CAMBRIDGESHIRE AND PETERBOROUGH HEALTH AND WELLBEING BOARD WHOLE SYSTEM JOINT SUB-COMMITTEE

Friday, 25 March 2022

09:15

Democratic and Members' Services
Fiona McMillan
Monitoring Officer

New Shire Hall
Alconbury Weald
Huntingdon
PE28 4YE

Sand Martin House, Bittern Way, Peterborough PE2 8TY [Venue Address]

AGENDA

Open to Public and Press by appointment only

1. **Election of Chair**

2. **Election of Vice Chair**

3. **Apologies for absence and declarations of interest**

   Guidance on declaring interests is available at http://tinyurl.com/ccc-conduct-code

4. **Chair Address**

5. **Minutes from the meeting on 29 June 2020** **5 - 10**

6.	**Approval of minutes from the Cambridgeshire and Peterborough Health and Wellbeing Boards** Cambridgeshire - 30 January 2020 **Peterborough - 7 December 2020**	**11 - 18**
7.	**Integrated Care Partnership Development (presentation to follow)**	
8.	**Covid Impact Assessment (presentation to follow)**	
9.	**Joint Health and Wellbeing / ICS Strategy 2022-2030 : Development and Overarching Strategic Approach - draft for consultation**	**19 - 40**
10.	**Establishment of a Joint Cambridgeshire & Peterborough Health and Wellbeing Board proposals**	**41 - 52**
11.	**Better Care Fund Plan 2021-22**	**53 - 110**
12.	**Ely Pharmacy Consolidation (response on behalf of Cambridgeshire Health and Wellbeing Board)**	**111 - 128**

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

Scott Haldane Councillor Anne Hay Councillor Richard Howitt Councillor Edna Murphy Councillor Kevin Reynolds and Councillor Susan van de Ven Jyoti Atri (Appointee) Councillor Ray Bisby (Appointee) Charlotte Black (Appointee) Councillor Simon Bywater (Appointee) Alison Clarke (Appointee) Councillor Gavin Elsey (Appointee) Julie Farrow (Appointee) Stewart Francis (Appointee) Councillor Geoff Harvey (Appointee) Councillor Mairead Healy (Appointee) Claire Higgins (Appointee) Dr Gary Howsam (Appointee) Councillor Julia Huffer (Appointee) Louise Mitchell (Appointee) Stephen Posey (Appointee) Joanne Proctor (Appointee) Councillor Shabina Qayyum (Appointee) Jan Thomas (Appointee) Caroline Walker (Appointee) Ian Walker (Appointee) Councillor Susan Wallwork (Appointee) Councillor Irene Walsh (Appointee) Matthew Winn (Appointee)

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Agenda Item No.5

MINUTES OF THE CAMBRIDGESHIRE AND PETERBOROUGH HEALTH AND WELLBEING BOARD WHOLE SYSTEM JOINT SUB-COMMITTEE HELD AT 10:00AM, ON 29 JUNE 2020 VIA ZOOM CONFERENCE

Committee Members Present:	Councillor Holdich, (Chairman), Peterborough City Council Councillor Fitzgerald, Peterborough City Council Councillor Hickford, Cambridgeshire County Council Councillor Massey, Cambridge City Council Councillor Harvey, South Cambridgeshire District Council Councillor Hoy, Cambridgeshire County Council Councillor van de Ven, Cambridgeshire County Council Councillor Wallwork, Fenland District Council Councillor Walsh, Peterborough City Council Councillor Jones, Cambridgeshire County Council Councillor Robinson, Peterborough City Council Councillor Bywater, Huntingdonshire District Council – left 11.15am Councillor Howell, Cambridgeshire County Council Wendi Ogle-Welbourn, Executive Director People and Communities Dr Liz Robin, Director for Public Health Val Moore, Cambridgeshire and Peterborough Healthwatch Louise Mitchell, Cambridgeshire & Peterborough Clinical Commissioning Group Dr Gary Howsam, Cambridgeshire & Peterborough Clinical Commissioning Group – left 10.41am Caroline Walker, North West Anglia NHS Foundation Trust – left 11.05am Joan Skeggs, NHS England Ian Walker, Cambridge University hospitals NHS Foundation Trust Charlotte Black, Service Director, Adults and Safeguarding Scott Haldane, C&P Peterborough NHS Foundation Trust Julie Farrow, Hunts Forum – left 11.15am
Officers Present	Gillian Beasley, Chief Executive Cambridgeshire County Council and Peterborough City Council Sue Grace, Director of Digital and Customer Service Christine Birchall, Head of Communications Cambridgeshire County Council & Peterborough City Council Dr Tony Jewell, Consultant Head of Medicine Paulina Ford Senior Democratic Services Officer Jayne Wisely, District Support Officer, Huntingdonshire District Council

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Jo Proctor, Cambridgeshire and Peterborough Safeguarding (Children and Adults) Partnership Board, Matthew Winn, Cambridgeshire Community Services NHS Trust, Stephen Posey, Royal Papworth Hospital NHS Foundation Trust, Tracy Dowling, C&P Peterborough NHS Foundation Trust, (Scott Haldane attended as Substitute), Councillor Shabina Qayyum (Councillor Lucinda Robinson attended as substitute), Zephen Trent, NHS England (Joan Skeggs attended as substitute), Jan Thomas, Cambridgeshire and & Peterborough CCG, Claire Higgins, Safer Peterborough Partnership, Councillor Huffer and Councillor Watkin-Tavener.

2. DECLARATIONS OF INTEREST

There were no declarations of interest.

3. THE COVID-19 LOCAL OUTBREAK PLAN

The report was introduced by Dr Liz Robin, Director of Public Health, Cambridgeshire County Council and Peterborough City Council. The Local Outbreak Plan outlined the work that was being undertaken to combat Covid-19 at a local level. It was critical that this was right to identify and manage local outbreaks of Covid-19. This was plan was essential in moving towards a 'new normal'. Although this plan was in place people needed to continue good personal hygiene practices and follow social distancing measures. Test and trace was a part of both this plan and responsibility people in local communities had in order to tackle Covid-19.

The Local Outbreak Plan was due for submission to national government on 30 June 2020, around £3.5 million had been allocated to Cambridgeshire and Peterborough in order to deliver the objectives outlined. One of the key principles of the plan was the building up of systems already in place at a local level to protect lives and combat outbreaks of Covid-19. Work had been undertaken with colleagues across the Public Health England prevention team at a local level as well as other health officials. There was evidence to suggest that plans already in place could be used to manage Covid-19.

The work around the plan started back in May by bringing together colleagues together from a number of organisations to collectively survey and be able to control any local outbreaks of Covid-19. Key organisations and people were identified as most critical if an outbreak were to occur. A multi-agency protection board was setup at any early stage to look at data and trends within local communities in order to identify risks and to ensure practical steps where in place in case testing was needed in certain areas.

Members were informed that a longer more complex plan was in place, however this was not for public consumption as it was overly technical. Officers were thanked for their work in translating the plan into a more user friendly and easier to understand public document.

Communication with the public and key stakeholders was still crucial going forward, members were directed towards the proposed Member Led Engagement Board which was to be formed around the Core Joint Health and Wellbeing Board Sub Committee membership, with additional appropriate membership, having the ability to co-opt local members if there was a local outbreak. The purpose of the board was to engage with the public and provide public communication.

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

- It was important to recognise the local capabilities available and if this had been done at any even earlier stage the pandemic might not have been as severe. It was good to hear that the plan was built on existing workstreams that had been successful in the past. It was also important that the Member Led Engagement Board was to meet in public as this allowed for public accountability over decisions taken to combat the virus.
- In terms of timely reporting to combat the virus, speed was of the essence when looking at increasing infection rates. In order to facilitate timely reporting, this needed to be made to the Public Health England protection team. Mechanisms were in place to ensure rapid reporting into those organisations that needed to know as soon as possible that an outbreak was occurring. A single email address and reporting line had been setup to assist with this. The communication lines with Public Health England had improved dramatically as a result of this.
- A daily surveillance cell meeting took place which involved the CCG, the local authority business intelligence team and public health intelligence and was chaired by the Deputy Director of Public Health. Information was analysed that came from Public Health England and other national sources as well as local information such as car usage and social distancing measures that were in place. It also took note of daily information from the CCG and within the NHS.
- There were some basic conditions around the funding that had been received, however it was not possible to draw a road map on the length of time this funding would last for. If there was to be a major outbreak, then there might be the possibility of additional funding or taking funding from current sources if needed. Funding that had been given would be wholly devoted to the Local Outbreak Plan that was in front of members. Local authorities were good at identifying when additional costs might be needed and using sources to help lobby central government for more funding especially as the plan was due to be an ongoing plan and it was likely to need further resourcing in the future.
- Guidance had been issued to taxi drivers in both Cambridgeshire and Peterborough, this guidance covered aspects such as face masks and ensuring customers were asymptomatic. Taxi drivers were also responsible for cleaning their cab and using contactless payment where possible.
- There was more capacity in terms of the number of tests available compared to the number of tests actually needed in Cambridgeshire and Peterborough. The biggest concern was being able to get a test done at the right time and place and then getting the results as quickly as possible. Overall the results from testing were being turned around quicker than at the beginning of the pandemic. Officers had identified that in some cases of an outbreak in a local community it was important that the testing system was mobilised quickly to deal with this. The CCG were one of the quickest organisations in being able to act if there was an outbreak. In addition, if swab tests were needed the military mobile test units were able to mobilise within 24-48 hours.
- In terms of the responsibility of reporting this was quite far reaching, there was initially a responsibility for those who contract Covid-19 to get tested and then to inform their employers. It was essential that communication lines were kept open between key organisations and partners in order to identify any patterns or trends.
- Public communication and engagement was critical. It was the public who stopped the first wave of Covid-19, as they observed the lockdown rules. As there was no vaccine it was crucial that the public followed the Public Health guidelines

in terms of keeping the infection rate down. There was a communication strategy in place for the work outlined above. There had been additional work around mobilising the community appropriately when a community outbreak was identified. The member led engagement board was not a decision making body and therefore could be called at 24 hours' notice if an outbreak was identified. Local authorities in the area were releasing key information that was being translated into a number of languages, ensuring all communities had the relevant information in order to protect themselves and their communities. In addition, bespoke information was being produced for different business sectors.

- The composition of the local engagement board was done through a number of consultations. However, this could be looked at going forward if necessary and could include members at a local level when required.
- It was important at local and district level that arrangements were in place to help those who were vulnerable and told to self-isolate, this could be getting food parcels or medicines delivered.
- In terms of schools a school's cell had been setup to ensure communication was carried out well and that this was in place if a school had a Covid-19 outbreak. The Service Director for Education had been communicating with schools to ensure that they had plans in place to deal with any outbreaks. In terms of the local outbreak plan members were informed that processes and procedures were in place, which had been agreed with schools.
- There was clear national guidance in place for anyone who had been discharged from hospital into a care home. If a care home was unable to confidently allow someone to self-isolate for 14 days, then other arrangements would be put in place.
- There had been a number of learning opportunities from outbreaks that had already occurred for example at Weston and in Leicester.
- Some members commented that although the plan was detailed there was a lack of reassurances within the plan, explaining to local communities what was going on and how local authority was going to respond to questions and concerns the community had.
- Members were assured that engagement with the community was taking place and that the local outbreak plan would be enhanced to show how this was being down, reassuring communities that they were fully involved in the fight against the virus.
- Local authorities were working closely with the community reference group and members were informed that this would be strengthened within the local outbreak plan.
- The National Behavioural Science unit had stated that people could only cope with lockdown for a certain length of time. It was important to identify that the pandemic was still at an early stage in terms of getting lifestyles back to some form of normality. There had been national surveys outlining what people had been doing in their 'normal lives' which could be circulated.
- It was a positive sign that there were finances attached to the local outbreak plan. Resources had already been identified in order to deliver what was outlined in the plan. The initial finances gave local authorities the breathing space in order to identify other areas where finances would be crucial over the next few weeks and months. The team around the plan were experienced in delivering strategies and plans of this nature. Going forward projected spends would be identified and the means of lobbying central government would be key to the right level of finances.
- There had been some evidence that schools that had an outbreak of Covid-19 managed this well. The Service Director Education worked with each individual school whenever there was an outbreak.

- Members were informed that the risks and hurdles identified around schools in the plan were to be made clearer.
- In terms of moving from a level one to two pressures would need to be identified at a regional level where the Public Health protection team would be struggling to cope with contact tracing. The key factor was whether the system was overloaded and unable to manage that would determine moving to a level two response. Research and modelling was taking place in order to come up with a plan to identify precisely when local authorities would need to be moved to level two.
- The local plan was about prevention management of outbreaks. There were overlaps with managing individual risks, however with individual risks it might beneficial and more appropriate to deal with these through NHS plans and supported by the wider public sector.
- People who had been in close contact with someone who had Covid-19 were themselves at risk of developing Covid-19 up to 14 days after that contact. It was essential that those people then self-isolated for 14 days. This was difficult to explain to people and it was therefore important that the message to self-isolate was made clear and circulated to households and businesses alike. The information relating to why people needed to self-isolate was due to be updated, there was furthermore detailed information on the test and trace communications that were referenced in the local outbreak plan.
- A joint decision was taken on the membership of the engagement board, whereby a local district representative would be invited to attend the meeting if there was a local outbreak in that district area.
- With regards to social distancing, it was key that the communication strategy in place was effective. This was outlined in the local outbreak plan and was about encouraging, engaging and explaining why this was important to the local community. Enforcement measures against those who did not follow social distancing were limited. A Public Health official could require someone who was showing symptoms to quarantine for 14 days in a safe environment. It was also possible to enforce an action against individuals or businesses through a Magistrates court order.
- Throughout the pandemic it was clear that community organisations and the voluntary sector had mobilised their resources to help communities against the outbreak, particularly around communication key messages from public health bodies. However, this communication and engagement needed to be even stronger especially as businesses and society were returning to some form of normality.
- Data around the number of cases was now including ‘pillar two’ data, this was information from home testing kits and test carried out at local test spots. Outbreaks were now identified using both pillar one and two data.
- Social distancing measures needed to be clearly communicated to the community in order to stop the spread of the virus.
- Contact tracing was a well-established public health procedure, a lot could be done using the telephone contact tracing that was in place. An app would be an additional tool as long as it worked well.
- Officers would reinforce the message that people needed to socially distance from others as much as possible to avoid the need for contact tracing. Clear messages that Covid-19 had not gone away was to be circulated shortly.
- Councillors were at the forefront of any organisational plans to tackle Covid-19. The next stage was to mobilise support around the local outbreak plan. Further information would be circulated in due course with ways of practically delivering the plan.

The Cambridgeshire and Peterborough Health and Wellbeing Board Whole System Joint Sub-Committee **RESOLVED** to:

1. Approve the Local Outbreak Control Plan, including comments made by the Board.
2. Note the requirement to set up a Cambridgeshire and Peterborough Local Outbreak Member-led Engagement Board

Chairman

10:00am – 11.47am

Agenda Item No.6

MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING HELD AT 1.00pm ON MONDAY, 7 DECEMBER 2020 VIRTUAL MEETING: PETERBOROUGH CITY COUNCIL'S YOUTUBE PAGE

Committee Members Present: Cllr J Holdich (Chair), Dr G Howsam (Vice-Chair), Alison Clarke, Cllr W Fitzgerald, Val Moore, Wendi Ogle-Welbourn, Cllr S Qayyum, Dr Robin, and Co-opted Member, Joanne Procter

Officers Present: Adrian Chapman, Service Director, Communities and Partnerships
Paulina Ford, Senior Democratic Services Officer

Also Present: Dr Tony Jewell, Consultant in Public Health
Dr Fiona Head, Acting Medical Director NHS Cambridgeshire and Peterborough CCG
Jan Thomas, Accountable Officer, Cambridgeshire and Peterborough Clinical Commissioning Group
Dr Jessica Randall-Carrick, CCG Clinical Lead for Diabetes and Obesity

The Chair welcomed Alison Clarke, Director of Intensive Support and System Lead Director for Cambridge & Peterborough, NHS England and NHS Improvement (East of England) who had replaced Zephan Trent as the NHS England representative on the Board.

The Chair also advised the Board that Louise Mitchell who had represented the Cambridgeshire and Peterborough CCG (C&P CCG) on the Board was no longer on the Board as she had moved to another role within the C&P CCG. A replacement had not yet been identified but Jan Thomas who was in attendance at the meeting would represent the C&P CCG for this meeting.

The Chair advised the Board that he had received a request to move item 5 NHS Cambridgeshire And Peterborough NHS Health Inequalities Strategy to the first substantive item on the agenda. The Board agreed unanimously to this change.

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Walsh, Charlotte Black and Co-opted Member Claire Higgins.

2. DECLARATIONS OF INTEREST

No declarations of interest were received.

3. MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING HELD ON 25 FEBRUARY 2020

The minutes of the Health and Wellbeing Board meeting held on 25 February 2020 were agreed as a true and accurate record.

4. NHS CAMBRIDGESHIRE AND PETERBOROUGH NHS HEALTH INEQUALITIES STRATEGY

The report was introduced by the Acting Medical Director NHS Cambridgeshire and Peterborough CCG. The purpose of this report was to present the Cambridgeshire and Peterborough NHS Health Inequalities Strategy to the Board for adoption.

Board Members were informed that the NHS System Health Inequalities Group, based on national and international recommendations, had developed seven “Guiding Principles” to be included in the strategy which were:

1. Explore the impact of decisions on health inequalities early in the decision-making process.
2. Value staff through parity of recruitment, promotion and employment.
3. Offer simple, hassle-free services.
4. Partner with other organisations to take a place-based approach to address social determinants of health.
5. Allocate health care resources proportionate to need.
6. Consider actions at different stages of life.
7. Harness the community benefits of the Social Value Act.

Action was required at all levels of the system to shift inequalities.

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

- One area mentioned within the report was the Early Years' experience and community impact. Much of the intervention within the Early Years Strategy was about partners working together. Healthwatch had identified three key areas of challenge where partners could work together more effectively:
  1. NHS dental health access and oral health concerns
  2. Attendance of the appropriate people at safeguarding case conferences. How will the strategy ensure this happens?
  3. Vaccine. How will the system ensure that the groups mentioned in the strategy have access to the vaccine to reduce the inequalities identified?
- In response to the key areas of challenge identified by Healthwatch the Acting Medical Director responded as follows:
  - It was acknowledged that NHS Dental access was an issue and in light of the pandemic may become worse. Poor dental health was a marker for deprivation. Not enough had been done to engage with NHS England Dentistry at a regional level and more would need to be done. The representative for NHS England and NHS Improvement advised that going forward NHS Dentistry would be passed to the new Integrated Care Partnerships.
  - Everything was being done to ensure the appropriate people were in attendance at safeguarding case conferences. The use of virtual technology had assisted with this.
  - The advantage of the flexible COVID vaccine programme was that changes could be made along the way to adapt the programme to reduce inequalities.
  - Now more than ever there was a need to make sure that any NHS Strategy was tightly bound and sitting underneath the Health Inequalities Strategy to improve the wider determinants.

- Ideally the Health and Wellbeing Board Strategy would have been presented at the same time as the Health Inequalities Strategy which addressed the key challenges that the system had agreed on, however due to COVID pressures this had not been possible. The two strategies together would ensure that there was joined up working across the system.
- The Health Inequalities Strategy had been widely disseminated across the health and care system. The pandemic had exacerbated the extent of the inequalities but there had also been an acknowledgement that the health inequalities were not new. It would take time to disperse the disparities, but it was up to the Board to maintain momentum and keep pace to eradicate the inequalities identified.
- The cross-partnership work which was being done through the Best Start in Life Strategy focussed on pre-birth to five and the Adolescent Strategy which focussed on five years to 19 years (25years, if there were special educational needs) which ran alongside the Child and Mental Health Strategy provided a good focus on child inequalities.
- Board Members noted that the Strategy did not appear to address the health of rough sleepers which had become highlighted during the pandemic. Would the Impact Assessment cover this vulnerable group of people? Board Members were informed that rough sleepers came under the term Inclusion Groups and the standard Impact Assessment covered rough sleepers.
- The Executive Director of People and Communities advised that at a recent Health and Wellbeing Executive Board meeting the issue of dental health and the impact of mothers who had had babies during the pandemic and the sense of loneliness that they had felt had been discussed. It had been agreed that both issues would be taken to the Children and Maternity Board to be addressed. The issue of safeguarding and the times when people needed face to face contact with health professionals which included the case conferences would also be on the agenda for discussion.

AGREED ACTIONS

The Health and Wellbeing Board considered the report and **RESOLVED** to:

1. Adopt the Health Inequalities Strategy and promote the awareness of the guiding principles within the strategy.
2. Continue to work in partnership across the system to address health inequalities in the delivering of services, with a focus on addressing health inequalities in the workforce and adopting a health inequalities impact assessment (HIIA) approach for all service changes.

5. **PETERBOROUGH EPIDEMIOLOGY DATA UPDATE**

The Director for Public Health gave a presentation which provided the Board with the latest epidemiology review. The presentation is attached at Appendix 1 of the minutes.

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

- Board Members wanted to know the age range for the death data and if those people had underlying health conditions associated with the death. The Director of Public Health advised that this information could be provided and would report back to the Board. It was known that the risk factors continued to link to age, gender and long-term conditions and some social risk factors.
- It was noted that people in care settings either at home or in care homes had been contracting COVID from carers and questioned whether carers would be placed as priority groups for the vaccine. The Director of Public Health confirmed that care home

staff were being tested more regularly than in the past and therefore more cases were being identified at an earlier point. The chief priority for vaccinations would be the over 80's. What was not yet know was the risk of carrying or transmission of the disease after vaccination, it was therefore still important that people who had been vaccinated still followed the rules of social distancing, hand washing and wearing of masks and the wearing of PPE for care home staff.

- The Hands, Face and Space message was still very important to follow even with the vaccine to help to stop the spread of the virus. The vaccination programme would take some time to vaccinate the whole population. It was essential to follow the government guidelines and not to mix two households indoors. The evidence showed that the bulk of transmissions happened indoors.

AGREED ACTIONS

The Health and Wellbeing Board considered the report and **RESOLVED** to note the latest epidemiology data for Peterborough as presented by the Director for Public Health.

6. PETERBOROUGH COMMUNITY RESILIENCE GROUP (CRG) HUB AND OUTBREAK MANAGEMENT UPDATE

The Executive Director, People and Communities accompanied by the Service Director, Communities and Partnerships presented the report which provided an update to the Health and Wellbeing Board on key activity of the Peterborough Hub and Outbreak Management response.

The Executive Director provided a brief overview of the report advising that as part of the response to the COVID-19 emergency, the Government had instructed every Local Resilience Forum (LRF) area to establish local hubs. Hubs were required to provide targeted support for those people who required support in dealing with COVID-19. The Peterborough local hub received support from over 90 bodies including voluntary and community organisations, City Council Services, Parish Councils, Faith Communities, the Light Project, the City Leadership Forum and City College. The Primary Care services in Peterborough had also provided a lot of support to rough sleepers. In practical terms the Peterborough hub offered advice and information and facilitated access to foods supplies, shopping and medication delivery, financial and debt advice, support to domestic abuse victims, family support, economic hardship advice and transport to appointments. Since the hub was launched on 22 April over 2000 requests for support have been received directly to the hub, but this did not include requests made directly to the 90 individual organisations. Preparations were being made for the anticipated increase in demand over the winter months.

