Agenda Item No: 16

Cambridgeshire South Care Partnership (ICP) Update

To:	Adults and Health Committee
Meeting Date:	15 December 2022
From:	Cambridgeshire South Care Partnership, Interim Managing Director
Electoral division(s):	Cambridge, East Cambridgeshire, South Cambridgeshire
Key decision:	No
Forward Plan ref:	N/A
Outcome:	To provide an update to the Committee on the Cambridgeshire South Care Partnership's vision, current work and future plans. With a particular focus on work currently underway and the important role of the local authority.
Recommendation:	The Adults and Health Committee is asked to note and comment on the contents of this report

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1. Background

1.1 This report provides an update on the Cambridgeshire South Care Partnership (Integrated Care Partnership) for the Adults and Health Committee to note and discuss on 15 December 2022.

1.2 Showing an overview of the Partnership's vision and purpose, and outlining some of the current and future opportunities, work underway, challenges and next steps.

2. Main Issues

1.3 **Cambridgeshire South Care Partnership – population and geography**

Cambridgeshire South Care Partnership (CSCP) will be responsible for the development and delivery of integrated health and social care through effective partner collaboration and transformation of services and pathways to deliver better outcomes for the 430,000 people living in the Cambridgeshire South place (Cambridge City, East Cambridgeshire and South Cambridgeshire).

1.4 **Our vision**

Is 'for our citizens to enjoy healthy lives in strong, connected communities', focused on delivering better, more equitable outcomes:

- With our people, family and carers – People are actively involved in directing their own wellbeing, and can easily access support and care when needed, as close to home as possible.
- With our service providers, workforce and carers – Community, public and private service providers are empowered to work together to provide high quality, safe care with a focus on wellbeing, integration and continuous improvement.
- With our population – We actively address health and care inequalities. The independence, resilience and health of our population improves as a result of a more proactive, integrated and local approach to care.
- With our Integrated Care System – The Cambridgeshire and Peterborough Integrated Care System is more effective, sustainable and achieves better value care.

1.5 **Our partners**

The following list shows the significant number and variety of partners who provide wellbeing, social and health care services for our population:

- One upper tier local authority: Cambridgeshire County Council
- One Health and Wellbeing Board: Cambridgeshire and Peterborough Health and Wellbeing Board
- Three District Councils: Cambridge City, East Cambridgeshire and South Cambridgeshire
- Healthwatch Cambridgeshire and Peterborough providing an independent patient and service user voice for health and social care
- 39 GP practices, including 3 in Hertfordshire

- One Cambridgeshire & Peterborough-wide Local Medical Committee, that represents, supports and advises GPs
- One GP Federation: Cambs GP Network
- Two community providers: Cambridgeshire and Peterborough Foundation Trust (CPFT) and Cambridgeshire Community Services (CCS)
- Two hospital providers: Cambridge University Hospitals (CUH) and Royal Papworth Hospital (RPH)
- One mental health provider: Cambridgeshire and Peterborough Foundation Trust
- One ambulance trust: East of England Ambulance Service NHS Trust (EEAST)
- One Integrated Care Board (ICB): NHS Cambridgeshire and Peterborough
- Other partners including parish councils and local voluntary, community and faith organisations

To facilitate integration of care and provision of services close to home, we also have:

- 9 Primary Care Networks (PCNs), that are building local partnership working and form a key part of the future vision for Integrated Neighbourhoods.

