Questions		
11am-12noon – 11th May 2021	**Cambridgeshire and Peterborough Local Outbreak Engagement Board**		
	Apologies for absence and declarations of interest	Oral	
	Minutes of the meeting on 6th April 2020	Oral	
	Cambridgeshire and Peterborough Health Protection Board Report	Liz Robin	
	Communication Plan		
	Public Questions		

FORWARD AGENDA PLAN - CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD, CORE AND WHOLE SYSTEM JOINT SUB-COMMITTEES AND LOCAL OUTBREAK ENGAGEMENT BOARD

24th June 2021	**Cambridgeshire Health and Wellbeing Board**		**CCC - Democratic Services**
	Notification of Chairman/Chairwoman	Oral	
	Election of a Vice-Chairman/Chairwoman	Oral	
	Apologies and Declarations of Interest	Oral	
	Minutes of the Meeting on 26th November 2020	Oral	
	Action Log	Oral	
	Person's Story		
	Agenda Plan	Oral	