A comprehensive communications plan had been established and included regular newsletters, radio interviews, press releases/publication articles and a leaflet was sent to all Peterborough households. The aim of these communication channels was to promote the hub and Peterborough Information Network, so residents were aware of how and where they could get support, when they needed it. The contact number for the hub was 01733 747474.

The Service Director for Communities and Partnerships gave a brief overview of the Outbreak Management Plan for COVID-19, and explained that as part of the Government's national strategy to manage and control the pandemic, every area in England was required to develop its own Local Outbreak Control Plan for COVID-19. Peterborough's plan, published in August and revised since, built on tried and tested existing plans for controlling other infectious diseases like tuberculosis. It relied on working closely with local

communities to reduce the risk of people contracting the disease in the first place by following clear public health messages.

The current situation was that there was a consistent cycle of about 200 cases per 100,000 population rate in Peterborough which needed to be broken. The community response and lockdown had eased the situation slightly but more needed to be done to get the rate down. On Street Marshalls had proved to be beneficial with levels of compliance in social distancing increasing significantly and wearing of face masks. The number of Marshals had therefore tripled in number with seven days a week cover, between the hours of 9.00am to 9.00pm.

A range of community led interventions had been commissioned particularly targeted at people for whom English was not their first language, and work with older people, agencies and agency workers. Community work was also being done with faith leaders and communities where lack of compliance was a problem. Work was also being done with Rural Communities through working with Parish Councils to ensure support was being provided to vulnerable people in those communities.

There had been a heightened level of activity in hot spot areas such as central Peterborough where COVID rates had risen again, and a business forum was being set up for small businesses and shop owners. There had also been increased engagement with schools and colleges to provide advice and support and a new dedicated Department for Education Helpline had been introduced. An enhanced communications campaign was being introduced to raise the awareness of Hands, Face, Space including billboards on the side of vans in different languages to try and get the message across.

The local hub was now offering support to people who had COVID and needed to self-isolate but who were not eligible for support through the national scheme.

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

The Clinical Chair for the C&P CCG commented on how well the hub services have been adopted and the valuable support it provided especially with elderly patients who often felt isolated and especially around Christmas time. He congratulated the work done through the hub and wanted to pass on thanks to those working in the hub from those in the Primary Care sector for all the valuable work being done to support the communities of Peterborough.

AGREED ACTIONS

The Health and Wellbeing Board considered the report and **RESOLVED** to note and comment on the progress of the Peterborough Hub and Outbreak Management activity.

7. REPORT OF THE COVID-19 HEALTH INEQUALITIES RECOVERY WORKING GROUP

The report was presented by the Consultant in Public Health who chaired the Local Resilience Forum subgroup on behalf of the Director of Public Health. The purpose of this report was to enable the Health and Wellbeing Board to review a focussed piece of work undertaken as part of the COVID-19 recovery framework, examining the impact of the pandemic on health inequalities.

The Board was informed that a series of recovery groups had been established as part of the approach to managing the impact and consequences of the COVID-19 pandemic. One of these groups had provided a focus on recovery from a Public Health and Prevention perspective.

The Public Health and Prevention Recovery Group focussed on five core themes, namely: health inequalities, screening, vaccinations and immunisations, health behaviours, mental health, housing. The work under each theme was driven forward by small working groups.

Councillor Fitzgerald left the meeting at this point.

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

- It was noted that ageing was a big risk factor with COVID, and death was predominantly in older people especially in those with underlying conditions. Males were also at greater risk than females.
- The COVID pandemic had shone a harsh light on inequalities and shown that deprivation was a major risk factor for getting severe illness and dying from the complications of the viral infection.
- The BAME populations were also at greater risk and this was often complicated by the co-existence of relative poverty, poor housing and occupational/environmental exposure.
- High risk occupations like those people in front line services was also a risk factor.
- As the pandemic continued the impact on mental wellbeing would continue to grow with adverse impacts already seen such as domestic violence, child abuse and deterioration in children's educational and life-skill milestones. Young people's future could also be jeopardised by COVID.
- There was a Sustainability and Transformation Plan piece of work being undertaken now which was looking at this piece of work and that of the Health Inequalities Strategy and looking at the connection between the two to ensure that there was a single system view on how to tackle inequalities.
- The Peterborough Local Community Resilience Group (CRG) which had been in place since March coordinated the local hub and comprised of representatives from the public, private, voluntary, independent and faith sectors involved in the response to the COVID-19 public health emergency. The CRG had met fortnightly since March with 30 people attending every time. The group had agreed to continue indefinitely and take the theme of Health Inequalities forward.
- Think Communities offered three basic principles: a place based hyper level approach, being people centred and thinking about what was right for the resident and trying to demystify the Public Sector for residents. This approach alongside the work being done through the other groups would hopefully drive generational change.

AGREED ACTIONS

The Health and Wellbeing Board considered the report and **RESOLVED** to:

1. Note and comment on the report attached at appendix 2
2. Suggest interventions or examples of good practice to be explored that may help to address the inequalities identified
3. Endorse the approach for driving this work forwards via the Community Resilience Group

8. BMI CAN DO IT: PROGRAMME TO SUPPORT OBESITY AND DIABETES INEQUALITIES – DECEMBER UPDATE

Jan Thomas, Accountable Officer, Cambridgeshire and Peterborough Clinical Commissioning Group had to leave the meeting, Dr Howsam therefore introduced the report in her absence accompanied by Dr Jessica Randall-Carrick, CCG Clinical Lead for Diabetes and Obesity. The purpose of the report was to update the Board on the work of

the NHS-driven BMI Can Do It Programme, in accordance with proposals made to the CCG's Governing Body in July 2020. The basis of the programme was to encourage people to move more, eat better and sleep better and by doing these three things also improve their mental health. The programme had been promoted through extensive communications and marketing. A brief overview of the report was provided by Dr Howsam and Dr Randall-Carrick.

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

- The Executive Director for People and Communities requested that officers connect with the Service Director, Communities and Partnerships to ensure joined up working with place-based co-ordinators via the local Community Resilience Hub. One of the key priorities that the hub was working on was behavioural change and the hub had links with 90 different organisations, agencies and communities. It was important that the work of the BMI Can Do It Programme was joined up with the work of the hub.
- The Director of Public Health advised that the Public Health team had enjoyed working with the programme which included work around childhood obesity and talking to schools. The work being done around COVID offered huge potential to impact on people's knowledge and behaviours around weight management and a healthier lifestyle.
- Board members noted the prevalence of health inequalities across the BAME communities and that it was sometimes difficult to get the messages across to them, especially with regard to weight loss and particularly to females. Members suggested reaching out to community radio stations and BAME food bloggers to try and get the messages across.
- It was noted that the best results came when engaging with communities and empowering everyone within those communities. Group activities, group sports, group walks motivated people and once the vaccination programme was underway more group activities would be able to take place. This was an ideal opportunity to get communities and people working together to support the health system and a healthier lifestyle.

The Chair thanked the Clinical Lead for Diabetes and Obesity for her enthusiasm and good work on the BMI Can Do It Programme.

AGREED ACTIONS

The Health and Wellbeing Board considered the report and **RESOLVED** to acknowledge updates for the BMI Can Do It programme, including the rollover of some budget allocations due to current COVID-19 pressures within Primary Care.

Chair

1.00pm to 2.30pm

Appendix 1 – Presentation Epidemiology Review, Peterborough – 7 December 2020

CAMBRIDGESHIRE & PETERBOROUGH HEALTH & WELLBEING BOARD WHOLE SYSTEM JOINT SUB-COMMITTEE	AGENDA ITEM No. 9
DATE: 25th March 2022	PUBLIC REPORT

JOINT HEALTH AND WELLBEING / ICS STRATEGY 2022-2030: DEVELOPMENT AND OVERARCHING STRATEGIC APPROACH – DRAFT FOR CONSULTATION

R E C O M M E N D A T I O N S	
To:	Cambridgeshire and Peterborough Health and Wellbeing Board Whole System Joint Sub-Committee
From:	Jyoti Atri – Director of Public Health

The Cambridgeshire and Peterborough Health and Wellbeing Board Whole System Joint Sub-Committee is recommended to:

1. **read the strategy and the set of priorities across the Health and Wellbeing Boards for Cambridgeshire and Peterborough, and the Cambridgeshire and Peterborough Integrated Care Partnership**

2. **agree the process for developing the overarching strategic approach and four priorities in two phases**

3. **agree the level of ambition and targets for the overarching strategic approach**

4. **agree the outline strategic approach presented to the Board on 25th March 2022 goes out to consultation in May 2022, with feedback from that consultation to be presented to the HWB in September 2022.**

	Officer contact:		***Member contact:***
Name:	Jyoti Atri	Name:	Cllr Susan Van de Ven and Cllr Irene Walsh
Post:	Director of Public Health	Role	Chair of the Cambridgeshire Health and Wellbeing Board & Chair of the Peterborough Health and Wellbeing Board
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1.	**BACKGROUND**
1.1	Health and Wellbeing Boards are required, as stated in the Health and Social Care Act 2012, to produce Health and Wellbeing Strategies. The last two years have required the whole system to focus on tackling the challenges of the Covid-19 pandemic and whilst a Health and Wellbeing Strategy had previously been written and consulted upon, it was not launched due to the pandemic. Since then, much has changed and a new approach is needed.
1.2	The direct and indirect impact of Covid-19 has brought threats and opportunities to our ways of working and our residents' health, which mean we must reconsider our priorities and actions. As the local and national response to the Covid-19 pandemic starts to wind down, it is time to rebalance our attention to other harms that have potential to cause great harm over the life course. There are clearly some real challenges ahead, and if we are to stand a chance of addressing these challenges, we must be ambitious and we must work together as a whole system, learning from our successes and prioritising our collective efforts and resources to where we can make the biggest difference to improving health and wellbeing.
1.3	The Health and Wellbeing Strategy must be informed by Joint Strategic Needs Assessments. For the purpose of this particular strategy, the Covid-19 Impact Assessment fulfils the function of the JSNA, summarising the joint work we have done across local government, the NHS and partners to understand the emerging impact of Covid-19. In addition, the JSNA core data set provides understanding of health and wellbeing in Cambridgeshire and Peterborough residents.
2.	**PURPOSE**
	A new single approach for improving our residents' health and wellbeing
2.1	The Covid-19 pandemic has positively changed the way we work together. All partners in Cambridgeshire and Peterborough have rallied to respond to the pandemic, each partner playing their part and delivering what was required, within very short time scales. We must not lose our collective learning from this.
2.2	There are also significant infrastructure changes such as the development of the Integrated Care System (ICS), which will support system partners to provide a more integrated approach and work more closely together. The Health and Wellbeing Boards in Cambridgeshire and Peterborough will work very closely with the emerging Integrated Care Partnership (ICP), and when we refer to 'joint' in this strategy this means jointly with the ICP, across geographies and with partners, communities and residents.
2.3	The Health and Wellbeing Boards and the Integrated Care Partnership (ICP) must remain separate legal entities with their own statutory responsibilities that cannot be delegated to each other. However, we intend to bring the HWBs and ICP much closer together with common membership and joint meetings as a combined HWB/ICP in practice, with many of the same individuals sitting on both the Board and the Partnership. All partners in the combined HWB/ICP commit to cooperative and supportive working as equal partners across organisations, with everyone putting aside organisational boundaries to be focused on improving health and wellbeing for the people they serve. We believe that working together as much as possible across organisations, pooling our data, our understanding, resources, knowledge and

	experience, will result in better outcomes for our residents
2.4	We recognise there will be other priorities across the system. The Combined Authority, the Integrated Care Board, the Public Service Board, and district local authorities and other organisations will all have their own sets of priorities and plans. For example, the ICS has five strategic objectives which are partly focused on NHS workforce and services as well as including population health. Many of these priorities will undoubtedly lead to improvements in health and wellbeing through improving NHS care and also through improvements in the wider determinants of health – education, jobs, housing, income and the environment. However, the priorities and vision in this Health and Wellbeing Strategy should form the core of the system's commitment to improving health and wellbeing.
2.5	**Developing the strategy and our joint approach for improving residents' health** Before work on this strategy had started, our local developing Integrated Care System consulted and developed a mission statement for the 'system' (health, local authorities and other partners working together) **"All together for healthier futures"** Partners from across the NHS and the local authorities, and the wider public and voluntary sector, then came together in late 2021 and early 2022 several times to discuss the Health and Wellbeing Strategy and review the evidence on health in our area and the impact of Covid-19.
2.6	At a workshop held on 6th October 2021, all partners agreed in principle to a **single plan** and set of priorities across the Health and Wellbeing Board and the ICS. In addition, it was agreed that the ICS vision that had been consulted on and agreed by Cambridgeshire and Peterborough - "*All Together for Healthier Futures*" - should become the vision across the ICP and the HWB.
2.7	This means there will not be a separate overall long-term health and wellbeing strategy for local government, nor for the local NHS although there will however be Integrated Care Board plans for service delivery. This "One Plan" approach is a first for our area and demonstrates a commitment of all partners to working together towards shared goals, while retaining organisations' different areas of expertise and statutory responsibilities.

The workshop on 6th October 2021 was informed by our work assessing the impact of Covid-19.

2.8 Key points from the impact assessment are:

- Covid-19 has exposed and exacerbated inequalities, as demonstrated by the differential impact of the pandemic on our black and ethnic minority communities and those living in our most deprived areas
- There are more people in poverty; this risks a long-term impact on health
- The mental health of our population has been impacted by the pandemic, particularly children and young people
- Obesity affects around a 1/3 of our year 6 children and up to 60% of adults and has been made worse by the pandemic
- Our health service is under pressure and the way that people access health care and preventative health care has changed
- There are risks and opportunities to our environment as result of the pandemic.

Three top-level overarching strategy goals and four key priorities for achieving these goals arose from discussions at this meeting on 6th October 2021. A subsequent development meeting on 17th January 2022 agreed, in principle, that these goals and priorities should form the core of the overarching Health and Wellbeing Strategy.

2.9 ***Health and Wellbeing Strategy for Cambridgeshire and Peterborough 2022-2030***

What will we focus on?

This 'overarching' strategic approach sets out our headline ambitions and the four priorities we will focus on to achieve these ambitions. We are aiming to work with our residents, patients and stakeholders to tackle some real challenges in improving the health and wellbeing of the people we serve, by reversing some of the health determinants and outcomes that were challenging before the pandemic and have worsened as a result of the pandemic. We also need to prioritise reducing the health inequalities which existed pre-pandemic but which were exacerbated and brought into sharper focus by Covid-19.

2.10 This will be an eight-year overarching strategy for the health and wellbeing of residents

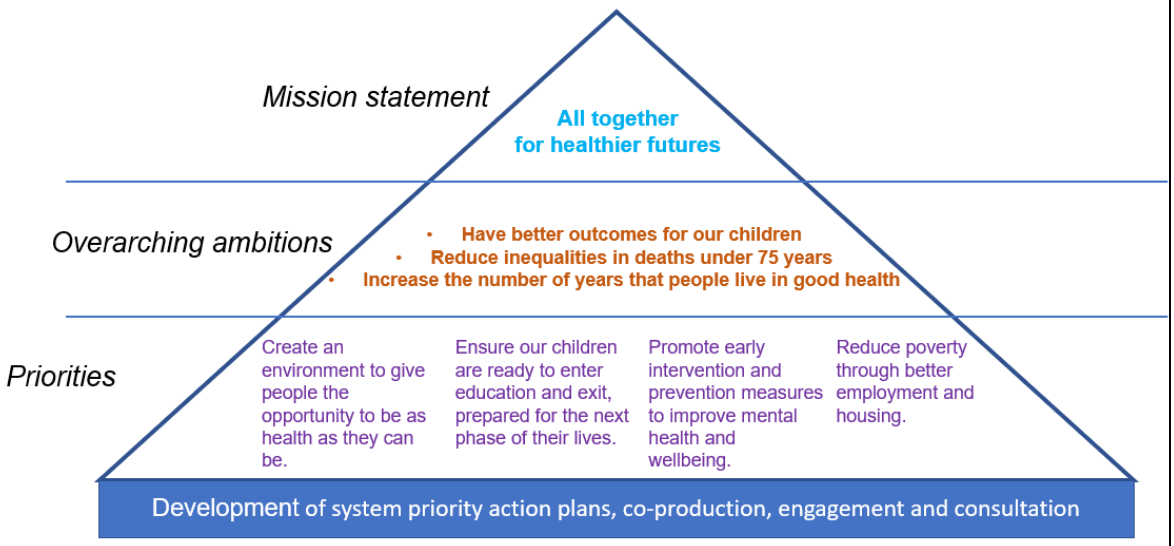
	in Cambridgeshire and Peterborough.[1] It will provide a clear statement of what we intend to achieve together across the NHS and local government system and will set out how we intend to develop and achieve it in partnership with our residents, patients, and stakeholders. This strategy is also the high-level long-term plan and priorities for our local NHS Integrated Care System,[2] which oversees NHS services across Cambridgeshire and Peterborough.
2.11	Working jointly across the NHS and local government will mean that we can be more ambitious and more accountable in addressing these issues. By sharing more of our data, we can develop a better common understanding of our residents' health and needs as well as service use. Bringing all our collective resources, knowledge and experience together means we make best use of these resources to create measurable and meaningful impact.
2.12	*What do we want to achieve?* Three overarching ambitions were agreed by consensus across local authority and NHS colleagues; reflecting the issues we know about in our population and the outcomes that are most important. Whilst these are recognised as ambitious, they are plausible, and all partners have committed to delivering these ambitions. This will require collective and organisation specific endeavours.
2.13	By 2030: **1. We will increase the number of years that people spend in good health** Life expectancy is often used as a measure of societal progress, and although it is important, it does not take into account the fact that towards the end of life there is often a period, perhaps many years, which is spent in poor health. Healthy life expectancy, on the other hand, measures the average time we can expect to live in good health. It is clearly worthwhile to prevent conditions that cause disability and poor health over a long time, in order to increase the number of years that people spend in good health. We know that healthy life expectancy is also strongly linked to deprivation, with people living in less well-off areas more likely to experience a long time at the end of life in poor health. By 2030 we want to see healthy life expectancy increase by at least two years for men and women in Cambridgeshire and Peterborough. **2. We will reduce inequalities in preventable deaths before the age of 75** Preventable premature mortality are deaths of people under 75, from causes of death that are largely or entirely preventable (for example, smoking related deaths, or deaths from vaccine-preventable disease). We know that there is a strong relationship between the wealth of an area and the rate of preventable premature mortality. Our most deprived areas see many more of these deaths than our least deprived areas. We will weaken this relationship between wealth and early preventable deaths so that people in our least well off areas are less likely to die young. **3. We will achieve better outcomes for our children** Working with parents and communities we will achieve better outcomes for our children, recognising the holistic needs of our children. Health and wellbeing

[1] This strategy covers Cambridgeshire and Peterborough; the two local authorities have joint working relationships and have agreed to delegate authority to a single Health and Wellbeing Board to act on behalf of both areas.

2 The Integrated Care System is also developing NHS-focused plans describing priorities in commissioning and delivering healthcare

	measures for children are broad and include determinants of health as well as health outcome measures. Investing in the health and wellbeing of our children, will pay dividends throughout their lives. In addition, investments in the early years are often the most cost effective[3]. This outcome would mean that on key measures of health and wellbeing for children, Cambridgeshire and Peterborough will be the best in a group of 'comparator' local authorities (those which are similar in size, wealth and some demographic factors). In other words, when it comes to our children and young people, we will be doing better than the other areas that we are most similar to us.
2.14	As part of our early workshops on this strategy, there was considerable discussion on how to set appropriate long-term goals for Cambridgeshire and Peterborough that would make a difference to the health of residents. The three overarching goals that were arrived at are intended to be stretching and ambitious, but also plausible and achievable. Together, the three goals will add up to a healthier and happier community, where the foundations for a good life are set in childhood, health inequalities are lessened, and wealth is less strongly linked to good health and wellbeing.
2.15	The technical appendix (appendix 1) presents the best available evidence on the current situation for the three overarching goals. It is important to note that for some of the indicators used to measure progress towards these goals, the full impact of the Covid-19 pandemic is not yet showing up in the data. We may in fact be starting from a lower point than the most recent data suggests.
2.16	***How we will achieve these ambitions*** Discussion at our system-wide workshops identified four priority areas where we know we need to do things differently in order to achieve our overarching ambitions. The four priorities for the Health and Wellbeing Board and the Integrated Care System focus on children, our environment and opportunities for health, poverty, and mental health and wellbeing. Each of these priority areas will be developed into a chapter of the Health and Wellbeing Strategy. The four priorities are listed overleaf.

[3] The best start for life: a vision for the 1,001 critical days - GOV.UK (www.gov.uk)



2.17

1. **Ensure our children are ready to enter education and exit, prepared for the next phase of their lives**

    - This is not limited to children's educational attainment
    - Children's physical and mental health and wellbeing are essential for children to participate effectively in education

2. **Create an environment to give people the opportunities to be as healthy as they can be**

    - 'Environment' here is used in the widest sense, so includes wider determinants of health such as health behaviours, infrastructure, and socio-economic factors, as well as access to green spaces and clean air.
    - This also includes the opportunities for better health which the NHS provides; partly healthcare, but also encouraging patients to take greater responsibility for their own health.

3. **Reduce poverty through better employment and better housing**

    - This especially recognises that the Health and Wellbeing Board / ICP partners are large employers within our local economy and the way we employ, treat our staff and commission services can have a big impact, as well as capturing work with wider partner organisations on the economy, employment and health.
    - Local and Combined authorities have a key role to play in improving housing across Cambridgeshire and Peterborough impacting health of residents
    - Better physical and mental health will improve employment for our residents

	4. Promote early intervention and prevention measures to improve mental health and wellbeing • Work to improve wellbeing across the population, as well as intervening early when people experience mental ill-health, will have huge benefits for all our residents.
2.18	Senior staff from across the local public sector will work with partners and communities to take on development and leadership of the four strategy priorities, supported by evidence and data about our population. The work on these system-wide priorities – deciding what will change, what will cease and what new approaches are necessary will take place over the next six months. The longer timescale for developing this work is necessary to include and summarise much of the work that is already being done in these areas. It is also important to allow sufficient time for meaningful co-production, engagement and consultation to take place with service users, patients and residents, as well as ensuring relevance and support from partner organisations. The process and principles for developing the priority chapters, including engagement work, is laid out in the engagement plan and timeline (Appendix 2).
2.19	Health and Wellbeing Board and NHS partners will have different roles to play in each of these priorities; for example, the health system does not provide housing, and the local authority does not commission most mental health interventions. However, each of the four areas has scope for action for all key partners, plus there are additional benefits that should come from working on these agreed priorities together as a system.
2.20	All four priorities will need to consider what needs to be done around the cross-cutting themes and ambitions of improving children's outcomes, reducing health inequalities and improving years of life lived in good health.
3.	**CONCLUSION**
3.1	We intend this Health and Wellbeing Strategy to shape work across the NHS and Cambridgeshire and Peterborough local authorities over the next eight years. We are starting from a challenging position given the impact of Covid-19 across our area, but we have set stretching but achievable ambitions. By working more closely across the NHS, the public sector, partners, communities and residents than we ever have before, we can achieve these ambitions and make a meaningful difference to the lives of our residents; happier and healthier children and young people, fewer early deaths in our more deprived areas, and more years spent in good health.
4.	**ANTICIPATED OUTCOMES OR IMPACT**
4.1	Section 2.14 details the anticipated outcomes for the Joint Cambridgeshire & Peterborough Heath & Wellbeing strategy under the following headings. **1. We will increase the number of years that people spend in good health** **2. We will reduce inequalities in preventable deaths before the age of 75** **3. We will achieve better outcomes for our children**

5.	**IMPLICATIONS**
	Financial Implications
5.1	*There are no direct financial implications as a result of this report*
	Legal Implications
5.2	*There are no direct legal implications as a result of this report.*
	Equalities Implications
5.3	*There are no direct equality implications as a result of this report.*
6.	**APPENDICES**
6.1	*Appendix 1 – Setting the level of ambition* *Appendix 2 – Timeline, co-production, engagement and consultation plan*
7. 7.1	**SOURCE DOCUMENTS** None.