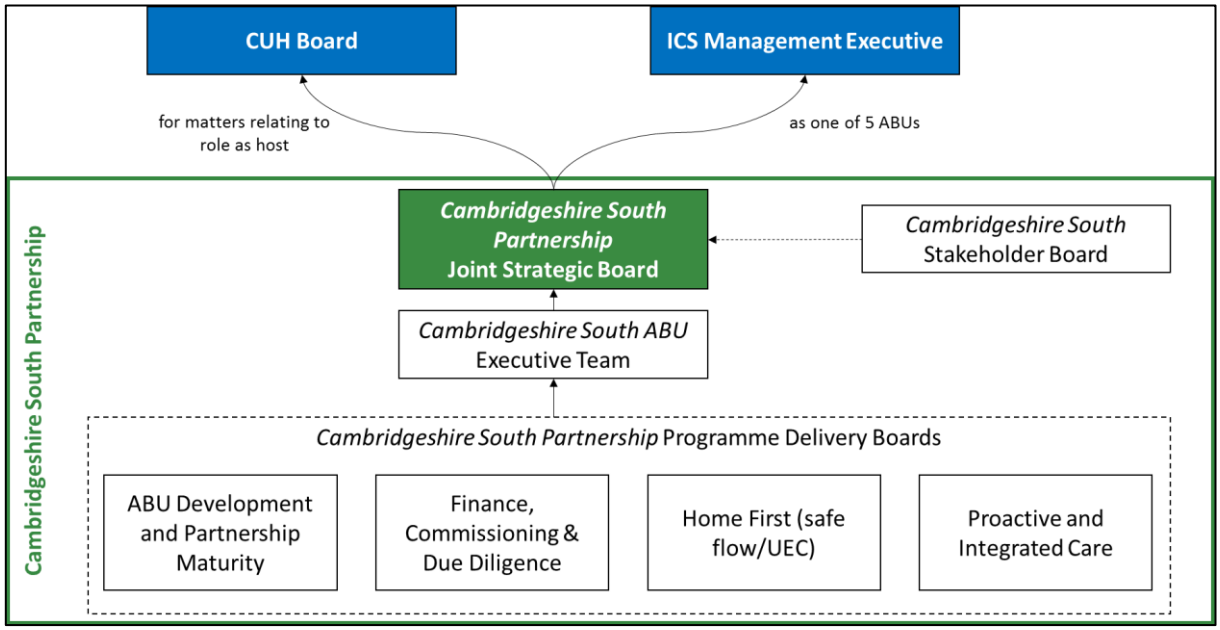
1.6 **Governance and aims**

Cambridgeshire South Care Partnership is overseen by a Joint Strategic Board which provides leadership of the partnership. This Board is jointly chaired including a Council chair and is underpinned by four programme delivery boards.

Cambridgeshire South Care Partnership's has 6 overarching workstreams in service of our aims:

- **Partnership engagement** to ensure effective partnership working is in place to allow integrated neighbourhoods to thrive
- Leading the further development and implementation of an **Operating Framework for Cambridgeshire South**, following the best available evidence, to drive for integrated care delivery and population health management
- Producing a **two year strategy** by March 2023 and a **long term strategy** in 2023/24 that will set out implementation plans and a supporting investment and redesign plan
- Overseeing a '**here and now' implementation plan** on priority improvement work for the next 6-12 months
- Lead and steer the **development of Cambridgeshire South Accountable Business Unit** to ensure it has the capacity and capability to be successful
- Have oversight of the Cambridgeshire South health and care system and the **sustainability of all partners**, leading where required to address challenges faced

Map of CSCP Governance



1.7 **The Role of the Local Authority in Cambridgeshire South Care Partnership**
The below is not an exhaustive list but shows some of the valuable current links with Cambridgeshire County Council and future opportunities to build from this:

- **Developing and designing new models of care** – Council involvement in developing and designing new models of care is crucial. Building on the current Council involvement in the system Homefirst, Transfer of Care and Urgent Community Response programmes.
- **Finance, commissioning and planning** – building on current joint working to understand the shared investment, workforce, care market, estates and assets to make a greater impact on our citizens' health and wellbeing.
- **Building Integrated Neighbourhoods** – colleagues currently are working to align the Local Authority Care Together programme of work with development of Integrated Neighbourhoods. Sharing learning and making sure this work aligns and is mutually supporting.
- **Population Health Management** – working closely with Council colleagues such as Public Health, but also in the future using the wider data and intelligence the Council holds to better plan care and support better for people and tackle inequalities.
- **Learning and organisational development** – Council colleagues have shared valuable insights into community development and strength's-based working. The Council will be crucial to any workforce or organisational development needed to ensure our workforce and organisations best serve our populations.