Joint Health and Wellbeing/ICP Strategy 2022-2030: **Setting the level of ambition** (Appendix 1)

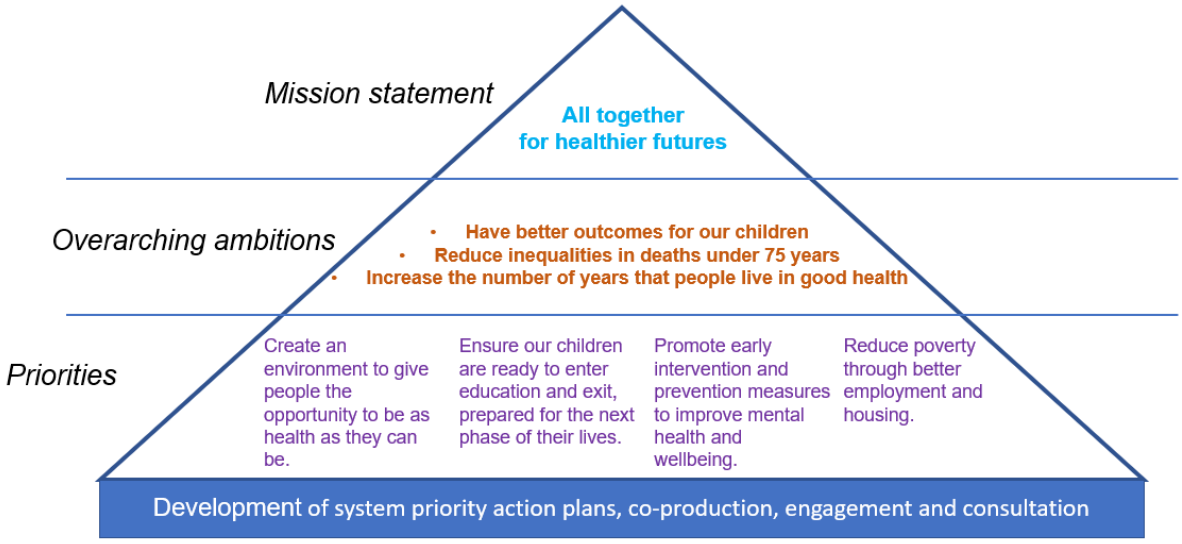
Introduction

The Health and Wellbeing Strategy overarching goals presented here are based on the system wide discussions held in October 2021 and January 2022. The January 2022 workshop specifically discussed the level of ambition for the Health and Wellbeing Strategy and highlighted that these goals should be stretching and ambitious while remaining plausible and achievable.

This technical appendix presents the best available evidence on the current situation for the three goals and proposes the level of ambition for each. It is important to note that the full impact of the Covid-19 pandemic is not yet showing up in the available data. We may in fact be starting from a lower point than the data below suggests; as such we suggest revisiting these targets once data is available that shows the full impact of the pandemic on our measures.

All the goals set out here are targets for the end of the strategy period in 2030.

All of the four priority areas (children, environment, poverty and mental health) will feed in to all three goals (image below), but some will have closer links than others. The priority areas will also develop their own targets which will include shorter-term metrics; these are yet to be determined but it will need to be clear how those targets feed in to these three overarching goals.



1. **We will increase the number of years that people spend in good health.**

   TARGET: We will increase healthy life expectancy by at least two years in Cambridgeshire and Peterborough, and we will reduce the gaps between men and women in our areas.

   What does healthy life expectancy mean?

   - For a particular area and time period, it is an estimate of the average number of years a newborn baby would live in good general health if he or she experienced the age-specific mortality rates and prevalence of good health for that area and time period throughout his or her life.
   - Put simply, it is the number of years in good health that an average person can expect. It was chosen for one of our goals over life expectancy because life expectancy includes the years often spent at the end of life in poor health, and we do not seek to extend these. Healthy life expectancy has been described as 'adding life to years' rather than 'adding years to life.'

   Table 1 presents the latest data on healthy life expectancy for our area. At present Cambridgeshire residents have considerably higher healthy life expectancy than in Peterborough, for both men and women. Interestingly, in Peterborough women can expect fewer years in good health than men, while the reverse is true in Cambridgeshire. Therefore, we aim to see an increase of at least two years for women in Cambridgeshire and men in Peterborough, but to narrow the gap between the sexes we also want to see a larger increase for Cambridgeshire men and Peterborough women.

   The initial system wide workshops in October 2021 and January 2022 discussed a improvement levels of 10% for each target. For Healthy Life Expectancy this would be an unrealistic increase of at least six years which would take us beyond the current best in England.

Table 1 Healthy Life Expectancy in Cambridgeshire and Peterborough

	Cambridge-shire (2017-19)	**Cambridge-shire Plus 2 yrs**	**Peterborough (2017-19)**	**Peterborough Plus 2 years**	**Best in England (2017-19)**
Male healthy life expectancy	64.3	66.3	62.8	64.8	71.5
Female healthy life expectancy	66.2	68.2	59.9	61.9	71.4

We should also bear in mind that, as with most public health measures, healthy life expectancy is strongly linked to deprivation. Although figures for small areas are not

available to demonstrate the link in our local areas, national data shows clearly that people living in wealthier areas enjoy considerably more time in good health on average compared to residents of more deprived areas. We cannot set local targets to preferentially improve healthy life expectancy in our more deprived areas, but if this strategy includes a focus throughout on health inequalities we would expect healthy life expectancy to improve faster in these areas.

Healthy life expectancy was recently mentioned in the 'Levelling Up' White Paper[1] with one of the 'missions' described as: "*By 2030, the gap in Healthy Life Expectancy (HLE) between local areas where it is highest and lowest will have narrowed, and by 2035 HLE will rise by five years."* This document refers to a forthcoming White Paper on health disparities that will set out the central governmental strategy for 'tackling the core drivers of inequalities in health outcomes. As such, we anticipate national policy support and action to facilitate this local target.

As with preventable premature mortality, increasing healthy life expectancy depends on core public health work and prevention and early intervention work delivered by the NHS. All four priorities will feed into increasing healthy life expectancy.

2. We will reduce inequalities in preventable deaths before the age of 75 years.

TARGET: We will reduce inequalities in preventable deaths before the age of 75 years by 20%.

Premature mortality here is defined as any death before 75 from causes considered preventable. It is presented as age-standardised rates per 100,000 rather than as absolute numbers.

Deaths are considered preventable if

- all or most deaths from the underlying cause could mainly be avoided through effective public health and primary prevention interventions.
- 'preventable' deaths include most infectious disease, some cancers, diabetes, cardiovascular disease, injuries and alcohol and drug-related deaths.[2]

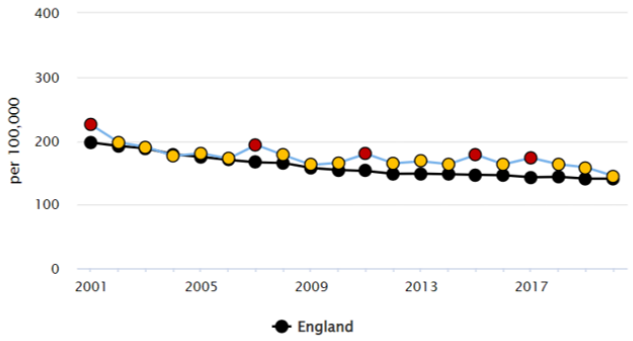
Preventable premature mortality rates are lower than the England average in Cambridgeshire but close to the England average in Peterborough (Figure 1). Rates have not changed much over the last ten years in either area, as the chart below shows. Comparing these two charts demonstrates an inequality between Cambridgeshire and Peterborough, which is probably a result of different levels of prosperity between these areas overall.

Figure 1 Preventable deaths under 75 per 100,000 in Cambridgeshire and Peterborough compared to England

[1] HM Government (2022) Levelling up the United Kingdom

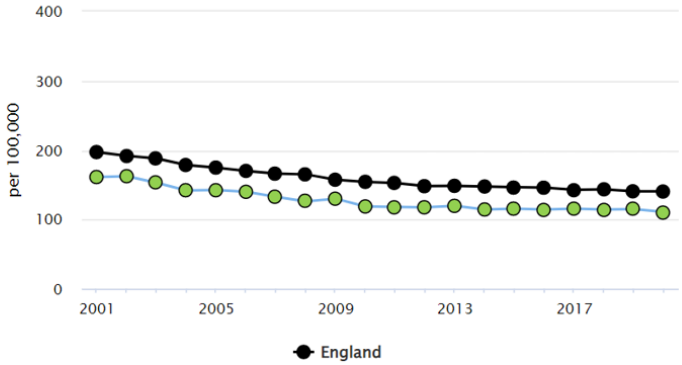
[2] For a full list of ICD-10 codes included in the definition of preventable deaths, see https://fingertips.phe.org.uk/mortality-profile#page/6/gid/1938133056/pat/15/ati/402/are/E10000003/iid/93721/age/163/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0

Peterborough



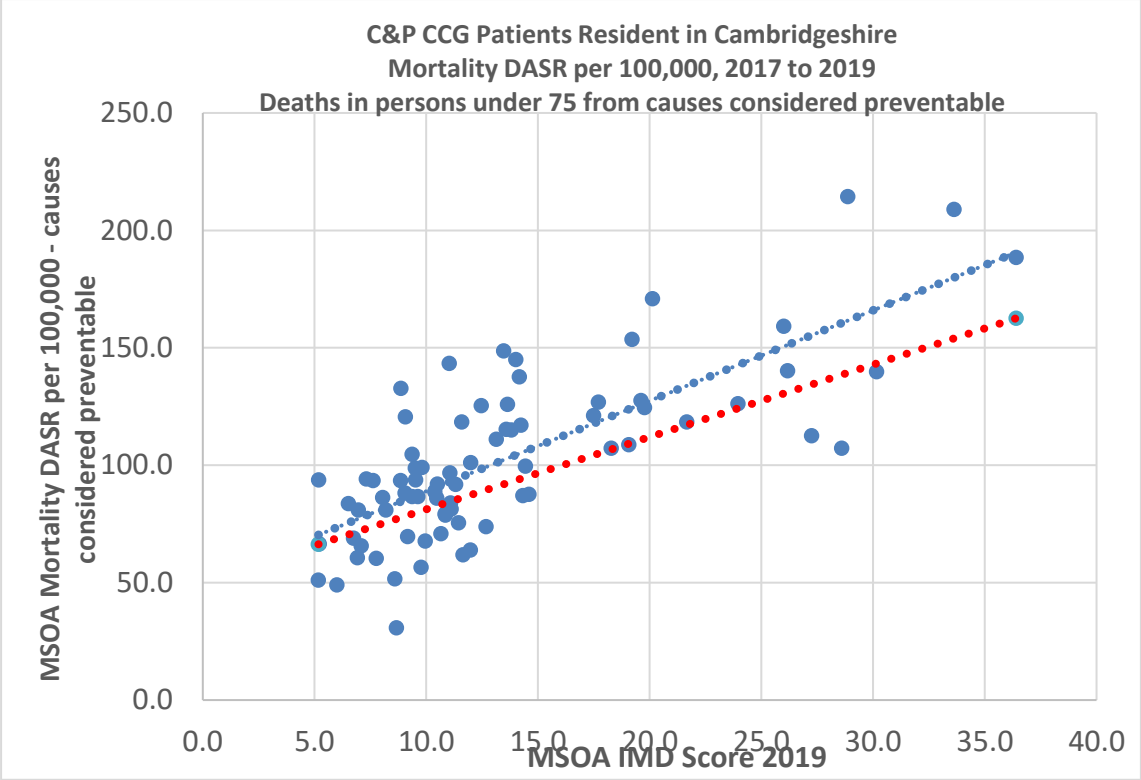
Period	Count	Rate
2010	210	165.6
2020	228	144.8

Cambridge



Period	Count	Rate
2010	587	118.8
2020	655	110.9

Preventable premature mortality rates also vary substantially by small areas (MSOA), with a clear link to deprivation. The chart below shows under-75 preventable mortality rates by Cambridgeshire MSOA (Peterborough not shown but a similar relationship exists). The blue line is the line of best fit for the current data (a regression line) which shows a strong relationship between increasing deprivation and increasing rates of preventable premature mortality. People in our some of our most deprived Cambridgeshire areas have a preventable mortality rate around four times higher than those in our least deprived areas; a substantial disparity. Please note that this data is the most recent available data and covers a three year period ending in 2019; as such the impact of the pandemic is not shown. At present the definition of premature preventable mortality data does not include deaths from Covid-19 (although it does include influenza deaths).



Reducing inequalities in premature mortality would require reducing the slope of this line to the red line shown above – our target. This is a 20% reduction in the slope of the line. This would have most benefit to those people in our most deprived communities but should also benefit people across the area; for instance, fairly well off areas (an IMD score between 10 and 20) also have some way to go to reduce their rates down to the red line.

The initial workshops discussed reducing targets by 10%. However, after considering what this would look like in practice, this has been considered as insufficiently ambitious and that in fact a 20% reduction was closer to the level of ambition discussed.

Reducing the slope of the line will also have the effect of reducing premature mortality overall. If the rates in the least deprived areas remain similar but the gradient reduces by 20%, we would have an overall preventable premature mortality rate of around 92 per 100,000 in Cambridgeshire, compared to 102 per 100,000 at present.[3] We will also have a target to reduce Peterborough's preventable mortality gradient by 20%

This target illustrates the principle of 'proportionate universalism'. To meet the target and reduce health inequalities, we need to work across our whole population, recognising there is room for improvement everywhere, but directing more efforts to those living in our most deprived areas where mortality is highest.

The work needed to reduce preventable premature mortality needs to take place largely in public health and in primary prevention. Improving health behaviour is key, as is early identification and intervention, including primary care and immunisation and

[3] Exact overall rate cannot be predicted.

screening. However, this target needs to also be seen in the context of the wider determinants of health and behaviour; the standard offers that reduce the risks of disease leading to premature mortality may not be sufficient (or may not be delivered to the same standard) in our most deprived areas. As such, each of the four priority areas has an important role to play in reducing premature mortality.

3. **We will have better outcomes for our children.**

TARGET: We will be the best of our comparators for core children and young people outcomes

Children and young people have been adversely affected by the pandemic across many areas of their lives, from loss of education, socialisation and jobs as well as increasing demand for mental health services from children and young people. Giving children the best start to life will pay dividends across the life course. Therefore, rather than a single outcome, the ambition is to improve across core children and young outcomes and be the best of our comparators. This priority is not limited to children's educational attainment; children's physical and mental health and wellbeing will be explicitly included.

Considerable work has already taken place on this topic and system-wide strategies currently already exist (or are in development) focusing on the main aspects of children and young people's lives. These strategies are led by the Children's and Maternity Collaborative who working across health, education and local authorities in Cambridgeshire and Peterborough. This has not been further defined at present because of the likely large overlap with the children and young People and mental health priority-specific targets. An important early step for these priorities will be to determine what outcomes should be included as overarching goals for the whole strategy and are likely to include the aspects below

- Best Start in Life (children 0-5 yrs)
- Strong Families Strong Communities (children and young people 5-25 yrs)
- Children and Young People's Mental Health
- Special Educational Needs and Disabilities including autism
- Autism

How are these goals linked?

These three overarching goals all interact. Improving child health will have significant effects on improving healthy life expectancy, because healthy life expectancy is strongly influenced by deaths in younger age groups. Reducing premature mortality will also affect healthy life expectancy, both by preventing death, but also because most of the conditions that contribute to premature mortality also cause substantial ill health for many people before death. If we are able to improve interventions to prevent these conditions in the first place then as well as preventing deaths, we will also prevent the associated ill health burden that reduces healthy life expectancy.

The focus on inequality means that we have to carefully consider how to do things differently – the 'easier' groups to influence are often those who are better off. Working with these better off groups would see overall rates decrease, but unless rates decrease faster for the more deprived then inequalities will worsen. Improving

outcomes for people at the most deprived end of the spectrum can be much harder, but it is also where there is most room for improvement.

The impact of Covid-19 on these metrics

Much of the full impact of the pandemic does not yet show up in these metrics. The healthy life expectancy data available at present only goes up to 2019, as do our small-area data on preventable premature mortality which allows us to see local inequalities in early deaths.

We know that overall life expectancy has shown a sharp downturn however in 2020, a pattern seen clearly in the charts below for men in Cambridgeshire and Peterborough though less apparent for women in our areas. Healthy life expectancy will have been similarly affected and so we will be starting from a lower base in 2022 than suggested by the figures above. We also know that Covid-19 has disproportionately affected our more deprived areas and communities, as is the case across the UK and beyond. As such, inequalities in healthy life expectancy and in premature mortality are likely to have worsened in the last two years.

We recommend revisiting the targets when data is available to give us a more accurate picture of our starting point at the beginning of 2022.

Joint Health and Wellbeing/ICP Strategy 2022-2030: Developing the Health and Wellbeing Strategy – timeline, co-production, engagement and consultation plan (Appendix 2)

The overarching strategy will be presented to the March meeting of the HWB/ICP for approval prior to public consultation. The initial development of the overarching strategy and targets has been done through two large stakeholder workshops on 6th October 2021 and 17th January 2022.

This paper sets out some more detailed information around the next steps for consultation and engagement for the overarching strategy and to enable the detailed development of the four priority chapters, their outcomes and action plans.

Timescales for development of overarching strategy

Date	
Oct 2021 – Feb 2022	Overarching strategy and targets developed based on system-wide workshops
Feb- Mar 2022	Socialised across system leads for comment and input
Mar 2022	Presented to HWB/ICP formal meeting with request for approval for public consultation on strategy
May-Jun 2022	Public consultation on overarching strategy; including an easy read version
Jun-Jul 2022	Formal approval of overarching strategy by HWB/ICP

Consultation and engagement for strategy priorities

We envisage that the bulk of the detailed co-production, engagement and consultation work on the HWB/ICP Strategy will be done on the content and direction of each priority chapter, key outcomes and action plans. Stakeholder groups and styles of engagement will vary with each topic and this will need careful consideration by topic leads to enable meaningful engagement and co-production.

Timescales for development of the four priorities

Date	
Oct 2021 – Mar 2022	Four priorities agreed and system leads identified
Mar 2022	As above, priorities presented to HWB/ICP formal meeting as part of the overarching strategy, with request for approval for public consultation on strategy
Apr-Nov 2022	Development and co-production of the four priorities by priority leads, partners and stakeholders with engagement as appropriate for each priority area.
Aug 2022-Dec 2022	Priority chapters of the strategy presented individually in detail to HWB/ICP formal meetings with request for approval for public consultation. Order to be determined.
Sep-Jan 2023	Formal consultation on priority chapters individually

March 2023	Formal approval of full overarching strategy with priority chapters by HWB/ICP.

Development of priority chapters

Each of the four priorities will have two senior responsible officer leads with experience of the relevant area. They will take account of relevant work that is already underway or in development across the system and consider how this fits together and how the system could work better to influence the three main overarching goals (children's outcomes, inequalities in premature mortality, and healthy life expectancy). The leads will also determine relevant indicators to monitor progress in each area.

A suggested structure for each of the four priority chapters:

- What is the scope for this priority and the overarching goal?
- Where are we now?
- What services and strategies are already in place (or development) across the system, including ICS work?
- What are we going to focus on (and how has this been decided)?
- Where can we get to with these areas of focus?
    - Bold ambitions for change that will prompt rethink of delivery and systems
    - How do these areas of focus contribute to overarching HWB priorities (healthy life expectancy, inequalities in premature mortality, and children's outcomes)?
- How can we get there – what will we do differently?
    - What will change?
    - Monitoring success - quick wins and ambitious medium and longer term targets

Principles for developing each chapter

Each of these four priorities is very wide-ranging with enormous scope. No strategy can be successful if it tries to improve everything all at once, so choices will be necessary while developing each of the four priorities. The senior leads for each priority will be making these decisions, but there are several principles that should be followed while these four priorities are being developed:

- We should use evidence-based approaches wherever possible, and embed evaluation and learning from new initiatives
- There should be an emphasis on prevention and early intervention
- The strategy must identify and tackle inequality in wellbeing across our places and by deprivation

- Given these principles above, where possible the choice of topics to focus on within each priority should be informed by stakeholder and service user and resident input on what is most important.
- It should be clear how actions and outcomes from each of the four priorities contribute to the three overarching goals of the strategy as a whole (improving outcomes for children, reducing inequalities in premature mortality, increasing years lived in good health), while having their own short and medium term goals.
- The goals within each priority should reflect different starting points for our different places, and also encourage reduction in inequalities by deprivation and ethnicity. Some short term ‘process’ outcomes may be necessary but medium (~5 yr) and long (~10 yr) outcomes should be clearly linked to the three overarching goals.
- Each priority should explicitly include children and young people.

CAMBRIDGESHIRE & PETERBOROUGH HEALTH & WELLBEING BOARD WHOLE SYSTEM JOINT SUB-COMMITTEE	AGENDA ITEM No. 10
DATE: 25th March 2022	PUBLIC REPORT

ESTABLISHMENT OF A JOINT CAMBRIDGESHIRE & PETERBOROUGH HEALTH AND WELLBEING BOARD PROPOSALS

R E C O M M E N D A T I O N S	
To:	*Cambridgeshire and Peterborough Health and Wellbeing Board Whole System Joint Sub-Committee*
From:	*Jyoti Atri, Director of Public Health*

The Cambridgeshire and Peterborough Health and Wellbeing Board Whole System Joint Sub-Committee is recommended to:

1. **read this report on the proposals to form a Joint Cambridgeshire & Peterborough Health & Wellbeing Board which works as an aligned board with the Integrated Care Partnership.**

2. **endorse the revised Terms of Reference set out in Appendix A.**

3. **recommend the changes to both Full Councils to enable the necessary changes to be made to the respective Councils' Constitution.**

	Officer contact:		***Member contact:***
Name:	Jyoti Atri	Name:	Cllr Susan Van de Ven and Cllr Irene Walsh
Post:	Director of Public Health	Role	Chair of the Cambridgeshire Health and Wellbeing Board & Chair of the Peterborough Health and Wellbeing Board
Email:	Jyoti.Atri@cambridgeshire.gov.uk	Email:	irene.walsh@peterborough.gov.uk susanvandeven5@gmail.com
Tel:	-	Tel:	-

1.	**BACKGROUND**
1.1	Under the Health & Social Care Act 2021 Upper Tier Local Authorities (UTLA) have a statutory function to have a Health & Wellbeing board (HWB) as a formal committee of the local authority. In 2019 procedures were put in place to establish joint working relationships between the Cambridgeshire HWB and Peterborough HWB.
1.2	Section 198 of the Health and Social Care Act 2012 provides that Two or more Health and Wellbeing Boards may make arrangements for: - (a) any of their functions to be exercisable jointly (b) any of their functions to be exercisable by a joint sub-committee of the Boards (c) a joint sub-committee of the Boards to advise them on any matter related to the exercise of their functions.
1.3	In 2019 both UTLAs agreed to an approach in establishing formal joint working relationships between the HWBs. This arrangement was possible as the two Health and Wellbeing boards had the same legal responsibilities. Both UTLAs changed their terms of references to allow for the creation of the Whole System Health & Wellbeing Board sub-committee and the Core Health & Wellbeing sub-committee. Both sub-committees had delegated authority to act on behalf of the Cambridgeshire and Peterborough HWB "Parent boards".
2.	**PURPOSE**
2.1	The landscape for HWBs has changed dramatically with the formation of the Integrated Care System and locally, consideration has been given to how existing arrangements can provide the opportunity to build greater alignment between different system partners.
2.2	Cambridgeshire and Peterborough health and care partners, through a number of HWB and ICP Integration development sessions have committed to establishing a single strategy for the system that will be owned by both the HWBs and ICP.
2.3	Our approach in Cambridgeshire & Peterborough has been to establish new collaborative working arrangements between the Health & Wellbeing Boards and the developing Integrated Care Partnership (ICP), so that there is a commonality of purpose that ensures effective joined up decision making.
2.4	To enable delivery of this ambition, work is underway on agreeing common membership for the ICP and the HWB and streamlining arrangements for holding meetings to allow business to proceed in a more coordinated way.
2.5	This paper proposes further changes to the terms of reference to allow for the creation of a Joint Cambridgeshire & Peterborough Health & Wellbeing Board that recognises the new collaborative arrangement for working together.

3.	**GOVERNANCE**
3.1	Guidance from the DHSC issued in September 2021 to support the implementation of Integrated Care Systems, including Integrated Care Partnership (ICP) Engagement Document: Integrated Care System (ICS) Implementation made it clear that the HWB cannot act as an ICP because they are separate legal entities with statutory responsibilities that cannot be delegated to each other. The White paper on Integration and Innovation: Working together to improve health and social care (published in 2021) establishes Integrated Care Systems (ICSs) on a statutory footing through both the NHS Integrated Care Board and an Integrated Care Partnership (ICP).
3.2	The dual structure recognises that there are two forms of integration a) with the NHS to remove barriers to collaboration and to make working together across the NHS an organising principle and b) between the NHS and others, principally local authorities, to deliver improved outcomes to health and wellbeing for local people.
3.3	The White paper specifies that an ICP should have the following functions:- • System level partnership with NHS and local government as equal partners • Alignment of partners strategies across the system • Improving care, health and wellbeing for the local population.
3.4	Through development sessions of HWB and ICP partners in October 2021 and January 2022 the collaborative approach to developing a single strategy has started to take form. The legislation is clear that both the ICP and HWBs would be independent boards but by working in alignment allows for a continued focus on the wider determinants of health. This approach reflects a genuine ambition across the local health and care system to develop innovative ways of working together.
3.5	Both ICP and HWBs would be independent boards with shared agendas. Where there is a need to take separate decisions, the function to do so could be achieved through a Part A (Shared HWB/ICP) and Part B (ICP only or HWB only) agenda. Both HWB and ICP members could sit at the one meeting with voting rights as assigned via the terms of reference. A common membership between the HWBs is proposed of around 11 members that would both be ICP and HWBs members. Both HWB and ICP will have some members that will not be shared and these are being worked through. For example Health partners will finalising membership from the acute and community provider Trusts and representatives from primary care, place based alliances and the community sector.
3.6	Changes to the terms of reference include the following: • Context & Introduction – providing the background to the integrated approach with the ICP and the proposal for a Joint Cambridgeshire & Peterborough HWB. • Removal of the two sub-committee – i.e. Whole System HWB sub-committee (replaced by the Joint Cambridgeshire & Peterborough HWB) and the removal of the Core sub-committee (functions also replaced by the Joint Cambridgeshire & Peterborough sub-committee) • Membership proposals – refining current membership so that a shared membership exists with the ICP to allow for collaborative decision making.
4.	**ANTICIPATED OUTCOMES OR IMPACT**
4.1	- Co-ordinated system approach with shared Health & Wellbeing strategy HWB - Continued focus on the wider determinants of health which have an impact on an individual's health and wellbeing.

	- Health & Social care system accountability on delivering outcomes based on needs of the population
5.	**IMPLICATIONS**
	Financial Implications
5.1	There are no financial implications as a result of this report.
	Legal Implications
5.2	The legal implications are around establishing a Joint Cambridgeshire & Peterborough Health & Wellbeing board are addressed in section 3. Specific reference is drawn to 3.5 and 3.6.
	Equalities Implications
5.3	There are no direct equality implications as a result of this report.
6.	**APPENDICES**
6.1	Appendix 1 Cambridgeshire & Peterborough Joint Health & Wellbeing Board Terms of Reference (draft)
7.	**SOURCE DOCUMENTS**

Source Documents	**Location**
Section 198 Health & Social Care Act 2012	https://www.legislation.gov.uk/ukpga/2012/7/contents
White Paper integration & Innovation DHSC Feb 2021	Integration and innovation: working together to improve health and social care for all (HTML version) - GOV.UK (www.gov.uk)
Integrated Care Partnerships Engagement Document	Integrated Care Partnership (ICP) Engagement Document: Integrated Care System (ICS) Implementation

Appendix 1

12. Cambridgeshire & Peterborough Health and Wellbeing Board

Introduction

The Cambridgeshire & Peterborough Health and Wellbeing Board (HWB) is established as a committee of the County Council under section 102 of the Local Government Act 1972. Its remit is to work to promote the health and wellbeing of Cambridgeshire's communities and its focus is on securing the best possible health outcomes for all residents. This will involve a system level partnership with NHS and Local Government as equal partners and the alignment of partners strategies across the system.

In consideration of the developments around the Integrated Care Partnerships (ICPs), Cambridgeshire & Peterborough HWB aims to ensure that integration is closely linked to prevention and tackling the wider determinants of health. A joint Cambridgeshire & Peterborough HWB will have collective accountability and responsibility for population health care outcomes. This board will maintain its separate statutory identify from the ICP but will where possible meet as a committee in common where agenda items will be split between ICP in one section and HWB in the other It is the intention to have one shared Cambridgeshire & Peterborough Health & Wellbeing Strategy that is owned across the local system.

Membership

* denotes statutory members of the Health and Wellbeing Board as required by Section 194 of the Health and Social Care Act 20121
There is also a statutory requirement for at least one Local Authority Councillor, and at least one representative of the ICS NHS Board, to be a member of the HWB.

Local Authority Members

- CCC Vice-Chair of Adults & Health Committee (Lead member for HWB)*
- CCC Chair of Adults & Health Committee
- PCC Cabinet / Lead member for Public Health/ HWB*
- PCC/CCC Director of Public Health*
- Executive Director of People & Communities* (representing CCC/PCC DAS)
- PCC/CCC Director Children Services
- PCC Service Director Adults & Communities
- District Council representative (one officer on behalf of all districts to be appointed by the Cambridgeshire Public Service Board)

Other Members

- Local Healthwatch Chair*
- Voluntary & Community Sector Representative (same rep as ICP)
- Cambridgeshire Constabulary (Chief Constable or officer to be determined)
- Cambridgeshire and Peterborough Combined Authority (CEO or officer to be determined)

NHS Members

- CEO ICB*
- Chair ICB
- One other TBC?
- NHS Commissioning Board*

Summary of Functions

Delegated Authority	Delegated Condition
Authority to prepare the Joint Strategic Needs Assessment (JSNA) for Cambridgeshire and Peterborough: To develop a shared understanding of the needs of the community through developing and keeping under review the JSNA and to use this intelligence to refresh the Health & Wellbeing Strategy.	Section 116, Local Government and Public Involvement in Health Act 2007 Section 196, Health and Social Care Act 2012
Authority to prepare the Joint Health and Wellbeing Strategy for Cambridgeshire and Peterborough based on the need identified in the Joint Strategic Needs Assessment and overseeing the implementation of the Strategy, which informs and influences the commissioning plans of partner agencies.	Section 116A, Local Government and Public Involvement in Health Act 2007. Section 196, Health and Social Care Act 2012
Authority to respond to consultations about commissioning plans issued by clinical commissioning groups in connection with Section 26 of the Health and Social Care Act 2012.	Section 26, Health and Social Care Act 2012
Authority to encourage persons who arrange for the provision of any health or social care services in the Council's area to work in an integrated manner.	Section 195, Health and Social Care Act 2012

Delegated Authority	Delegated Condition
Authority to provide any advice, assistance and support it thinks appropriate for the purpose of encouraging the making of arrangements under Section 75 of the National Health Service Act 2006.	Section 195, Health and Social Care Act 2012 Section 75, NHS Act 2006
Authority to produce the Pharmaceutical Needs Assessment (PNA) and liaise with NHS England and Improvement (NHSE&I) to ensure recommendations and gaps in services are addressed.	NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (SI 2013/349)
To consider options and opportunities for the joint commissioning of health and social care services for children, families and adults in Cambridgeshire to meet identified needs (based on the findings of the Joint Strategic Needs Assessment) and to consider any relevant plans and strategies regarding joint commissioning of health and social care services for children and adults.	
To identify areas where joined up or integrated commissioning, including the establishment of pooled budget arrangements, would benefit improving health and wellbeing and reducing health inequalities.	
By establishing subgroups as appropriate give consideration to areas of joint health and social care commissioning, including but not restricted to services for people with learning disabilities.	
To keep under consideration, the financial and organisational implications and impact on people's experience of joint and integrated working across health and social care services, and to make recommendations for ensuring that performance and quality standards for health and social care services to children, families and adults are met and represent value for money across the whole system.	
Authority to prepare and provide Health and Wellbeing Board sign off for the Better Care Fund Plan.	
Authority to approve non-statutory joint strategies on health and wellbeing issues (e.g. Cambridgeshire and Peterborough suicide prevention strategy).	

Delegated Authority	Delegated Condition
Authority to discharge any other functions specifically reserved to be undertaken by the Health and Wellbeing Boards as set out in legislation, guidance, circulars and directives received from national Government.	
Authority to consider whether ICS Board draft forward plans take proper account of the joint local health and wellbeing strategy which relates to the period (or any part of the period) to which the plan relates.	Section 14Z54 White paper
Authority to respond to NHS England on any steps that the ICS Board has taken to implement any joint local health and wellbeing strategy to which the board was required to have regard to.	Section 116B(1) of that Act of 2007
To provide oversight to the work undertaken by the member partners to take forward the Cambridgeshire and Peterborough ICS to deliver the “triple aim” duty for all NHS organisations of better health for the whole population, better quality of care for all patients and financially sustainable services for the taxpayer.	
To provide a system wide governance forum, including NHS, Local Government and wider partners, to enable collective focus and direction to the responsibilities and decision making of the individual partners.	

Cambridgeshire & Peterborough Health and Wellbeing Board (Standing Orders)

1. Co-optees

The Board will be entitled to appoint non-voting and voting co-opted members of the Board. It shall determine whether the co-options shall be for a specified period, for specific meetings or for specific items. Co-options may only be made if the person co-opted has particular knowledge or elected expertise in the functions for which the Board is responsible, or knowledge/responsibility for a geographic or academic agenda issue.

2. Notice of Meetings

Meetings of the Board will be convened by the Integrated Care Board on behalf of Cambridgeshire County Council and Peterborough City Council. The County Council and the City Council will arrange the clerking of the HWB part of the agenda and recording of the whole meeting (a member of Cambridgeshire County Council's or Peterborough City Council's Democratic Services Team will act as clerk or business support lead).

3. Chair

The appointment of the Chair will be determined by the Board at its first meeting of each municipal year, or at any subsequent meeting should the need arise.

4. Quorum

The quorum for all meetings of the Board will be nine members and must include at least one elected representative from Cambridgeshire County Council and Peterborough City Council and a representative of the ICB.

5. Appointment of Substitute Members

Nominating groups may appoint a substitute member for each position. These members will receive electronic versions of agendas and minutes for all meetings. Notification of a named substitute member must be made in writing or by email to the clerk. Substitute members may attend meetings after notifying the clerk of the intended substitution before the start of the meeting either verbally or in writing Substitute members will have full voting rights when taking the place of the ordinary member for whom they are designated substitute.

6. Decision Making

It is expected that decisions will be reached by consensus, however, if a vote is required it will be determined by a simple majority of those members present and voting. If there are equal numbers of votes for and against, the Chair will have a second or casting vote. There will be no restriction on how the Chair chooses to exercise a casting vote.

7. Meeting Frequency

The Board will meet at least four times a year. In addition, extraordinary meetings may be called from time to time as and when appropriate. A Board meeting may be called by the Chair, by any three members of the Board or by the Director of Public Health if they consider it necessary or appropriate.

8. Supply of information

The Health and Wellbeing Board may, for the purpose of enabling or assisting it to perform its functions, request any of the following persons to supply it with such information as may be specified in the request—

(a) the local authority that established the Health and Wellbeing Board;
(b) any person who is represented on the Health and Wellbeing Board by virtue of section 194(2)(e) to (g) or (8) of the Health and Social Care Act 2012 ("the 2012 Act");
(c) any person who is a member of a Health and Wellbeing Board by virtue of section 194(2)(g) or (8) but is not acting as a representative.

A person who is requested to supply information under (a), (b) and (c) must comply with the request. Information supplied to a Health and Wellbeing Board under this section may be used by the Board only for the purpose of enabling or assisting it to perform its functions.

9. Status of Reports

Meetings of the Board shall be open to the press and public and the agenda, reports and minutes will be available for inspection on the Cambridgeshire County Council and Peterborough City Council's website at least five working days in advance of each meeting. [This excludes items of business containing confidential information or information that is exempt from publication in accordance with Part 5A and Schedule 12A to the Local Government Act 1972 as amended.] Other participating organisations may make links from their website to the Board's papers on Cambridgeshire County Council or Peterborough City Council's website.

10. Press Strategy

An electronic link to agendas for all meetings will be sent to the local media. Cambridgeshire County Council and/or Peterborough City Council will be responsible for issuing press releases on behalf of the Board and dealing with any press enquiries. Press releases issued on behalf of the Board will be agreed with the Chair or Vice-Chair and circulated to all Board members.

11. Members' Conduct

Part 5 - Codes and Protocols of the Cambridgeshire County Council's Constitution applies to all elected and 'co-opted' members of the Board.

12. Amendment of the Terms of Reference

The Board may recommend variations to its Terms of Reference by a simple majority vote by the members provided that prior notice of the nature of the proposed variation is made and included on the agenda for the meeting.

13. Governance and Accountability

The Board will be accountable for its actions to its individual member organisations. There will be sovereignty around decision making processes. Representatives will be accountable through their own organisations for the decisions they take. It is expected that Members of the Board will have delegated authority from their organisations to take decisions within the terms of reference. Decisions within the terms of reference will be taken at meetings and will not normally be subject to ratification or a formal decision process by partner organisations. However, where decisions are not within the delegated authority of the Board members, these will be subject to ratification by constituent bodies. It is expected that decisions will be reached by consensus. Board members bring the responsibility, accountability and duties of their individual roles to the Board to provide information, data and consultation material appropriate to inform the discussions and decisions.

14. Reporting

The Board will take an annual report to Full Council in Cambridgeshire County Council and Peterborough City Council and will provide NHS England and Improvement (NHSEI) via the regional Team reports as required.

CAMBRIDGESHIRE & PETERBOROUGH HEALTH & WELLBEING BOARD WHOLE SYSTEM JOINT SUB-COMMITTEE	AGENDA ITEM No. 11
DATE: 25th March 2022	PUBLIC REPORT

BETTER CARE FUND PLAN 2021-22

R E C O M M E N D A T I O N S	
To:	*Cambridgeshire and Peterborough Health and Wellbeing Board Whole System Joint Sub-Committee*
From:	*Will Patten, Head of Commissioning*

The Cambridgeshire and Peterborough Health and Wellbeing Board Whole System Joint Sub-Committee is recommended to:

1. **read this report on the Better Care Fund (BCF) Plan Submission for 2021-22 and attached document and spreadsheets.**

2. **retrospectively approve the plan in order to comply with NHS England conditions.**

	Officer contact:		***Member contact:***
Name:	Will Patten	Name:	Cllr Susan Van de Ven and Cllr Irene Walsh
Post:	Director of Commissioning	Role	Chair of the Cambridgeshire Health and Wellbeing Board & Chair of the Peterborough Health and Wellbeing Board
Email:	Will.patten@cambridgeshire.gov.uk	Email:	irene.walsh@peterborough.gov.uk susanvandeven5@gmail.com
Tel:	07448 379944	Tel:	-

1.	**BACKGROUND**
1.1	Under the terms of the Better Care Fund, jointly invested by the NHS (CCG) and Local Authorities, the health and wellbeing boards have a statutory duty to submit agreed plans for Cambridgeshire and Peterborough.
1.2	Due to the tight timelines for submission of local plans and the suspension of Health and Wellbeing Board meetings, the Chairs approved jointly agreed plans on behalf of both Health and Wellbeing Boards prior to submission to NHS England on the 16th November 2021.
1.3	To ensure formal compliance with national conditions, it is requested that the Board retrospectively approves these plans.
2.	**PURPOSE**
2.1	NHS England BCF Planning Guidance for 2021-22 was released on the 30th September 2021.
2.2	The guidelines clarified that this was to be a one-year planning cycle. The focus is on continuity of local plans, building on learning and good practice throughout the pandemic.
2.3	There has been a slight upturn in the level of investment, all of which aims to join-up health and care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible. The CCG minimum uplift equated to an additional 5.5% (£2.237m) for Cambridgeshire and 5.7% (£739k) for Peterborough.
2.4	The full allocations are outlined in the below table:

	Peterborough			Cambridgeshire		
	2019/20	**2020/21**	**2021/22**	**2019/20**	**2020/21**	**2021/22**
CCG Minimum Contribution	£12,270,498	£12,991,510	£13,730,182	£38,651,879	£40,770,371	£43,006,921
Disabled Facilities Grant	£1,970,984	£1,970,984	£2,236,384	£4,467,928	£4,467,929	£5,069,551
Improved Better Care Fund	£6,466,276	£7,259,937	£7,259,937	£12,401,221	£14,725,277	£14,725,277
Winter Pressures Grant	£793,661	-	-	£2,324,056	-	-
Total BCF Allocation	**£21,501,419**	**£22,222,431**	**£23,226,503**	**£57,845,084**	**£59,963,577**	**£62,801,749**

2.5	In 2021-22, the BCF Plan will include the following funding elements: • Minimum NHS (Clinical Commissioning Groups) contribution • Disabled Facilities Grant (capital funding for adaptations to houses) • Grant allocation for adult social care (improved Better Care Fund). • Winter Pressures grant funding
2.6	Our local BCF Plans continue to build on 2020-21 plans and the work undertaken to date. However, plans have been refreshed to ensure alignment with wider system plans, including local NHS recovery plans, Health and Wellbeing priorities and Integrated Care System (ICS) plans, which represents a real shift to collaborative, integrated, place-based delivery.
2.7	It should be noted that there have been few changes to the proposed investment since the 2020-21 plan, but rather a refreshment of finances. Additional voluntary CCG base funding was added to the pooled budget this year. This funding is being used for the

	health contribution to the Integrated Community Equipment budget. A full breakdown of the income and expenditure proposals can be found in the appendiced Better Care Fund Plan Submissions.
2.8	Our local plans take the approach of consistency, whilst building on learning and successes during the last year. Due to the onset of the pandemic in early 2020, we agreed locally to maintain provision of service capacity currently funded by the BCF pooled budget, so we continued provision in these areas. Wider integration plans were impacted by COVID, which meant that the system had to focus priorities on the local emergency response, meaning some work such as integrated neighbourhoods under the alliances was delayed. However, the pandemic strengthened community provision in other ways, e.g., our community hubs and joint working, which provides us with a strong base to progress our integration journey towards an Integrated Care System further.
2.9	Our local BCF plans recognise that we are still in a significant period of change, emerging from the pandemic, alongside moving to a local Integrated Care System, and therefore reflect the need to flex and adapt to the changing landscape to ensure alignment across wider local system plans.
2.10	Our approach in 2021-22 continues to build on the vision contained in the previous year's BCF plans: *"In Cambridgeshire and Peterborough we want to move to a system in which health and social care help people to help themselves, and the majority of people's needs are met through family and community support where appropriate. This support will focus on returning people to independence as far as possible with more intensive and longer-term support available to those that need it."*
2.11	This vision translates into a number of key joint priorities throughout 2021-22: • Integrated, person centred, place-based delivery, with prevention and early intervention at its core • Addressing health inequalities through a population health management approach • Supporting Hospital Discharge flow • Implementation of a local shared care record • Working collaboratively as a system to deliver these priorities.
2.12	There have been some changes to the national metrics for BCF. Two existing metrics will continue: • Effectiveness of reablement (proportion of older people still at home 91 days after discharge from hospital into reablement or rehabilitation) • Older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population
2.13	The previous non-elective admissions metric will be replaced by: • Avoidable admissions – unplanned hospitalisation for chronic ambulatory care sensitive conditions.
2.14	Discharge metrics, which will replace the previously reported DTOC metric, will now be:

	• Reducing length of stay in hospital, measured through the percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days • Improving the proportion of people discharged home using data on discharge to their usual place of residence
2.15	Local plans were submitted to NHS England on the 16th November 2021 and formal approval was received for both Cambridgeshire and Peterborough plans in January 2022.
2.16	Amendments to the local Section 75 agreements between the local authorities and CCG are now being finalised by legal teams.
2.17	Retrospective approval is sought for the proposed investments in the areas outlined in both the attached spreadsheets detailing plans for Cambridgeshire and Peterborough (provided separately) as well as the Strategic Narrative which is common to both Local Authority Areas (attached).
2.18	Quarterly national reporting has been suspended for 2021-22 due to the delays in submission deadlines. A year end report will be required at the end of the financial year.
2.19	No information on the 22/23 planning guidance yet. Early indications are that it will be a 1-year approach with minimum change. Potentially moving to a longer planning cycle afterwards which will incorporate more ambitions and outcomes and alignment with the white paper and reforms.
3.	**CONSULTATION**
3.1	The following key stakeholders have been involved in the development of our local Better Care Fund (BCF) plans: • Peterborough City Council • Cambridgeshire County Council • Cambridgeshire and Peterborough Clinical Commissioning Board (CCG) • Public Health • Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) • North West Anglia Foundation Trust (NWAFT) • Cambridgeshire University Hospital NHS Foundation Trust (CUHFT) • Voluntary Sector • District Councils • Healthwatch In the developing and drafting of the BCF plan there were discussions with partners, including discussion at the system wide Chief Operating Officers (COO) meeting, the Joint Cambridgeshire and Peterborough Integrated Commissioning Board, which has system wide health and care representation and has overseen the development and monitoring of local BCF plans in line with national requirements. To ensure that local BCF plans align with wider strategic priorities around transition to being an Integrated Care System (ICS), engagement has happened with representatives from the North and South Integrated Care Partnerships (ICPs) and Health and Wellbeing Board chairs.