1.8 **Our work**

This section highlights some of the work currently being delivered and or supported by Cambridgeshire South Care Partnership in more detail.

1.8.1 **Homefirst and Transfers of Care**

Supporting people to get the right care, at the right place and at the right time. Helping to make sure we give people the best chance of staying and recovering at home following an accident or period of ill health. Some key deliverables from this workstream are:

- **Integrated Urgent Community Response model** – to implement a single point of contact to access clinical advice, guidance and support. To ensure the system has the right wraparound health and care support to help reduce waiting times, make best use of ambulatory care capacity and help keep people safe at home.
- **Virtual care models** – to support the mobilisation of Acute Virtual Ward services across Cambridgeshire and Peterborough. Currently providing acute level care to approximately 100 patients per month in the community in Cambridgeshire & Peterborough. This out of hospital care will scale up as per delivery plans to treat even more people in their own homes instead of in an acute hospital
- **Integrated Transfer of Care Hub** – to scope, develop and implement a Transfer of Care Hub model in Cambridgeshire and Peterborough. With health, social care and VCS partners working closely together in a multi-agency and multidisciplinary way. Putting key operational roles in place, implementing a system dashboard to bring together data across different partners and to put in place standard operating procedures that support joint working.
- **Pathway redesign –** reviewing and making changes to pathways with a particular focus on supporting recovery. For example, trusted assessment between acute and community therapists to reduce the need for triage, referrals and assessments, work to improve the access and sustainability of CPFT's home based recovery and commissioning capacity to support people who will need long term bedded support.

1.8.2 **Proactive and Integrated Care and our neighbourhoods**

This workstream is currently focused on:

- Helping build and strengthen the foundations for Integrated Neighbourhoods
- Co-designing a Target Operating Model with partners for how we want Integrated Neighbourhoods to develop, building on the current innovation and relationships
- Delivering winter projects which support primary care and partners
- Embedding Population Health Management approaches
- Embedding Co-Production approaches

The CSCP Integrated Neighbourhood team of 8 Programme and Project Managers work closely with all system partners. The below sections provide a summary of our neighbourhoods, our populations and some of the work in neighbourhoods that partnership working has make possible.

Locality	Neighbourhood & Primary Care Networks	Insight into our neighbourhoods
Cambridge City	Cantab ~50,000 patients registered	• Lower proportion aged over 65 and under 18 compared to South Place & England • Relative deprivation is lower than South Place & England. Approx 8.3% of children & 9.3% of older people live in poverty. • Lower proportion of White British compared to South Place & England. • Low prevalence of CHD, hypertension, stroke, asthma, COPD, diabetes and cancer compared to the South Place averages.
Cambridge City	Cam Medical ~46,500 patients registered	• Population estimated to increase by 16% between 2019 and 2026. • Higher proportion of 16-65s, in relatively good health. Lower proportion of under 18s and over 65s compared to England. • Relatively ethnically diverse with higher proportion of White Other, Mixed and Asian groups compared to England • Relatively low levels of deprivation but some small areas of higher ‘urban’ deprivation. 9.8% of children & 12.2% of older people live in poverty
Cambridge City	Cambridge City ~50,500 patients registered	• Lower proportion aged over 65 and compared to South Place & England. • Relative deprivation is higher than the South Place but lower than England. Approx 15% of children & 15% of older people live in poverty. • Lower proportion of White British compared to the South Place and England. • High prevalence of stroke, asthma, COPD & diabetes compared to South Place.