4.	**ANTICIPATED OUTCOMES OR IMPACT**
4.1	The approval of plans enables us to comply with the national conditions associated with the release of BCF monies.
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	There are no direct legal implications as a result of this report.
	Equalities Implications
5.3	There are no direct equality implications as a result of this report.
6.	**APPENDICES**
6.1	Appendix 1 – Cambridgeshire Better Care Fund Planning Template Appendix 2 – Peterborough Better Care Fund Planning Template Appendix 3 – Joint Better Care Fund Strategic Narrative
7. 7.1	**SOURCE DOCUMENTS** Better Care Fund Planning Guidance 2021-22 Better Care Fund planning requirements 2021-22

Better Care Fund 2021-22 Template

2. Cover

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Please Note:
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- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2021-22.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Cambridgeshire
Completed by:	Caroline Townsend
E-mail:	caroline.townsend@peterborough.gov.uk
Contact number:	7976832188

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Chair of Health and Wellbeing Board
Name:	Cllr Susan Van de Ven

Has this plan been signed off by the HWB at the time of submission?	Delegated authority pending full HWB meeting	
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:	Mon 31/01/2022	<< Please enter using the format, DD/MM/YYYY Please note that plans cannot be formally approved and Section 75 agreements cannot be finalised until a plan, signed off by the HWB has been submitted.

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Susan	Van de Ven	susanvandeven5@gmail.com
	Clinical Commissioning Group Accountable Officer (Lead)		Jan	Thomas	jan.thomas@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers		Jan	Thomas	jan.thomas@nhs.net
	Local Authority Chief Executive		Gillian	Beasley	Gillian.Beasley@peterborough.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Charlotte	Black	Charlotte.Black@cambridgeshire..gov.uk
	Better Care Fund Lead Official		Will	Patten	Will.Patten@cambridgeshire.gov.uk
	LA Section 151 Officer		Tom	Kelly	Tom.Kelly@cambridgeshire.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence -->					

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Template Completed

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	Yes
7. Planning Requirements	Yes

<< Link to the Guidance sheet

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Better Care Fund 2021-22 Template

3. Summary

Selected Health and Wellbeing Board: Cambridgeshire

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£5,069,551	£5,069,551	£0
Minimum CCG Contribution	£43,006,921	£43,006,921	£0
iBCF	£14,725,277	£14,725,277	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£4,529,060	£4,529,060	£0
Total	**£67,330,809**	**£67,330,809**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£12,316,114
Planned spend	£24,485,067

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£17,927,441
Planned spend	£17,927,441

Scheme Types

Assistive Technologies and Equipment	£2,560,293	(3.8%)
Care Act Implementation Related Duties	£0	(0.0%)
Carers Services	£1,834,307	(2.7%)
Community Based Schemes	£24,480,243	(36.4%)
DFG Related Schemes	£5,069,551	(7.5%)
Enablers for Integration	£380,513	(0.6%)
High Impact Change Model for Managing Transfer of	£3,081,520	(4.6%)
Home Care or Domiciliary Care	£2,020,253	(3.0%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£31,160	(0.0%)
Bed based intermediate Care Services	£3,898,583	(5.8%)
Reablement in a persons own home	£8,900,000	(13.2%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£0	(0.0%)
Prevention / Early Intervention	£3,475,000	(5.2%)
Residential Placements	£11,261,386	(16.7%)
Other	£338,000	(0.5%)
Total	**£67,330,809**	

Metrics >>

Avoidable admissions

	20-21 Actual	21-22 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	685.8	830.6

Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients	LOS 14+	12.8%	14.0%
	LOS 21+	6.8%	7.4%

Discharge to normal place of residence

	0	21-22 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	0.0%	95.0%

Residential Admissions

		20-21 Actual	21-22 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	419	438

Reablement

		21-22 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	70.1%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	PR1	Yes
	PR2	Yes

	PR3	Yes
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	Yes
NC4: Plan for improving outcomes for people being discharged from hospital	PR6	Yes
Agreed expenditure plan for all elements of the BCF	PR7	Yes
Metrics	PR8	Yes

Better Care Fund 2021-22 Template

4. Income

Selected Health and Wellbeing Board: Cambridgeshire

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Cambridgeshire	£5,069,551
DFG breakerdown for two-tier areas only (where applicable)	
Cambridge	£847,451
East Cambridgeshire	£690,078
Fenland	£1,214,776
Huntingdonshire	£1,492,102
South Cambridgeshire	£825,144
Total Minimum LA Contribution (exc iBCF)	**£5,069,551**

iBCF Contribution	Contribution
Cambridgeshire	£14,725,277
Total iBCF Contribution	**£14,725,277**

Are any additional LA Contributions being made in 2021-22? If yes, please detail below	No

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	

CCG Minimum Contribution	Contribution
NHS Cambridgeshire and Peterborough CCG	£43,006,921
Total Minimum CCG Contribution	**£43,006,921**

Are any additional CCG Contributions being made in 2021-22? If yes, please detail below	Yes

Additional CCG Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
NHS Cambridgeshire and Peterborough CCG	£4,529,060	CCG Baseline allocation
Total Additional CCG Contribution	**£4,529,060**	
Total CCG Contribution	**£47,535,981**	

	2021-22
Total BCF Pooled Budget	**£67,330,809**

Funding Contributions Comments Optional for any useful detail e.g. Carry over
N/A

Better Care Fund 2021-22 Template

5. Expenditure

Selected Health and Wellbeing Board: Cambridgeshire

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£5,069,551	£5,069,551	£0
Minimum CCG Contribution	£43,006,921	£43,006,921	£0
iBCF	£14,725,277	£14,725,277	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£4,529,060	£4,529,060	£0
Total	**£67,330,809**	**£67,330,809**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£12,316,114	£24,485,067	£0
Adult Social Care services spend from the minimum CCG allocations	£17,927,441	£17,927,441	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Promoting Independence	Prevention and early intervention services, e.g. Technology enabled care, community equipment and VCS provision	Prevention / Early Intervention	Social Prescribing		Social Care		LA			Local Authority	Minimum CCG Contribution	£1,525,000	Existing
2	Intermediate Care and Reablement	Reablement	Reablement in a persons own home	Reablement to support discharge - step down		Social Care		LA			Local Authority	Minimum CCG Contribution	£8,600,000	Existing
3	Carers Support	Carers Services	Carers Services	Respite services		Social Care		LA			Local Authority	Minimum CCG Contribution	£1,500,000	Existing
4	VCS Joint Commissioning	Voluntary Sector support	Prevention / Early Intervention	Social Prescribing		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£1,950,000	Existing
5	Discharge Planning and DTOC	Discharge Planning Teams	High Impact Change Model for Managing	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	Minimum CCG Contribution	£944,000	Existing

6	Protection of Adult Social Care	delivery of statutory duties of social care, including assessment/review teams	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as		Social Care		LA			Local Authority	Minimum CCG Contribution	£3,070,441	Existing
7	Social Care Commissioning and Protection	Commissioning	Other		Commissioning capacity	Social Care		LA			Local Authority	Minimum CCG Contribution	£338,000	Existing
8	Disabled Facilities Grant	Housing adaptations	DFG Related Schemes	Adaptations, including statutory DFG		Social Care		LA			Local Authority	DFG	£5,069,551	Existing
9	Social Care Investment and Capacity	Capacity to support delivery of statutory duties	Community Based Schemes	Multidisciplinary teams that are supporting		Social Care		LA			Local Authority	iBCF	£1,298,221	Existing
10	Costed Plan to support Discharge	Capacity to support discharge flow	High Impact Change Model for Managing	Home First/Discharge to Assess - process		Social Care		LA			Local Authority	iBCF	£1,987,520	Existing
11	Protection of Adult Social Care	Care Placement Spend	Residential Placements	Care home		Social Care		LA			Local Authority	iBCF	£9,127,000	Existing
12	Reablement	Additional reablement capacity to support discharge	Reablement in a persons own home	Reablement to support discharge - step down		Social Care		LA			Local Authority	iBCF	£300,000	Existing
13	Domiciliary Care	Discharge car capacity	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge		Social Care		LA			Private Sector	iBCF	£2,012,536	Existing
14	Promoting Independence	Assistive Technologies	Assistive Technologies and Equipment	Telecare		Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£189,967	Existing
15	Intermediate Care and Reablement	Intermediate Care Beds	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£3,898,583	Existing
16	Integrated Neighbourhood Teams	Integrated Neighbourhood Teams	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£14,993,285	Existing
17	Carers Support	Carers Prescription service and Help at Home / Home Support	Carers Services	Other	Carers Prescription service and help	Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£334,307	Existing
18	Community Health	Intermediate Care Workers support people at home/2 hour crisis	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£2,372,507	Existing
19	Discharge to Assess	Community beds to support D2A	Residential Placements	Discharge from hospital (with reablement) to		Community Health		CCG			Private Sector	Minimum CCG Contribution	£2,134,386	Existing
20	Community Equipment	Integrated Community Equipment Store	Assistive Technologies and Equipment	Community based equipment		Community Health		Joint	48.6%	51.4%	Private Sector	Minimum CCG Contribution	£1,156,445	Existing
20	Community Equipment	Integrated Community Equipment Store	Assistive Technologies and Equipment	Community based equipment		Community Health		Joint	48.6%	51.4%	Private Sector	Additional CCG Contribution	£1,213,881	New
21	Healthcare at Home	Community IV antibiotic service to facilitate early discharge	Community Based Schemes	Low level support for simple hospital discharges		Community Health		CCG			Private Sector	Additional CCG Contribution	£783,833	New
22	Hospice at Home	Hospice at home service to support home first model and early	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			Charity / Voluntary Sector	Additional CCG Contribution	£1,961,956	New
23	Hunts Forum	Engagement in development of ICS	Enablers for Integration	Voluntary Sector Business Development		Community Health		CCG			Charity / Voluntary Sector	Additional CCG Contribution	£17,769	New

24	Palliative Care Hub	specific option for 111 greeting to direct patients/carers	Enablers for Integration	Integrated models of provision		Community Health		CCG			NHS Community Provider	Additional CCG Contribution	£362,744	New
25	Information and Advice	Signposting, information and advice for older people	Integrated Care Planning and Navigation	Care navigation and planning		Community Health		CCG			Charity / Voluntary Sector	Additional CCG Contribution	£31,160	New
26	Support on Discharge	Volunteer visits to support patients/carers on discharge	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge		Community Health		CCG			Charity / Voluntary Sector	Additional CCG Contribution	£7,717	New
27	Discharge Support	Discharge support and planning within acutes	High Impact Change Model for Managing	Early Discharge Planning		Acute		CCG			Charity / Voluntary Sector	Additional CCG Contribution	£150,000	New

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Health and Wellbeing Board:	Peterborough
Completed by:	Caroline Townsend
E-mail:	caroline.townsend@peterborough.gov.uk
Contact number:	7976832188

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Chair of Health and Wellbeing Board
Name:	Cllr Irene Walsh

Has this plan been signed off by the HWB at the time of submission?	Delegated authority pending full HWB meeting	
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:	Mon 31/01/2022	<< Please enter using the format, DD/MM/YYYY Please note that plans cannot be formally approved and Section 75 agreements cannot be finalised until a plan, signed off by the HWB has been submitted.

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Irene	Walsh	Irene.Walsh@Peterborough.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)		Jan	Thomas	jan.thomas@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers		Feb	Thomas	jan.thomas@nhs.net
	Local Authority Chief Executive		Gillian	Beasley	Gillian.Beasley@peterborough.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Charlotte	Black	charlotte.black@cambridgeshire.gov.uk
	Better Care Fund Lead Official		Will	Patten	Will.Patten@cambridgeshire.gov.uk
	LA Section 151 Officer		Peter	Carpenter	Peter.Carpenter@peterborough.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence -->					

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Template Completed

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	Yes
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2021-22 Template

3. Summary

Selected Health and Wellbeing Board: Peterborough

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£2,236,384	£2,236,384	£0
Minimum CCG Contribution	£13,730,182	£13,730,182	£0
iBCF	£7,259,937	£7,259,937	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£621,557	£621,557	£0
Total	**£23,848,060**	**£23,848,060**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£3,800,595
Planned spend	£5,575,298

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£8,070,650
Planned spend	£8,070,650

Scheme Types

Assistive Technologies and Equipment	£927,365	(3.9%)
Care Act Implementation Related Duties	£407,000	(1.7%)
Carers Services	£186,436	(0.8%)
Community Based Schemes	£9,365,214	(39.3%)
DFG Related Schemes	£2,236,384	(9.4%)
Enablers for Integration	£0	(0.0%)
High Impact Change Model for Managing Transfer of	£745,000	(3.1%)
Home Care or Domiciliary Care	£3,522,000	(14.8%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£0	(0.0%)
Bed based intermediate Care Services	£0	(0.0%)
Reablement in a persons own home	£250,000	(1.0%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£0	(0.0%)
Prevention / Early Intervention	£70,000	(0.3%)
Residential Placements	£6,138,661	(25.7%)
Other	£0	(0.0%)
Total	**£23,848,060**	

Metrics >>

Avoidable admissions

	20-21 Actual	21-22 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	630.3	784.6

Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients	LOS 14+	12.0%	12.3%
	LOS 21+	6.2%	6.6%

Discharge to normal place of residence

	0	21-22 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	0.0%	95.0%

Residential Admissions

		20-21 Actual	21-22 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	420	428

Reablement

		21-22 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	71.7%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	PR1	Yes
	PR2	Yes

	PR3	Yes
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	Yes
NC4: Plan for improving outcomes for people being discharged from hospital	PR6	Yes
Agreed expenditure plan for all elements of the BCF	PR7	Yes
Metrics	PR8	Yes

Better Care Fund 2021-22 Template

4. Income

Selected Health and Wellbeing Board: Peterborough

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Peterborough	£2,236,384
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£2,236,384**

iBCF Contribution	Contribution
Peterborough	£7,259,937
Total iBCF Contribution	**£7,259,937**

Are any additional LA Contributions being made in 2021-22? If yes, please detail below	No

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	

CCG Minimum Contribution	Contribution
NHS Cambridgeshire and Peterborough CCG	£13,730,182
Total Minimum CCG Contribution	**£13,730,182**

Are any additional CCG Contributions being made in 2021-22? If yes, please detail below	Yes

Additional CCG Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
NHS Cambridgeshire and Peterborough CCG	£621,557	CCG Baseline Allocation
Total Additional CCG Contribution	**£621,557**	
Total CCG Contribution	**£14,351,739**	

	2021-22
Total BCF Pooled Budget	**£23,848,060**

Funding Contributions Comments Optional for any useful detail e.g. Carry over
N/A

Better Care Fund 2021-22 Template

5. Expenditure

Selected Health and Wellbeing Board: Peterborough

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£2,236,384	£2,236,384	£0
Minimum CCG Contribution	£13,730,182	£13,730,182	£0
iBCF	£7,259,937	£7,259,937	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£621,557	£621,557	£0
Total	**£23,848,060**	**£23,848,060**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£3,800,595	£5,575,298	£0
Adult Social Care services spend from the minimum CCG allocations	£8,070,650	£8,070,650	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Care Act Implementation / Enhanced Offer	Ensuring compliance with statutory duties under the Care Act	Care Act Implementation Related Duties	Carer advice and support		Social Care		LA			Local Authority	Minimum CCG Contribution	£407,000	Existing
2	Section 256 agreement (Independent Sector Placements)	Care placement spend	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Local Authority	Minimum CCG Contribution	£3,522,000	Existing
3	Protecting Adult Social Care Services	Provision of social care statutory duties, including reablement and transfers of care	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care		Social Care		LA			Local Authority	Minimum CCG Contribution	£3,166,650	Existing
4	7 Day Services / Supporting Discharge	Reablement	Reablement in a persons own home	Reablement to support discharge - step down		Social Care		LA			Local Authority	Minimum CCG Contribution	£250,000	Existing
5	Person Centred Services	Technology Enabled Care	Assistive Technologies and Equipment	Telecare		Social Care		LA			Local Authority	Minimum CCG Contribution	£100,000	Existing

6	Ageing Healthily and Prevention	Quality Improvement and Assurance	Community Based Schemes	Other	Quality Improvement and Assurance teams	Social Care		LA			Local Authority	Minimum CCG Contribution	£550,000	Existing
7	Carers Support	Support and Respite	Carers Services	Respite services		Social Care		LA			Local Authority	Minimum CCG Contribution	£75,000	Existing
8	Disabled Facilities Grant	Housing Adaptations	DFG Related Schemes	Adaptations, including statutory DFG		Social Care		LA			Local Authority	DFG	£2,236,384	Existing
9	Social Care Capacity and Investment	Capacity to support delivery of statutory duties	Community Based Schemes	Multidisciplinary teams that are supporting		Social Care		LA			Local Authority	iBCF	£306,276	Existing
10	Falls Prevention	Falls prevention programme	Prevention / Early Intervention	Other	Falls Prevention	Social Care		LA			NHS Community Provider	iBCF	£70,000	Existing
11	Costed Plan to support Hospital Discharge	Capacity to support discharge flow	High Impact Change Model for Managing	Home First/Discharge to Assess - process		Social Care		LA			Local Authority	iBCF	£745,000	Existing
12	Protection of Adult Social Care	Care placement spend	Residential Placements	Care home		Social Care		LA			Local Authority	iBCF	£5,345,000	Existing
13	Nursing Home Capacity	providing sufficient nursing capacity	Residential Placements	Nursing home		Social Care		LA			Local Authority	iBCF	£793,661	Existing
14	Integrated Neighbourhood Teams	Integrated Neighbourhood Teams	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£5,342,288	Existing
15	Carers Support	Carers Prescription Service and help at home/home support	Carers Services	Other	Carers Prescription and help at home/	Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£76,575	Existing
15	Carers Support	Carers Prescription Service and help at home/home support	Carers Services	Other	Carers Prescription and help at home/	Community Health		CCG			Charity / Voluntary Sector	Additional CCG Contribution	£34,861	Existing
16	Community Equipment	Integrated Community Equipment Store	Assistive Technologies and Equipment	Community based equipment		Community Health		Joint	65.0%	35.0%	Private Sector	Minimum CCG Contribution	£240,669	Existing
17	Community Equipment	Integrated Community Equipment Store	Assistive Technologies and Equipment	Community based equipment		Community Health		Joint	65.0%	35.0%	Private Sector	Additional CCG Contribution	£586,696	Existing

Appendix 3a

Better Care Fund 2021-22

Narrative Plan

Health and Wellbeing Board(s)

Cambridgeshire and Peterborough

Section 1 - Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, district councils)

How have you gone about involving these stakeholders?

The following key stakeholders have been involved in the development of our local Better Care Fund (BCF) plans:

- Peterborough City Council
- Cambridgeshire County Council
- Cambridgeshire and Peterborough Clinical Commissioning Board (CCG)
- Public Health
- Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
- North West Anglia Foundation Trust (NWAFT)
- Cambridgeshire University Hospital NHS Foundation Trust (CUHFT)
- Voluntary Sector
- District Councils
- Healthwatch

In the developing and drafting of the BCF plan there were discussions with partners, including discussion at the system wide Chief Operating Officers (COO) meeting, the Joint Cambridgeshire and Peterborough Integrated Commissioning Board, which has system wide health and care representation and has overseen the development and monitoring of local BCF plans in line with national requirements.

To ensure that local BCF plans align with wider strategic priorities around transition to being an Integrated Care System (ICS), engagement has happened with representatives from the North and South Integrated Care Partnerships (ICPs) and Health and Wellbeing Board chairs.

We are exploring how existing governance arrangements, such as the Health and Wellbeing Board (HWBB), can provide the opportunity to amalgamate and ensure effective and more joined-up decision-making with the ICP's and Integrated Care Board (ICB). An engagement document was released on 15 September to support Local Authorities, ICB and other key stakeholders to consider what arrangements might work best in their area when laying the foundations for establishing Integrated Care Partnerships (ICPs), this includes practical steps for implementation.

To complement this work, we are developing an ICS Partners Memorandum of Understanding (MOU) and are working with the System Governance Group to develop this.

The local BCF Plans have been approved by both the local CCG Governing Body and both Peterborough City Council and Cambridgeshire County Council. The plans have also been

approved by both the Cambridgeshire and Peterborough Health and Wellbeing Boards (HWBBs), via delegated authority to the HWBBs chairs following a meeting with chairs on the 11th November 2021. The plans will be presented at the next organised full HWBB meetings for full retrospective approval, but this will not be prior to submission of the BCF plans to NHSE.

Stretch targets have been agreed as part of this process for all the national metrics. This includes agreement with local partners, including the acute trusts; North West Anglia NHS Foundation Trust (NWAFT) and Cambridgeshire University Hospital NHS Foundation Trust (CUHFT), to ensure there is system ownership of stretch targets. Appendix 1 contains a more detailed overview and rationale associated with these targets).

In addition to the national metrics, we have agreed a number of additional prevention focused metrics, which we will monitor locally. We feel that this is an important indication to our commitment as a system to prevention and early intervention, recognising the need to monitor the effectiveness of preventative strategies on admissions avoidance and outcomes for people. Through effective management of disease, this has a positive impact on people's health and wellbeing, and ultimately delays or avoids unnecessary admissions. Locally, in in support of the system wide focus on our CVD prevention strategy, we will use the NICE Quality and Outcomes Framework Indicators (QOF) to measure this, focusing on key areas that recognise the local targeted approach we are adopting to prevention. Initially this will focus on the QOF metrics associated with Cardiovascular Disease (CVD), with a particular focus on hypertension. In addition we will monitor the admissions for heart attacks and strokes. We will continue to look at other local metrics around wider prevention initiatives as work progresses on local priorities, such as mental health, obesity and smoking,

Section 2- Executive Summary

This should include:

- ***Priorities for 2021-22***
- ***key changes since previous BCF plan***

This document forms part one of Cambridgeshire and Peterborough's BCF Plans for 2021-22, a joint narrative, highlighting the integrated approach to BCF plans across the Cambridgeshire and Peterborough Health and Wellbeing Board areas.

Our local BCF Plan continues to build on 2019-20 plans and the work undertaken to date. However, plans have been refreshed to ensure consistency and alignment with wider system plans, including local NHS recovery plans, Health and Wellbeing priorities and ICS plans, which represents a real shift to collaborative, integrated, place-based delivery.

Our plans take the approach of consistency, whilst building on learning and successes during the last year. Due to the onset of the pandemic in early 2020, we agreed locally to maintain provision of service capacity currently funded by the BCF pooled budget, so we continued provision in these areas. Wider integration plans were impacted by COVID, which meant that the system had to focus priorities on the local emergency response, meaning some work such as integrated neighbourhoods under the alliances was delayed. However, the pandemic strengthened community provision in other ways, e.g., our community hubs and joint working, which provides us with a strong base to progress our integration journey towards an Integrated Care System further.

The following table outlines some key integration successes and challenges we experienced as a system as outlined in our in BCF 2020-21-year end returns, which we aim to learn from:

Successes	**Challenges**
• In response to the Hospital Discharge policy, health and social care implemented jointly commissioned additional services during the pandemic to ensure appropriate capacity was in place to respond to the demands of the pandemic. Strong system leadership developed to jointly implement and redeploy resources to support existing D2A services. The system has worked jointly to support providers throughout the pandemic, ensuring we have consistent messaging and a central coordination point for management of issues. This has included development of a Care Home Cell providing support by Public Health, Infection control and Quality Team providing training and guidance. • A robust governance structure was developed to manage the central finance allocation across the system ensuring appropriate use of funds to support the emergency response. This governance structure included an effective and timely approval process allowing a rapid response to changes in demand and ensuring minimal delays to service delivery.	• The Hospital Discharge Guidance and speed of response to implement during the first wave often meant patient choice was not available. This was also compounded by numerous outbreaks in care homes limiting choice further. The system is undertaking a review of the D2A pathways reflecting on what went well and not so well to inform decision making on future service design. • Covid has caused the private provider market additional financial challenges due to implementing national guidance causing additional cost of PPE, reduced capacity available to adhere to infection prevention control measures and management of outbreaks. Whilst the system has provided a range of support to the market, both financial and practical, the implication of COVID has impacted on capacity, workforce morale and financial resilience.

We have continued to learn and adapt, but we still face a level of uncertainty re the full impact of COVID as we go forward. Whilst there have been many challenges, there have also been successes, with our local authority led Think Communities programme having thrived and developed in this time through the community hub, prevention and early intervention model, giving us an even stronger platform to develop further from, recognising that:

- We need to work together to make it simpler for residents and easier for communities to influence support and create opportunity relevant to their local needs
- Over the last 2 years the Think Communities Partnership approach has been building momentum across local councils, the public sector, health, and the voluntary, community and faith sector
- Through the last few months, the experience of COVID-19 has shown us practically how we can work together more closely to put our residents at the centre of what we do

- Whilst we are facing significant immediate challenge from the impact of COVID19 we believe that we need to continue to ensure we sustain more joined-up system working.

Our local BCF plans recognise that we are still in a significant period of change, emerging from the pandemic, alongside moving to a local Integrated Care System, and therefore reflect the need to flex and adapt to the changing landscape to ensure amalgamation across wider local system plans. This is against a continued backdrop of significant financial challenge for both our local authorities and Clinical Commissioning Group (CCG). The implication of COVID on demand means we are starting to see more demand coming through, with higher levels of need. This is alongside significant impacts on wider social care providers, impacting on capacity and costs of care. Workforce challenges present a very real pressure to us locally, with challenges in recruitment and retention of staff across both health and social care providers as a result of:

- Staff health and wellbeing is challenged due to the extreme pressures the pandemic has presented
- Low rates of pay for social care staff which are not competitive with other sectors, e.g. retail and leisure.
- Impact of sickness, isolation and recruitment challenges.
- Increased agency costs to offset shortages in staff.
- Impact of mandatory vaccinations in care homes, which is also now due to be extended to frontline NHS staff.
- Compound effect of the pandemic and EU Exit, with people returning home due to economic viability, and the impact of immigration regulations on recruitment for a workforce where there is a high dependency on non-British nationals.

Having good quality capacity is predicated on a suitable skilled workforce which can be retained and new skills recruited to meet the ongoing demand. Working with the market to develop a workforce strategy with the care sector at a national, regional and local level, as well as supporting providers to manage associated cost pressures is a key priority in how we continue to support the market to be sustainable and this is being embedded across local plans.

Our local priorities for 2021/22 continue to reflect the key strategic themes we outlined in previous plans, but these have been refreshed to focus on current workstreams and priorities as outlined below:

- Prevention and Early Intervention:
    - Focus on prevention and early intervention to support people to remain independent in their own communities for as long as possible
- Community Services / Place Based Delivery: Progress integrated place-based delivery models (including integrated neighbourhoods) through the ICPs and Think Communities programme. Key areas of focus include:
    - Our work with community catalysts to support the development of local micro-enterprises to deliver new models of local care, delivered by local people within local communities, reducing travel costs and duplication in existing arrangements, enhancing continuity of care and connecting people with their local communities.
    - Community navigators helping people to find and access localised solutions. Supporting older people, people affected by disability and /or their carers to

maintain and improve their health, wellbeing and independence. The Community Navigators support people by:

- Informing people about, and referring them to, relevant activities and services
- Helping people to use information to answer questions and enable them to do things for themselves
- Helping people overcome barriers to make use of relevant activities and services
- Supporting people to access activities that enable them to remain independent, safe and well.
- Identifying where more activities and services are needed and working with local people to develop these
- Targeting people at risk of poor health and wellbeing
- Reaching out to communities to engage with people

- Hospital Discharge Flow:
    - Refinement and improvement of Discharge to Assess and 'Home First' model, embedding the outcomes from NESTA and ECIST improvement work
- System Enablers:
    - Population health management approach to address health inequalities. Cambridgeshire County Council has committed to embedding a 'health in all' policy approach across all aspects of local authority delivery
    - System approach underpinned by strong joint commissioning principles
    - Shared Care Record Implemented across health and social care
    - Establishment of ICS system governance, ensuring amalgamation of Health and Wellbeing Board priorities

Section 3 - Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

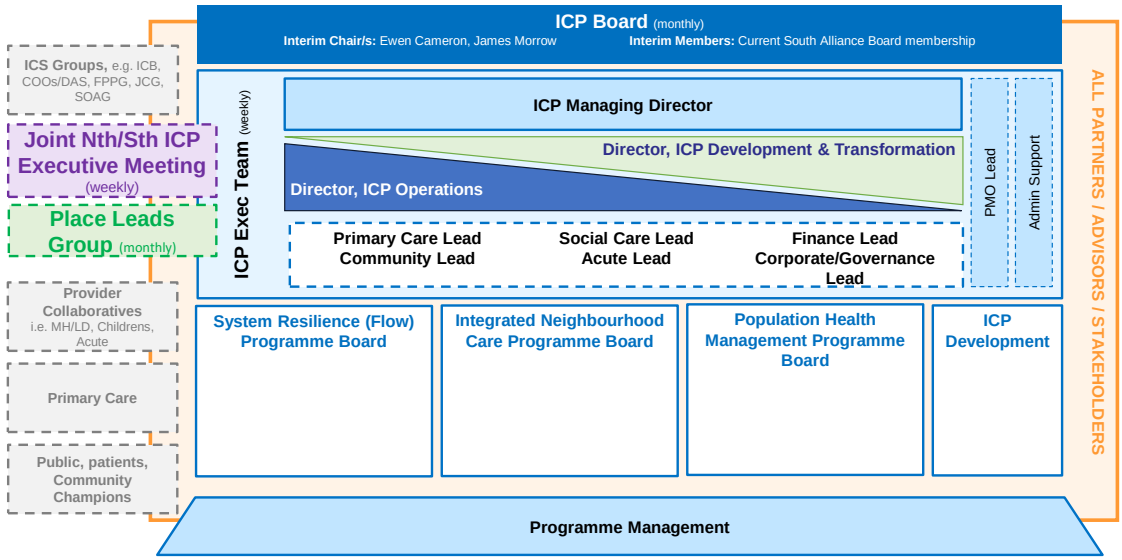
The existing governance oversight for the BCF sits with the Health and Wellbeing Boards (HWBBs) for Cambridgeshire and Peterborough, who have delegated responsibility down to the joint Integrated Commissioning Board.

It is important that we ensure amalgamation with the ICS governance, whilst recognising the need to ensure the protection of social care, drive local delivery and ensure oversight of progress.

We are working through the detail of the guidance related to ICS functions and governance and have scoped out via a governance diagnostic what we need to develop by when, to ensure that we meet the milestones set out in the latest ICS Establishment Timeline and are able to operate as an ICS from 1 April 2022. This will include developing the interface between Integrated Care Partnerships (ICPs) and Collaboratives.

We are exploring how existing governance arrangements, such as the Health and Wellbeing Board (HWBB), can provide the opportunity to build greater amalgamation and ensure effective and more joined-up decision-making with the ICP and Integrated Care Board (ICB). System wide workshops are being held throughout October and November to inform this arrangement. The below diagram outlines the interim ICP structure at this stage for further information.

Phase 1: Interim ICP Structure



Oversight of performance of BCF metrics
The oversight of performance against local targets sits with the North and South System Resilience Groups. These meetings have senior system wide leadership representation. The SRGs have routine oversight of system wide data on performance, alongside responsibility for programme oversight of wider flow and acute UEC transformation and improvement work. Discharge flow in relation to Queen Elizabeth Hospital NHS Foundation Trust (QEH) in relation to Cambridgeshire and Peterborough patients sits within the remit of the North ICP, which is establishing links with the QEH SRG.

Section 4 - Overall approach to integration

Brief outline of approach to embedding integrated, person centred health, social care and housing services including

- ***Joint priorities for 2021-22***
- ***Approaches to joint/collaborative commissioning***
- ***Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.***
- ***How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2020-21.***

Our approach in 2021-22 continues to build on the vision contained in the previous year's BCF plans:

"In Cambridgeshire and Peterborough we want to move to a system in which health and social care help people to help themselves, and the majority of people's needs are met through family and community support where appropriate. This support will

focus on returning people to independence as far as possible with more intensive and longer-term support available to those that need it."

This vision translates into a number of key joint priorities throughout 2021-22:

- Integrated, person centred, place-based delivery, with prevention and early intervention at its core (also see section 6)
- Addressing health inequalities through a population health management approach (also see section 7)
- Supporting Hospital Discharge flow (see section 5)
- Implementation of a local shared care record
- Working collaboratively as a system to deliver these priorities.

Currently, in line with our system wide Joint Commissioning Principles, the local authorities jointly commission c. £200m of services in conjunction with the NHS in addition to the Better Care Fund, including:

- Section 75 agreement with CPFT for the delivery of mental health support
- Section 75 agreement with CPFT for the delivery of Occupational Therapy (OT) services
- Learning Disabilities Partnership
- Integrated Community Equipment Service (ICES) and Technology Enabled Care (TEC)
- Prevention and Early Intervention Framework

In addition to the formal arrangements and delegated models, there are a number of teams and services delivering an integrated pathway or approach alongside NHS staff, including:

- Discharge to assess pathway 1: this includes CCC reablement and CPFT intermediate care staff working in a complimentary way.
- Transfer of care team: the council has staff based in our local acute hospitals working with clinicians to plan discharge.
- Care home support team and Brokerage: work closely with the CCG's Quality Team and Public Health supporting independent providers with quality, staffing or infection control issues.
- Multi-disciplinary teams (MDTs) with primary care – named social workers have been identified to work with Primary Care Network MDTs and advise and support decision making, sharing information and planning together how to prevent need from escalating.

The next step in our community journey is to develop place-based delivery, across the County, in which a wide range of organisations work together to govern the common resources available to them to deliver place base services which provide proactive, integrated and person-centred care to people, keeping them well and independent in their own communities for as long we possible.

Personalisation and a strengths-based approach is central to our model of delivery. 'Changing the Conversation' continues to focus on having the right conversations at the right time. This approach has been rolled out an embedded across adult social care via the

Council's Adults Positive Challenge transformation programme. The focus now is widening the scope to partners and providers, such as occupational therapists, place-based co-ordinators and commissioned providers, to widen the number of strengths-based conversations taking place across the whole system. There will be a pilot of changing the conversation with the block car providers for domiciliary care, with a view to rolling this out more widely to other providers based on the learning and impact evidenced.

"Community power is an inherently preventative way of thinking about public services"

Community power starts with the principle that people have the best insight into their own situation. As an ethos for public services, it entails a shift of power away from bureaucratic centres towards people on the ground, building on values such as collaboration and participation. Due to its focus on communities and places, community power is an inherently preventative way of thinking about public services. It understands, in its DNA, the importance of social determinants of health, as its focus is on the things that create ill-health at the level of populations and groups of people.

- This all works to counter spiralling demand. Instead of dealing with the issues of individuals at the point at which they become 'problems', community power means addressing things upstream – and, as a result, preventing problems from occurring in the first place. This reduces pressure on acute services.
- Community power also involves shifting the internal character of public sector institutions. For the NHS, this would mean becoming more outward looking, and forging closer relationships with other key place-making institutions, not least local government, local communities, voluntary and community groups to better intervened upstream and address local issues and challenges.
- This integration agenda, and the imminent national roll-out of Integrated Care Systems will help with this on a structural level. However, for real change to happen, culture needs to mirror and reinforce the new strategy. Health needs to be understood as being something bigger than the NHS – something that is created through the environment, through housing, through education, and through society itself. In recognition of the impact that social and wellbeing preventative measures can have in reducing long-term health and social care needs. This means recognising the importance of policy levers held outside the NHS, and for much deeper and more meaningful engagement with communities, as well as other public sector institutions.
- It also means system-wide targeted approaches to tackling health inequalities that recognises the impact of social determinants of health on health and wellbeing outcomes for individuals, for example the work on anti-poverty, which supports the Health and Wellbeing Board priority of 'preventing people falling into debt'. Cambridgeshire County Council and Public Health are leading on the development of a system-wide anti-poverty strategy that supports health outcomes.

Decentralisation is key to tackling inequalities, deprivation, poverty, unlocking the power in communities and providing opportunities rather than focusing on managing demand or saving money. To do this:

- we will work with district/city councils to understand what already exists by means of local governance, and seek to align ourselves to that rather than creating anything new
- we will bring our resources to the table up front – data and intelligence, skills service, libraries, youth services, budgets etc - but also get to a shared understanding quickly

of the challenges and issues so we can identify other resources that can be devolved or delivered differently
- if a district/city wants or needs to focus on smaller geographies (e.g. Wisbech, North Hunts, Abbey) we will focus resources there too and work on agreed boundaries that make most sense to our residents
- We will adapt our Adult Skills and Think Communities service offer to support the nurturing and development of new community leaders

Prevention and Early intervention is a continued focus for local BCF plans, with the continued embedding of approaches that prevent or delay the need for more intensive health and social care services. Our 2021-22 plans will build on the huge amount of work already undertaken in this area, e.g.:

- Public health led falls prevention programme
- Investment in Voluntary sector provision
- Carers Support and respite
- Day Opportunities
- Technology Enabled Care (TEC) and Community Equipment (ICES) and the embedding of a TEC first approach
- Information and advice, including community navigator service and social prescribing
- Reablement as default pathway for hospital discharge across Peterborough and Cambridgeshire

Joint commissioning across health and social care underpins the approach, and we will move towards commissioning at a place-based level, based on outcomes and supporting social value. This includes evolving options for devolving commissioning budgets to local ICP footprints where appropriate and developing new models of commissioning care.

Some options being explored include:

- **New model of home care:** A shift away from the Home Care model to develop a place-based approach, which comprises:
    - A community based, case management approach
    - Carers who live and work in their own community, including care micro-entrepreneurs, supported by Community Catalysts
    - Part of, and integrated into local health and care teams and resources
    - Investment in carers, reduces travel time, reduces attrition and improves career prospects and outcomes

  Given the scale of transformation, the first phase will be the development of a single early adopter pilot in East Cambridgeshire. Following successful evaluation, it is proposed to apply the learning from the early adopter site across the county.

- **Build more care and support around peoples' homes:** Alongside supporting older people to remain living independently through community-based care, commissioners are seeking to evolve the local residential and nursing care to develop tenancy-based models of care as alternatives to the traditional residential and nursing care home. Stimulating development of new capacity in this way will generate the much-needed provision to meet population growth forecasts and do so at an affordable cost. It will also offer greater choice, control and care flexibility for those older people no longer able to remain living safely at home.

- **Personalisation of Care and expansion of Self-Directed Support:** Individual Service Funds are being rolled-out in both Cambridgeshire (initially in East Cambridgeshire, under the Care Together project) and Peterborough. These will enable more people to gain choice, control and flexibility of the services they access with more support from providers who will link up with community assets to ensure individual agreed outcomes are achieved.

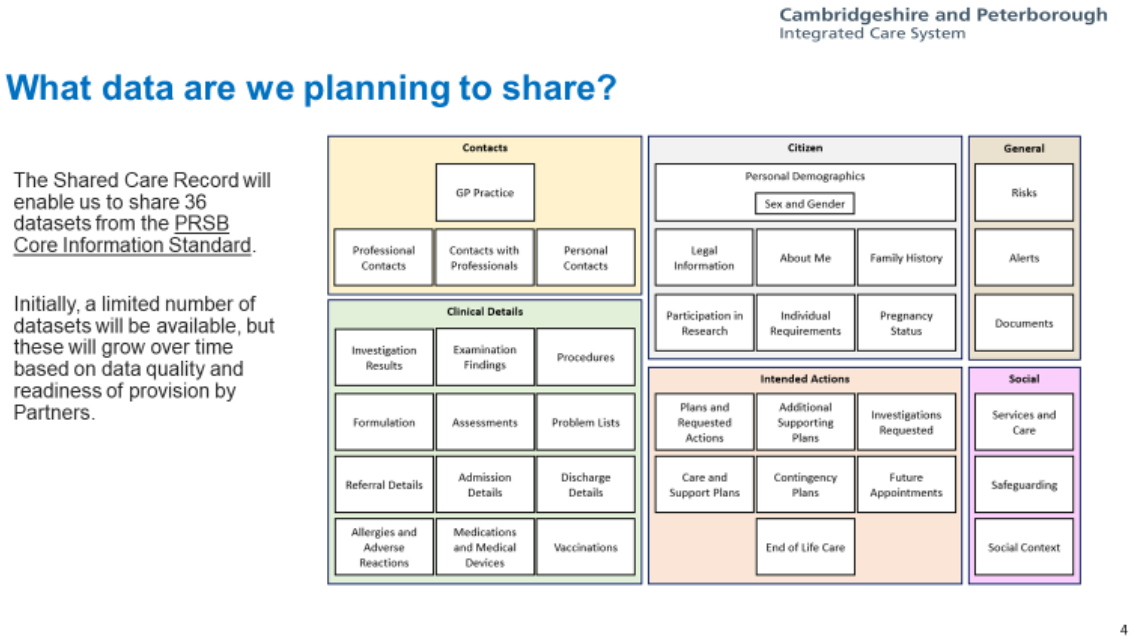
Shared Care Record

We want to bring together patient data currently held by our partners across our health and care system, into one single patient record view for direct care purposes.

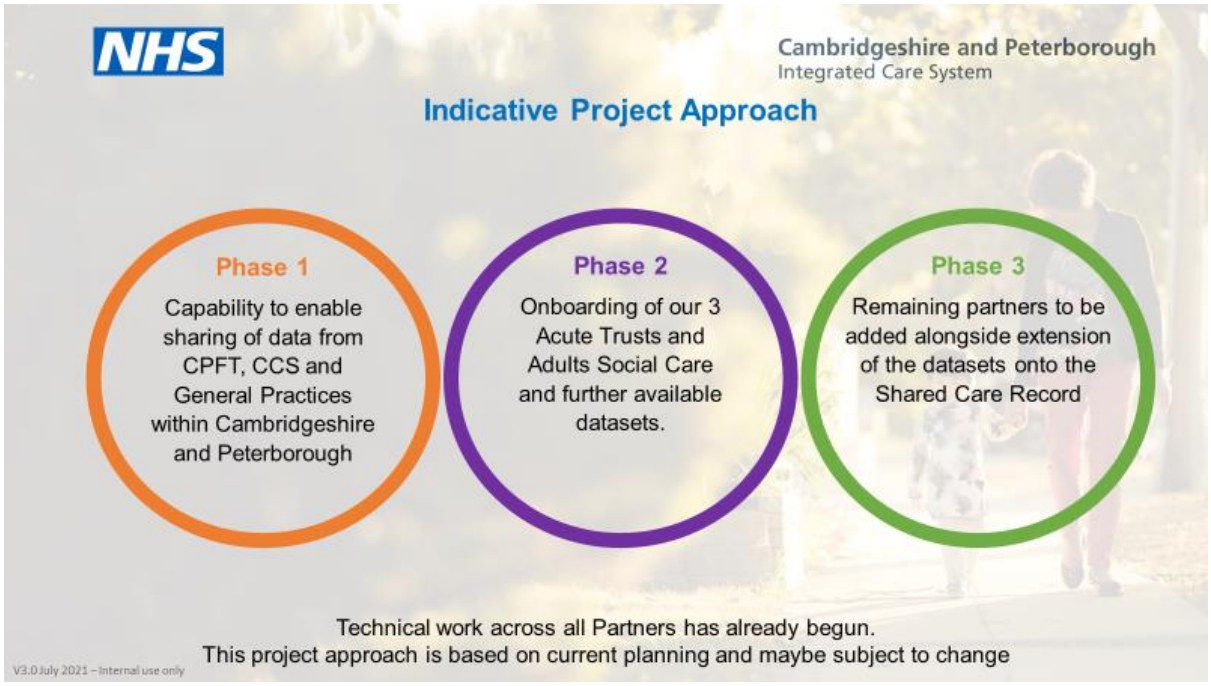
What will this involve:

- Data sharing capability between our core Partners
- Data will be shared in near real-time across Partners and presented, on-demand, in one of two ways:
    - In context presentation through existing Partner systems e.g. EMIS, SystmOne, MOSAIC etc
    - A standalone web browser
- Single sign on to the Shared Care Record, through Partner systems.
- Adopting a national common information standard to ensure sharing of consistent data quality and integrity using compliant interoperability standards.
- Compliance with NHS information governance framework and Cyber Essentials Plus

The type of data we are aiming to share is as per the below.

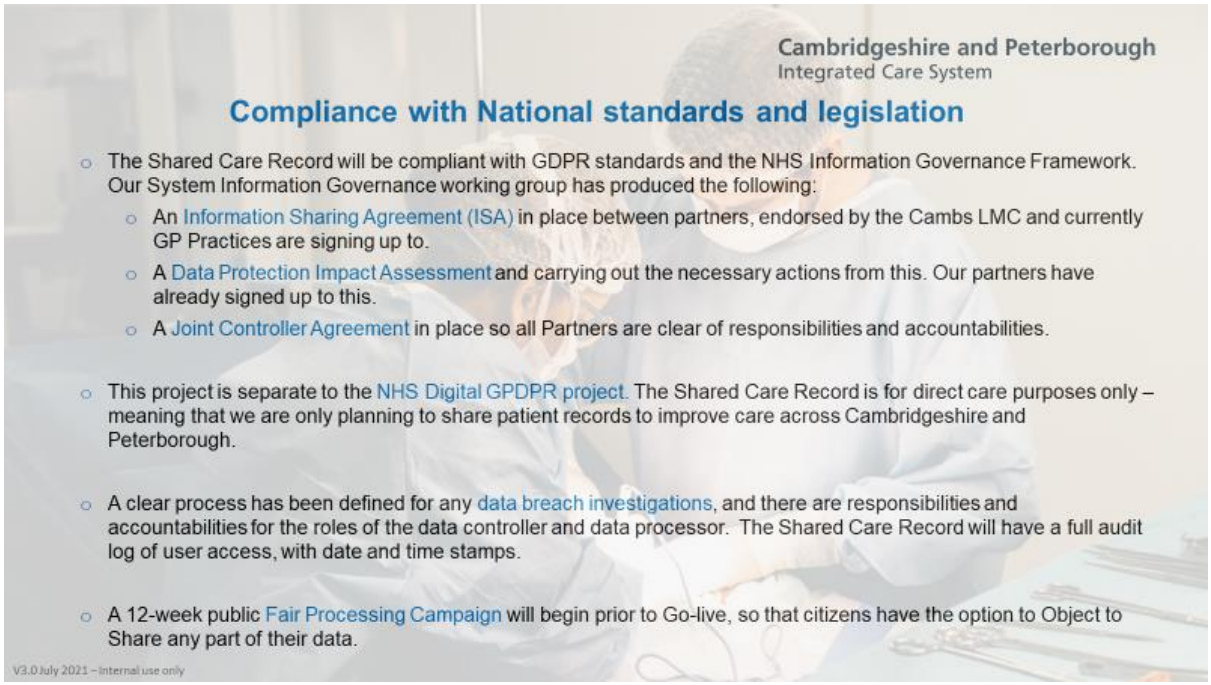


The roll out will happen in a phased way, as outlined below.