Cambridge City	Cambridge City 4 ~56,400 patients registered	• Higher proportion aged 16-64 and lower proportion aged over 65 compared to South Place • Relative deprivation lower than South Place. 9% of children & 10% of older people live in poverty. • High prevalence of Serious Mental Illness compared to South place. • Life expectancy significantly lower than the South Place for both males and females.
East Cambridgeshire	1 Neighbourhood with Ely North and Ely South PCNs ~78,000 patients registered	• Almost 20% increase in population between 2021-2026 • It has a higher % of older people aged over 65 than the rest of South Place. • 10% of children and older people live in poverty & 17% of adults smoke • 14% of children and young people and 62% of adults are overweight • People experience higher rates of diabetes, cancer, stroke and support from Early Help • Transport challenges leave many isolated and lonely in small villages
South Cambridgeshire	Granta ~43,000 patients registered	• Higher proportion aged over 65 compared to England • Above average Birth rates for the South place • Obesity in adults is significantly higher than the South Place • Significantly high prevalence of CHD, hypertension, stroke, asthma, diabetes, cancer, depression and dementia when compared to the averages for the South Place
South Cambridgeshire	Meridian ~48,000 patients registered	• Higher proportion aged under 18 and over 65 compared to England • Above average birth rates for the South place • High prevalence of coronary heart disease, hypertension, stroke, asthma, diabetes and cancer compared to the South Place averages
South Cambridgeshire	North Villages ~47,000 patients registered	• Higher proportion aged under 18 and over 65 compared to England • Above average birth rates for the South place • Significantly High prevalence: depression, dementia, coronary heart disease, hypertension, stroke, asthma, diabetes and cancer compared to the South Place averages

Locality	Examples of partnership working in our neighbourhoods
Cambridge City	• Winter Wellbeing projects to proactively support people who are older or housebound this winter, with all four PCNs working with Care Network Cambridgeshire, Age UK and Caring Together and Public Health • Events such as a Diabetes Wellness Day held at Cambridge Central Mosque with partner organisations. With 400 attendees. And Healthy You now offering a Monthly Health Hub with health checks and lifestyle advice. • Piloting single sessions of support with a therapist for children, young people and families with mild to moderate mental health issues within two weeks of referral. A second pilot is now taking place within Younited • Health Champions recruited by Cambridge Ethnic Community Foundation to deliver health promotion messages and listen to people's experiences. Working in Cambridge Bangladeshi Health Fair • Supported the City and County Council's Cost of Living Support Pop Ups - promoting events through patient text messaging • Building relationships between PCN, Healthy You and the Traveller Health Nurse to better meet the needs of people living on Fen Road Travellers Site. Offering health checks and encouraging people to register their ethnicity with their GP surgery.
East Cambs	• Joint Decision Making Boards bringing together the Community Safety Partnership, PCN and Neighbourhood Boards • Jointly-funded new models of care such as: a Drug and Alcohol Recovery Worker, the Moon Project for children affected by Domestic Violence and a Carers Care Coordinator • Working closely with Care Together and CPFT on Holistic Home Care and micro-care enterprises • Appreciative Enquiry: 36 partners trained to undertake Appreciative Enquiry Conversations • Collaborative Forums established: Neighbourhood Health and Wellbeing Team, Building Caring Communities, Parish and Communities Forum, and Mental Health • Dementia friendly communities – Littleport, Soham and Fordham, a care and short breaks coordinator and dementia clinics • Diabetes care and prevention: Healthier Weight Project including Menopause Wellness Event, awareness raising tools, health checks, healthy walks, housebound insulin dependency reviews, group consultations and peer support • Menopause Wellness Event: Lighthouse Centre with almost 400 attendees • Vaccination Programme: 250 Volunteers and 145,917 vaccinations given
South Cambs	• ICS funded, District Council delivered Heating & Health Project and warm hubs • Winter Pressures Projects providing personalised care planning for people. Including warden calls and connection into community support for people on the frailty register and to help prevent people being readmitted to hospital • Recruiting a Children and Young People's Mental Health social prescriber to support a caseload of children and families alongside the Primary Care Network Mental Health worker and to help develop the services and support available • Working with the ICS estates team to ensure all PCN's are engaging in the Clinical and Estates strategy • Linking in with Planning teams to secure appropriate health facilities & a healthy environment • Establishing a coproduction process for a "community – led / professionally supported" Northstowe Mental Health project • Coronary Artery calcification (CAC) community pathway. Exploring how people identified receive preventative support • GP Practice specific safeguarding concerns, working with partners in North Villages for a deeper dive into the root causes

3. Source documents guidance

3.1. Source documents – There are no source documents used in this report, hyperlinks to case study videos and webpages have been included in the body of the text where relevant