In relation to integration of social care records, we are looking to prioritise access for the older peoples community referral pathway (including reablement and OT) and LDP first with January 22 go live - with a view to full integration by September 2022.

The below provides an overview in terms of compliance with National standards and legislation and the local approach.



Working Collaboratively as a system to deliver these priorities

The reforms set out in the White Paper 'Integration and Innovation' published in February 2021 and the creation of an integrated care system (ICS), offer an opportunity to transform health and social care at a national and local level.

Integrated Care System (ICS) development is being driven nationally and all systems are required to have an ICS established by April 2022. Locally the proposals for an Integrated Care System for Cambridgeshire and Peterborough have been approved. The proposed ICS covers a footprint of nearly 1 million people.

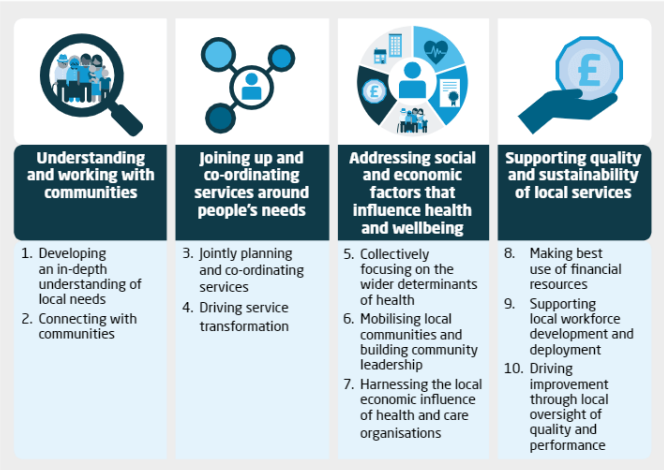
Integrated Care Boards (ICB) will be established to replace the Clinical Commissioning Group (CCG) which are being abolished.

The ICS in Cambridgeshire and Peterborough will include two ***Integrated Care Partnerships (ICPs)*** in the North and South building on the existing North and South Alliances:

- North: covers Peterborough, Fenland and parts of Huntingdonshire; and
- South: covers Cambridge City, South Cambridgeshire and East Cambridgeshire.

The ICPs will be a strategic body bringing together the ICB and local authorities within the ICS to facilitate the local integrated care strategy. Local decision-making, local knowledge and local democratic accountability are essential components of the ICS. Giving a meaningful voice to local people is at the heart of our vision for health and social care. The mechanism for local democratic accountability is through elected politicians and thus the ICS will be a partnership of equals across the NHS and local government, ensuring that local politicians share responsibility for the integration of health and social care through local democratic structures.

Locally, we are considering how we can streamline strategy and governance to amalgamate the ICPs with the Health and Wellbeing Boards. The role of the Integrated Commissioning Board, which has delegated responsibilities from the HWBs will also be reviewed as part of this. The key functions of ICPs is outlined in the below diagram.



The below diagrams show an overview of the ICP key workstreams, which reinforces the alignment between local BCF plans and the work that the ICPs will be progressing to take place-based delivery and priorities to the next level.

South ICP Roadmap

System Resilience (Flow) Programme Board (monthly)
Chair/SRO
Clinical/Professional Leads
Members

- NEL pathway management – daily rhythm and process improvement
- D2A Nesta 100 Day Challenge
- Surge/winter planning
- Community Care Coordination Hub
- *Virtual ward and virtual hospital models (with Acute Provider Collaborative)*

Integrated Neighbourhood Care Programme Board (monthly)
Chair/SRO
Clinical/Professional Leads
Members

- Co-develop refresh of IN Framework / Primary Care Strategy (incl. LMC)
- Building PCN and IN capability, capacity & infrastructure, incl OD
- Co-design Early Adopter INT model
- Community/Patient engagement
- *Link SR and PHM programmes to design and implement new OOH pathways*

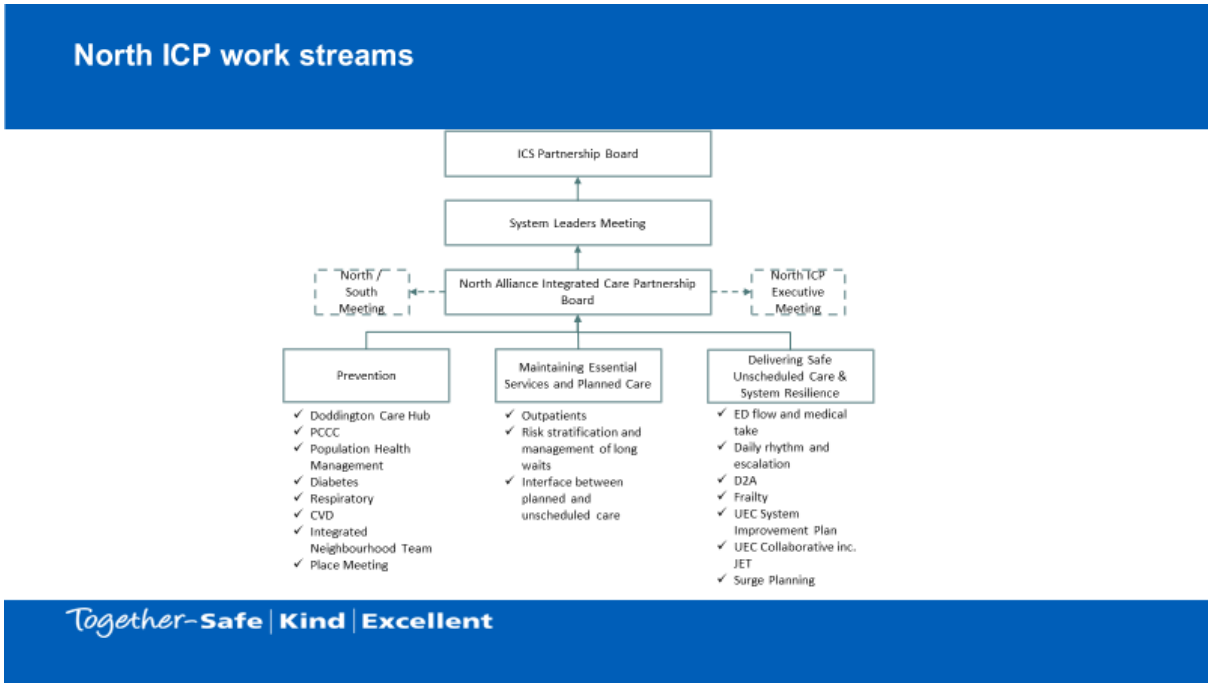
Population Health Management Programme Board (monthly)
Chair/SRO
Clinical/Professional Leads
Members

- Population Health Management Development Programme
- Risk Stratification – high intensity users [link to SR Programme]
- Anticipatory Care (Ageing Well and LTCs), including OOH pathway/model of care redesign
- *Prevention and early intervention*

ICP Development Group (weekly?)
Members

- Organisational Development
- Development Plan & Operational Plan
- Due Diligence requirements

North ICP Roadmap



Integrated Neighbourhoods have been established in a number of specific areas. These are still in their early stages and provide a test bed for innovation and integration to reflect local needs and demand.

There is also work underway to develop a number of ***'Provider Collaboratives'***, including one focused on mental health and learning disabilities and another in relation to maternity and children's services.

Section 5 - Supporting Discharge (national condition four)

What is the approach in your area to improving outcomes for people being discharged from hospital?

How is BCF funded activity supporting safe, timely and effective discharge?

Over the past year our well-established system Discharge to Assess (D2A) group has worked together to increase acute admission capacity and improve flow across our health and care system.

What we have achieved so far:

- We have begun implementation of the criteria to reside in our acute and community hospitals
- We have increased community and social care capacity through re-deployment, increased ICT to enhance our home support offer, recruitment of Integrated Care Workers (ICWs) and rapid commissioning of community bedded capacity
- We have implemented a multi-partner single point of access and multi-disciplinary decision-making process that has enabled us to commit to no assessments taking place in hospital (only exception being MCAs for safeguarding purposes) and manage patient flow as a system
- We have simplified processes under D2A pathway 1 to eradicate unnecessary 'hand offs' between services and ensure patients get continuity of care from hospital discharge to long term care arrangements where appropriate regardless of whether the lead commissioner of their care is health or local authority
- We have reinstated clinical criteria led admission to inpatient rehabilitation and health interim beds to ensure proactive rehabilitation of patients that are appropriate for this pathway
- We have ensured daily discharges are maximised and continued to pro-actively troubleshoot system issues through our steering group
- We have agreed a Memorandum of Understanding (MoU) across system partners outlining the processes required to manage any potential delays in the 6-week D2A period ensuring all patients are clearly allocated to a case manager to support them through to discharge home or into long term care
- Our dedicated ward pharmacy services have demonstrated reductions in patient length of stay and the Discharge Medicines Service will soon be implemented across our system
- We have continued to develop our integrated care home medicines optimisation service reviewing those at greatest risk, to support early discharge and prevent readmission for those residents in care homes or assisted living
- We have recruited two pharmacy technicians in our community services pharmacy team to work with people in their usual place of residence to feel confident to manage their medication, in turn reducing the need for care packages and possible admission to hospital
- Implementation of discretionary DFGs to facilitate quick hospital discharge for clients who need minor adaptations to be able to be independent at home, as well as for hoarders that require a deep clean to enable them to be discharged back home.

The local D2A model aims to achieve the following outcomes:

- Avoiding unnecessary hospital admissions;
- Improving patient flow through the system and particularly on discharge;
- Improving outcomes for individuals, with the right care and support being offered in the right setting at the right time, with long term care needs being determined once patients recovery and health has been maximised;
- Maximising opportunities for reablement and rehabilitation to promote independence and recovery, promoting the 'home first' model;
- Resources and capacity are commissioned based on flow and utilised effectively

The implementation of this model has resulted in simplified processes and the configuration of health and social care staff to support D2A in the community.

The provision of 7 flow has improved since D2A commenced with brokerage, acute discharge planning and social care transfer of care teams all now working 7 days, building on 7 flow from intermediate care and reablement. The JET service also supports Out of Hours provision, particularly at weekends, which also helps with admission

avoidance. NHS Hospital Discharge funding, which has been varied into the BCF section 75 has enabled capacity to be increased to support a number of identified areas, including:

- Brokerage capacity
- Social worker capacity
- Therapy capacity
- Intermediate care capacity
- Spot purchasing of bed capacity
- Voluntary sector
- Community IV service
- Additional nursing and residential bed capacity
- Additional home care capacity to support discharge

The Voluntary and Community Sector (VCS) offers dedicated support for older people and adults aged 18+ (with physical disabilities, sensory impairments, learning disabilities and/or autism, mental health issues, and/or their carers) when coming home from hospital, which is fundamental to support Pathway 0. Age UK, Care Network and British Red Cross offer discharge support services with the aim of helping people to return home from hospital in a safe and timely manner and to prevent readmission through a range of practical support and information and advice activities such as:

- One-to-one support
- Telephone support/welfare check-ins
- Collecting prescriptions and shopping
- Installing grab rails and key safes
- Food parcels
- Information and advice
- Support for discharge planning
- Wellbeing activities
- Triage into other local voluntary sector support

Examples of triage into other local voluntary and community sector services could include:

- Carers support offered by Caring Together and Making Space (who support people looking after someone with mental illness)
- Support for people with sensory impairments, for example Cambridgeshire Hearing Help, Camsight, etc.
- Homes support services (offering help with general domestic tasks including cleaning) and shopping services (such as those provided by Age UK Cambridgeshire and Peterborough)
- Referrals into local strength and balance exercise classes (promoted by Public Health's 'Stay Stronger for Longer' campaign) to reduce people's risk of falls
- Putting people in touch with local community groups and schemes where they live, such as Timebanks, Good Neighbour Schemes, etc.

These services, many of which are funded by BCF funding, complement our existing Reablement offer and provide localised support to people, enabling them to rebuild networks and establish support within their communities.

It is important to note the ongoing work with Queen Elizabeth Hospital NHS Foundation Trust (QEH) to support length of stay and discharge flow for Cambridgeshire and Peterborough resident patients. Social care and community provider discharge planning teams work actively with QEH, including regular attendance at long length of stay meetings, patient tracker meetings and escalation calls. We are supporting multi-disciplinary team discharge conversations for patients to ensure that their discharge is supported in a safe and timely manner. A virtual discharge room has been established across the system, which QEH, are part of. This enables staff to drop in at any time for updates and queries relating to patient discharges. In addition we have a dedicated social worker linked to the hospital who is based on site.

Discharge Improvement

Over the next 6 months we will build on this good work and lessons learned (locally, regionally and nationally) to develop a sustainable, equitable and resilient D2A pathway and intermediate care/reablement model that incorporates our patient and service user feedback, is outcomes focussed and financially sustainable. We will work together to:

- Continue to simplify the processes in acute and community hospitals to reduce bureaucracy and support patients' discharge when they no longer meet the criteria to reside
- Develop a pooled and flexible staffing model for therapy/OT staff across our system, with outreach from acutes and rotation of staff through acute and community settings
    - A gap in therapy resource has been identified and system discussions are taking place to address the funding gap
- Take forward recommendations for pathways 1 & 2 based on what worked well during Covid-19 and what is needed going forward for the next 6 months
- Continued use of the Care Home Trusted Assessor model for pathway 3, with potential for greater efficiencies through some remote working
- Continue to build on the Single Point of Access, multi-disciplinary working, whole system patient tracker and continue to manage patient flow as a system
- Continue to engage with and expand the use of the voluntary sector support
- Review our system capacity for intermediate care and home first, to include a comprehensive review of wrap around services, e.g. therapy, social care, DPSNs and primary care support. We have commissioned NESTA to lead a 100-day challenge in September to further refine this model. This will highlight any gaps in recurrent funding which require a system solution
- Review and improve the commissioning framework for D2A beds to ensure that the system has the flexibility to adjust what we commission in response to unplanned events
- Use data to inform our understanding of health inequalities across our services and pathways and ensure that any future model is proactively addressing this through delivery at place and monitoring population health outcomes
- Continue to work seamlessly with the community services pharmacy team to expedite the discharge process by providing medication administration training for the large number of new ICWs and advice and guidance
- Increase the availability of pharmacy technicians in the community service pharmacy team as it is currently only funded for half the county

A single programme structure has been established to ensure a consistent approach to the improvement programme of work.

Our local vision for Discharge to Assess – By November 2022, will ….

- Focus on people, keeping them at the heart of all our decisions
- Focus on outcomes, with the metrics we focus on created and agreed by the people the metrics relate to
- Do no harm (emotional or physical) to patients because of capacity constraints or process delays
- Have the right people, in the right place, at the right time
- Deliver smooth flow and exceptional experience through simple referrals done at the right time
- Enable patients to leave hospital within 24 hours of no longer needing to be an inpatient, going home wherever possible

This improvement work is being supported by NESTA who have tasked system leaders across the North and South ICPs with making improvements to current pathways and processes to get better outcomes.

- North – exploring how to develop both push and pull models to support people home quicker and safer from hospital into the right care setting
- South – looking at how to improve things for people who require care and support to leave hospital

NESTA's focus is less about discrete projects, but more about empowering multi-agency teams to make improvements over 100 days and then the progress and benefits from these will be used as a foundation for how we continue to progress

The ICPs are also taking responsibility for flow at Place level and are currently looking at how to develop initial arrangements for winter around:

- Triage
- Escalation
- Management of flow

How is BCF funded activity supporting safe, timely and effective discharge?

BCF funding supports a number of key areas that support discharge flow, including the below examples:

- Significant contribution towards reablement and intermediate care provision. This includes both care at home to support the 'Home First' model, as well as rehabilitation and reablement beds where bed-based rehabilitation is required.
- NHS Discharge money has been pooled into the local BCF and has been used to increase capacity to deliver the D2A model, as outlined previously.
- Improved Better Care Funding is utilised to fund additional provision, including nursing capacity in Peterborough and discharge capacity in Cambridgeshire.
- Significant Improved Better Care Funding in our local DTOC/Discharge plans, this includes funding of specific interventions such as our local care home trusted assessor model, discharge team social worker capacity, CHC assessment capacity and D2A leads.
- BCF funding of social care placements, to ensure sufficient capacity in the market to support discharge
- Funding of voluntary sector support, which aids discharge of patients with low level needs, e.g. Care Network, British Red Cross.

Section 6 - Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people.

In Cambridgeshire, DFG monies are passed to the District Council. In Peterborough, as a unitary authority, responsibility for the DFG sits with Peterborough City Council. DFG monies are used to support home adaptations and to better support people to remain in their homes for longer. There is a strong local commitment to ensure that we use adaptations, Technology Enabled Care (TEC) and Community Equipment (ICES) proactively to support independence.

The role of the District Councils across Cambridgeshire, Peterborough City Council as a unitary authority and the Home Improvement Agencies (HIAs) are fundamental to this approach and ensuring that people are supported to access the adaptations and assistance that they need. More information on the HIAs in Cambridgeshire and Peterborough can be found at:

- Cambridgeshire: Cambridgeshire HIA
- Peterborough: Care and Repair

Integration of housing with health and care services is a crucial element to supporting the outcomes of the BCF and housing colleagues are actively represented at the Integrated Commissioning Board, to ensure housing is integrated with strategic joint commissioning intentions across the system.

Both Cambridgeshire and Peterborough have Housing Renewal Policies which introduce discretionary funding in addition to the mandatory DFG funding already covered in legislation. This has enabled DFG funding to be used as ‘top up grants’ and to support physical works to homes to expedite hospital discharges or prevent hospital admissions, or to support relocation grants to enable applicants to move to a more suitable property that can be more easily adapted if necessary.

In line with the County-wide policy, we have also implemented the following which has aided speeding up hospital discharges and avoided unnecessary hospital admissions:

- Implemented the Community Warden pilot scheme as part of our Doddington Hub work.
- Addressed the significant delay in Occupational Therapist (OT) assessments by commissioning private OT capacity.

Alongside this, in 2020/21 we ran a boiler replacement programme for vulnerable households, making homes warmer and more efficient on cost to again benefit the health and well-being of the households and we are looking at the potential to run this again this financial year. Just looking at the spend profile to see if feasible to offer anything along those lines this year.

Community equipment (ICES) and TEC work hand in hand with the DFG to enable more innovative models of support and we continue to build on this to further enhance a holistic approach. The Integrated Community Equipment Service provides short- and long-term loans of equipment, ranging from simple walking aids, through to larger and more complex items, such as pressure relieving mattresses and hoists. Equipment may also be designed to

help carers with the safer delivery of care. The service can also include installation, servicing and maintenance, depending on the type of equipment specified. This equipment plays an important role in diverting demand away from long-term care and this is an area where BCF funding actively supports provision via a pooled integrated model of delivery.

The TEC service continues to deliver interventions which reduce, prevent and delay the need for long term social care support and avoidance of health needs. Through BCF we seek to expand the impact of TEC, with it embedded in care pathways as core element of the support we offer at every stage of the journey.

Throughout the pandemic the TEC first approach has continued to be the default. The Council has also focused on building up the lifeline provision through direct delivery of a lifeline service. TEC huddles continue as a means of keeping practitioners up to date with new TEC, which is constantly emerging. The pandemic emphasised more than ever, the need for digital resilience to go hand in hand with TEC and the need to address digital exclusion inequalities. For 2021/22, a joint TEC and digital resilience plan has been developed with Think Communities, incorporating a range of shared actions around the following four outcomes:

- Intervention and prevention to reduce demand on adult social care services
- Development of a consistent TEC model across Cambridgeshire and Peterborough
- Link with the existing digital resilience offer
- Establishing a place-based pilot in Fenland in collaboration with North Alliance

A good example of housing, social care and health integration is the recent implementation of our Out of Hospital Care Models for Homelessness pilot in Peterborough and Cambridge City, for which we received bid funding from the Home Office in 2020/21 – 2021/22. The funding has enabled the recruitment of Senior Housing officer posts to offer dedicated housing advice and support where housing needs or homelessness are identified as a barrier to hospital discharge. The posts have been embedded within the existing discharge to assess (D2A) pathway across the Cambridgeshire and Peterborough. This ensures that appropriate housing support and decision making is in place at the point of multi-disciplinary discharge triage. In addition, the funding has secured dedicated step-down accommodation for the project, with wraparound intermediate care and/or reablement support, to support rehabilitation and independence where there is an identified need.

Section 7 - Equality and health inequalities.

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- ***Changes from previous BCF plan.***
- ***How these inequalities are being addressed through the BCF plan and services funded through this.***
- ***Inequality of outcomes related to the BCF national metrics.***

In Cambridgeshire and Peterborough stark inequalities exist in the social determinants of health, risk factors, health care provision and clinical outcomes across socio-economic, disadvantaged and inclusion health groups. A 10-year life expectancy gap exists between men living in the poorest areas of Peterborough compared to the richest areas of Cambridge. The gap in life expectancy is driven by early deaths in cardiovascular disease, cancer and respiratory conditions. COVID-19 has increased the pre-existing inequalities.

Our local BCF Plan is aligned with our local Cambridgeshire and Peterborough 'Health Inequalities Strategy 2020' (https://www.cambridgeshireandpeterboroughccg.nhs.uk/about-us/health-inequalities/). The strategy has three objectives:

1. Develop Guiding Principles to tackle health inequalities
2. Agree health inequality indicators
3. Identify specific areas for priority action

Drawing on national and international recommendations we have developed seven Guiding Principles. These are:

- Explore the impact of decisions on health inequalities early in the decision-making process
- Value staff through parity of recruitment, promotion and employment
- Offer simple, hassle-free services
- Partner with other organisations to take a place-based approach to address social determinants of health
- Allocate health care resources proportionate to need
- Consider actions at different stages of life
- Harness the community benefits of the Social Value Act

A Health Inequalities Board has been established to monitor and drive action on health inequalities, promote awareness of the guiding principles and embed them in commissioning and delivering of services.

The Health Inequalities work is overseen at system level by a Health Inequalities Board with Executive Director level membership from all organisations in the ICS, the Communities Directorate of our Local Authorities, Public Health and Health Watch. This Board is working with distributed system leadership; it is chaired by a CEO from one provider, has NED support from another provider and an SRO from a third organisation. In this way we are ensuring that reducing Health Inequalities is a system-wide and system-owned priority.

The Health Inequalities Board will be underpinned by a newly formed Health Inequalities Operational Group.

Basic Population Health Management approaches are already in use in our system through the use of “Eclipse Vista”. Eclipse Vista uses primary and secondary care data to provide risk stratification, patient segmentation and patient alerts to maximise primary and secondary prevention. Additionally, the ICS is part of a project with Optum to use joined up data to carry our population health management.

Sentinel indicators for Health Inequalities were developed as part of the overall system strategy and are reviewed by the CCG monthly as part of integrated performance monitoring and will become part of the regular information reviewed by the Health Inequalities Operational group over 2021/22.

In December 2020 NHS Cambridgeshire and Peterborough's application was accepted for the wave 3 Population Health Management programme. This programme will be run through a blend of NHSE/I teams, external SME (Optum) and transformation partners. Phase 1 will work with one place (the North of the system was chosen by the HI Board and the decision has since been ratified by system leaders) and 3-4 PCNs from anywhere across the system, likely to be a mix of both North and South of the system, taking into consideration local deprivation and population needs. It aims to help us understand the challenges being faced by specific groups in the health and care system and identify actions to address these.

The PHM Wave 3 Development Programme is a 22-week supported action learning programme to facilitate:

- Working with each tier of the system to **link local data sets**
- **Build analytics skills** across the system
- Find rising risk cohorts
- Risk stratification of elective backlogs and explore alternative models of service delivery.
- Support the design and delivery of new models of care for impactable patients
- Costed segmentation to develop new population based blended payment models and evaluate impact of interventions.

The second phase of the program will look to roll out the datasets and learning to all PCNs across the system. This may be via QlikView, Eclipse or via the Cambridgeshire and Peterborough Shared Care Record.

Social Mobility Strategy Development

This strategy is being developed, working with system and community partners across county, city, district and parish councils; voluntary, community & faith sectors; in conjunction with the Health Alliances and Police.

- Focus is on levelling-up communities, and addressing the absolute root causes of inequality
- The approach is designed to create the right conditions for citizens to take greater control and to make informed choices about their own future

To achieve this, our aspiration is that:

- Place teams exist – multi-disciplinary, multi-organisational, multi-age range
- Holistic assessments, triage, conversations are standard across all services
- A whole-family, whole-person, whole-place approach is embedded into decision making
- Interdependencies are understood, and impacts of decisions are owned by the whole place team

- Barriers to improved social mobility are understood by all, involvement in services always leads to opportunity
- The most appropriate worker takes the lead - but the whole place team supports the worker
- When intervention is needed, this leads to the right level of support, but step down is planned well in advance with the community
- Local volunteering opportunities are linked to the place team to support a seamless experience
- Information sharing agreements are embedded – systems co-exist but share information and data which is analysed and interpreted looking forward and looking back
- The roles of community connectors and social prescribers are embedded into the place team to support community opportunities
- Clear and holistic menu of interventions and opportunities has been created and is understood

Our Health Inequalities Strategy and Population Health Management approach is a core element to embed within our BCF Plans, particularly in support of place based Integrated Neighbourhood development, ensuring that local commissioning and provision of services is targeted to address health inequalities and meet local identified needs in an integrated manner. It will also support the risk stratification of patients, to enable targeted multi-disciplinary early interventions, preventing the unnecessary escalation of need and delivering the best outcomes for people.

Better Care Fund 2021/22

Performance Metrics

Cambridgeshire and Peterborough

Better Care Fund -National Metrics

- Effectiveness of reablement (proportion of older people still at home 91 days after discharge from hospital into reablement of rehabilitation)
- Older adults whose long-term care needs are met by admission to residential or nursing care per 100,000
- Avoidable admissions – unplanned hospitalisation for chronic ambulatory care sensitive conditions
- Reducing length of stage in hospital, measured through the percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days
- Improving the proportion of people discharged home using data on discharge to their usual place of residence

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services - **Peterborough**

Recommended 2021/22 Target: 71.7%

Past BCF Performance 2019/20:

Target: 82.9%

Actual: 80.2%

		19-20 Plan	19-20 Actual	21-22 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	82.9%	80.2%	71.7%
	Numerator	116	65	76
	Denominator	140	81	106

Rationale:

- COVID and the changes to the D2A pathways have impacted on performance of this target.
- we are seeing lower numbers of older people coming down the pathway, though activity is starting to increase
- due to a reduction in elective admissions we are seeing a higher acuity of need post discharge which has impacted outcomes.
- we have a low level reablement commissioned offer through British Red Cross and Care Network, which means reablement tends to pick up higher acuity of need packages which impacts on outcomes.
- There is a continued significant investment in reablement provision, and reablement is the default pathway for discharges and there is a growing focus on community referrals to avoid admission.
- Nationally, the England average performance decreased from 79.5% in 2019/20 to 74.9% in 2020/21
- 2020/21 performance was 70.4%. Current indicative performance in 2021/22 to date is below, but final year end data will be based on Q3 snapshot performance:

Month	Percentage at home after 91 days post Hospital
Jun 2021/22	87.50%
Jul 2021/22	82.05%
Aug 2021/22	63.16%
Sep 2021/22	68.97%

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services - **Cambridgeshire**

Recommended 2021/22 Target: 70.1%

Past BCF Performance 2019/20:

Target: 82%

Actual: 77.5%

		19-20 Plan	19-20 Actual	21-22 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	82.0%	77.5%	70.1%
	Numerator	451	317	225
	Denominator	550	409	321

Rationale:

- COVID and the changes to the D2A pathways have impacted on performance of this target.
- we are seeing lower numbers of older people coming down the pathway, though activity is starting to increase
- due to a reduction in elective admissions we are seeing a higher acuity of need post discharge which has impacted outcomes.
- we have a low level reablement commissioned offer through British Red Cross and Care Network, which means reablement tends to pick up higher acuity of need packages which impacts on outcomes.
- There is a continued significant investment in reablement provision, and reablement is the default pathway for discharges and there is a growing focus on community referrals to avoid admission.
- Nationally, the England average performance decreased from 79.5% in 2019/20 to 74.9% in 2020/21
- 2020/21 performance was 70.4%. Current indicative performance in 2021/22 to date is below, but final year end data will be based on Q3 snapshot performance:

Fiscal Month Year of day 91	Percentage at home after 91 days post Hospital
Jun 2021/22	100.00%
Jul 2021/22	68.75%
Aug 2021/22	69.16%
Sep 2021/22	72.03%

Older adults whose long-term care needs are met by admission to residen tial or nursing care per 100,000 - **Peterborough**

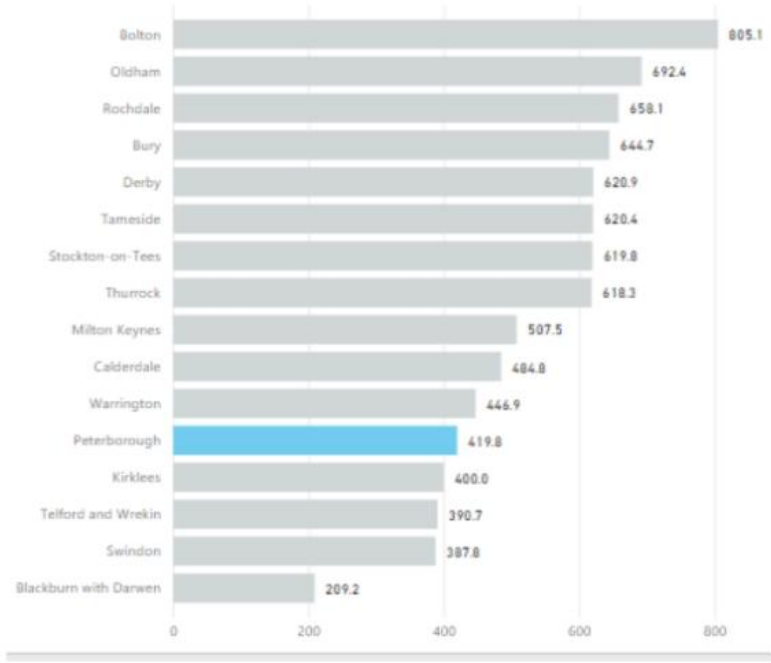
Recommended 2021/22 Target: 428

Past BCF Performance 2019/20:

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	424	376	420	428
	Numerator	128	113	128	134
	Denominator	30,190	30,051	30,493	31,287

Rationale:

- We have continued to maintain a low rate of residential admissions
- Targets have been set to remain comparatively low, but to rise slightly accounting for an increase in demand similar to previous years, due to continuing evidence of increased acuity of needs.
- Target is based on 6% increase based on the numbers we are seeing coming through short stay to permanent.
- Current 2021/22 data is indicating c. 88 placements in the 1st 7 months. If this trend continued then we would see a larger increase of c.150 if the trend continued for the full year.
- Current performance compares well to regionally.
- Focus on prevention and early intervention to avoid/delay residential admissions, including Technology enabled Care, Enhanced Response Service expansion, new models of place-based delivery (e.g. Caring Together, Independent Living Services) and strength based practice embedded.



Older adults whose long-term care needs are met by admission to residen tial or nursing care per 100,000 - **Cambridgeshire**

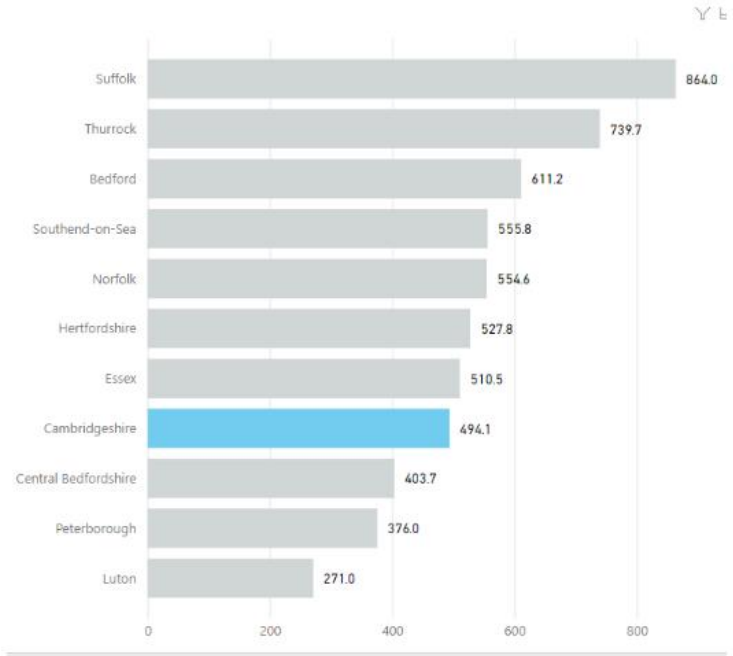
Recommended 2021/22 Target: 438

Past BCF Performance 2019/20:

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	473	494	419	438
	Numerator	594	619	534	566
	Denominator	125,656	125,275	127,322	129,278

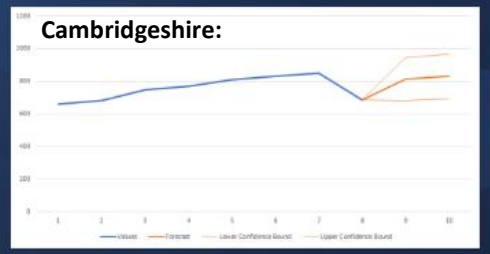
Rationale:

- We have continued to maintain a low rate of residential admissions
- Targets have been set to remain comparatively low, but to rise slightly accounting for an increase in demand similar to previous years, due to continuing evidence of increased acuity of needs.
- Target is based on 6% increase based on the numbers we are seeing coming through short stay to permanent.
- Current 2021/22 data is indicating an increase in demand going up.
- Current performance compares well to regionally.
- Focus on prevention and early intervention to avoid/delay residential admissions, including Technology enabled Care, Enhanced Response Service expansion, new models of place-based delivery (e.g. Caring Together, Independent Living Services) and strength based practice embedded.

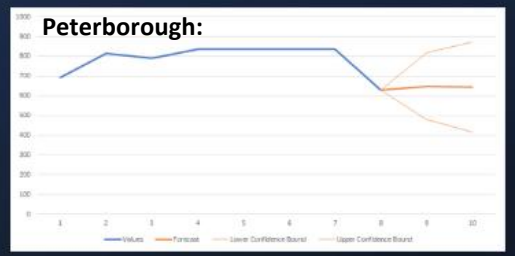


Avoidable admissions – unplanned hospitalisation for chronic ambulatory care sensitive conditions

Cambridgeshire:



Peterborough:



Recommended 2021/22 Target:

Cambridgeshire: Annual rate 830.6
Peterborough: Annual rate 784.6

Rationale:

- The table below compares local SUS data for 19/20 against the data pack provided by NHSX. The national average rate per 100,000 population for 19/20 is 896.52 as per NHSX data.

HWB	NHSX 19/20	Local SUS 19/20	Actual 20/21	Plan 21/22
Cambridgeshire	825.2	851.6	685.8	830.56
Peterborough	935.0	836.4	630.3	784.55

- Although Cambridgeshire rate is below national average, based on local historical data, the rate has increased year on year since 2013/14 from 659.21 per 100,000.
- In Peterborough, the rate has remained steady between 835-837 per 100,000 since 2016/17, the local data being significantly below the information provided by NHSX.
- 2020/21 was an exceptional year with a significantly lower number of unplanned admissions due to the covid pandemic. Therefore the 2021/22 proposed plan is based on a mid-point projection of local data.
- The Cambridgeshire and Peterborough system has the following in place to support:
  - An established UCR service supporting Primary Care, Community Services and the Out of Hours service. The service works with ED to identify patients who can be supported in the community without being admitted.
  - Local Primary care led scheme in the North to allow ambulance crews to access health and social care support for up to 5 days to allow the patient to remain at home with support who would otherwise be conveyed
  - Enhanced Support Service (ERS) – A local authority led service providing input into patients who have called/triggered their lifeline call system (normally following a fall) – this service provides direct rapid response either via telephone/F2F to rapidly intervene to avoid an ambulance being called/dispatched
  - NHS 111 validation of 999/ED call dispositions by a GP to avoid an ambulance dispatch.
  - Dedicated NHS 111 clinical assessment service (CAS) to facilitate Minor injury assessment and consultant opinion
  - Dedicated Palliative care helpline via NHS 111 direct to a specialist palliative care nurse
  - Dedicated Mental Health first response service via NHS 111 Option 2 for people experiencing a MH Crisis
  - Review/refresh of the NHS 111 Directory of Services – to ensure that patients can be provided with the most up to date information on services other than Hospital following a call to NHS 111 or 999
  - Ensuring that all MIUs are staffed and open to provide an alternative urgent care pathway to that of hospital
- Moving towards an ICS and the work on system recovery priorities focusing on Long Term Conditions which affect the group of patients in this metric. This is supported by our strategic approach to place-based delivery via integrated neighbourhoods to ensure that people are supported in their communities to remain independent for as long as possible. The development of pilot projects extending the scope of the current UCR service and considering the use of digital technologies to enable conditions to be effectively managed at Home are being developed.

Reducing length of stage in hospital, measured through the percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days

Recommended 2021/22 Target:

Cambridgeshire:

Quarter	14 Day Target	21 Day Target
Q3	12.8%	6.81%
Q4	14%	7.41%

Peterborough:

Quarter	14 Day Target	21 Day Target
Q3	12%	6.2%
Q4	12.3%	6.6%

Rationale:

- Local Cambridgeshire data for 2021/22, Q2 is 12.8% (14+ days) in, the planned target for Q3 is to hold the same position. Historically performance decreases in Q4 due to winter pressures, although an increased target when comparing the performance in Q4 to Q1, this represents an increase 2.36% which is less than the actual increase of 3.07% in 2020.21.
- Local data for 2021/22, Q2 is 12% (14+days) in Peterborough, also the plan is to hold the same position in Q3, with an increased target in Q4, due to the current pressures in the system with a target lower than 2020/21 Q4 actual of 12.69%.
- The BCF funding enables, continued support from Community Services, Local Authority and Voluntary Sector in the timely discharge of patients from hospital. Building on the integrated ways of working established during the pandemic, ECIST and NESTA are supporting the system to transform discharge pathways, introduction of 100 day discharge challenge and 'push and pull' pilot models.
- The BCF funding enables the Local Authority to ensure there is sufficient capacity in the system to reduce delays. An approach being worked on is changing the way Domiciliary Care is commissioned to deliver at place.
- To improve patient flow the Trusts will review their internal processes and to identify other reasons for delays in discharge.
- For the remainder of this year these targets will be particularly challenging as services recover to reduce backlogs, NEL Admissions in Peterborough are back to 2019/20 levels whilst managing the continued effects of covid. Workforce within the hospitals is reduced to covid and capacity in the community is limited. In addition, it should be noted that Peterborough and Cambridgeshire have been designated as Enhanced Response Areas due to the particular challenges we are experiencing relating to covid.
- During the winter there is additional investment in the voluntary sector to support patients being discharged from our local hospitals, including QEHKL.

Improving the proportion of people discharged home using data on discharge to their usual place of residence

Recommended 2021/22 Target:

Cambridgeshire: 95%
Peterborough: 95%

Rationale:

- The 2021/22 plan of 95% to discharge patients to their usual place of residence for both Cambridgeshire and Peterborough, is based on the projected upper confidence level of local SUS data. In the last 12 months the actual percentage discharged was 91.01% in Cambridgeshire and 91.6% in Peterborough.
- The accuracy of this data is not assured due to 'discharge to usual place of residence' being the default. Further discussions will be required for assurance on the data and what validation methods are used.
- The system are currently reviewing the Discharge pathways 0 and 1 which will support the delivery of this target.

CAMBRIDGESHIRE & PETERBOROUGH HEALTH & WELLBEING BOARD WHOLE SYSTEM JOINT SUB-COMMITTEE	AGENDA ITEM No. 12
DATE: 25th March 2022	PUBLIC REPORT

ELY PHARMACY CONSOLIDATION (RESPONSE ON BEHALF OF THE CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD)

R E C O M M E N D A T I O N S	
To:	*Cambridgeshire and Peterborough Health and Wellbeing Board Whole System Joint Sub-Committee*
From:	*Iain Green, Team Manager Health in All Policies*

The Cambridgeshire and Peterborough Health and Wellbeing Board Whole System Joint Sub-Committee is asked to note the submitted response to the Ely Pharmacy Consolidation application approved by the Chair and the Director of Public Health on behalf of the Cambridgeshire Health and Wellbeing Board.

	Officer contact:		***Member contact:***
Name:	Iain Green	Name:	Cllr Susan Van de Ven
Post:	Team Manager Health in All Polices	Role	Chair of the Cambridgeshire Health and Wellbeing Board
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1.	**BACKGROUND**
1.1	The Health and Wellbeing Board has a **statutory duty** to respond to applications for "consolidations" (consolidations are where two or more pharmacies apply to merge). The proposed merger could result in a pharmacy closing and therefore could create a gap in pharmacy provision.
1.2	Applications for consolidations are not common, usually less than 2 per year are received by each Board, however with the frequency of board meetings it is not always possible to bring a draft response to a consolidation application to the Board for approval within the prescribed response time of 45 days. Therefore at the 30th May 2019 Board meeting delegated approval was given to the Director of Public Health with the Chair and Vice Chair of the Board to approve consolidation application responses on behalf of the board (should an application be received outside of the board's meeting schedule).
1.3	An application for a consolidation was received by the Cambridgeshire Health and Wellbeing Board in December 2021 for a consolidation of two pharmacies in Ely. As there was not a meeting of the Board scheduled within 45 days of the application being received a response was produced and agreed by the Chair and the Director of Public Health and submitted to NHS England in accordance with the agreed delegated authority.
2.	**PURPOSE**
2.1	Members of the Board are asked to note the response already submitted on the Board's behalf. A full copy of the response can be found at Appendix A to this report.
2.2	The application was for the consolidation onto the site at 64 St Marys Street, Ely, Cambridgeshire, CB7 4EY of Advanced Pharmacy already at that site and St Marys Pharmacy currently at 50 St Marys Street, Ely, Cambridgeshire, CB7 4EY.
2.3	The main conclusions submitted as part of the response are: • Cambridgeshire now (January 2022) has one pharmaceutical service provider per 4,501, compared to 1 per 4,402 residents as at January 2020, and one per 4,261 residents at the time of the 2017 PNA. A reduction of one community pharmacy as a result of this consolidation application, from 106 to 105, would result in the rate of pharmaceutical service providers per 100,000 resident population in Cambridgeshire remaining at 22/100,000. • Accessibility to pharmacy services in Ely by all modes of transport remain relatively unaffected by the closure of the 50 St Marys Street site, the vast majority of Ely residents will still have access to a pharmacy within a journey time of 15 minutes by walking or 12 minutes by cycling, and all residents will have access to a pharmacy with 20 minutes by other modes of Transport. • The proposed opening times for the consolidated site do lead to a reduction in opening hours compared to the current actual opening hours as the closing site is a 100 hours pharmacies, however there are two remaining 100 Hour pharmacies (Tesco and Sainsbury's). Tesco is a 6-10 minute drive from the closing pharmacy and Sainsbury's is 5-6 minutes away by car. • There are no proposed changes to the dispensing of appliances and no change in advanced and enhanced services provided. • The Health and Wellbeing Board is concerned that the consolidated site does not propose to expand its physical capacity, and therefore there may be additional

	pressures resulting from increased use of the consolidated site from former customers of the closing site, in addition Ely is a high growth area. Therefore in conclusion, it is the opinion of the Cambridgeshire Health and Wellbeing Board that the proposed removal of premises from the pharmaceutical list (the consolidation of the 50 St Marys Street site and 64 St Marys Street site) would **not** create a gap in pharmaceutical services that could be met by a routine application (a) to meet a current or future need for pharmaceutical services, or (b) to secure improvements, or better access, to pharmaceutical services, but is concerned that the consolidated site may not be large enough to cope with the pressures put on it by the consolidation and transfer of clients and the anticipated growth in Ely.
3.	**CONSULTATION**
3.1	In accordance with the approved delegated authority the Chair of the Health and Wellbeing Board, the Director of Public Health were consulted. In addition comments were also sought and received from the Local Members for Ely, and the Chair of the Adults and Health Committee.
4.	**ANTICIPATED OUTCOMES OR IMPACT**
4.1	The response to the application will be used by NHS England in making their decision as to whether the consolidation application should be approved or refused.
5.	**IMPLICATIONS**
	Financial Implications
5.1	None
	Legal Implications
5.2	The Health and Wellbeing Board has a statutory duty to respond to applications for “consolidations”, for all other applications the board has power to respond but not a duty. Consolidations are where two or more pharmacies apply to merge, which could result in a pharmacy closing and therefore could create a gap in pharmacy provision. The submitted response fulfils the legal duty placed on the Board.
	Equalities Implications
5.3	There are no direct equality implications as a result of this report.
6.	**APPENDICES**
6.1	Appendix 1 – CAS-114240-Q5G0Q9 Consolidation St Marys Street Ely Cambs HWB Response Final

7.	**SOURCE DOCUMENTS**

Source Documents	Location
Pharmaceutical needs assessments Information pack for local authority health and wellbeing boards October 2021	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1029805/pharmaceutical-needs-assessment-information-pack.pdf

My ref:

Your ref: CAS-114240-Q5G0Q9
Date: 04-02-2022

Contact: Iain Green
Direct 01223 703257
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Cambridgeshire County Council

Public Health Directorate
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Dear Mr Speight

Consolidation onto the site at 64 St Marys Street, Ely, Cambridgeshire, CB7 4EY of Advanced Pharmacy already at that site and St Marys Pharmacy currently at 50 St Marys Street, Ely, Cambridgeshire, CB7 4EY.

Thank you for consulting the Cambridgeshire Health and Wellbeing Board on the above application; this is a response on behalf of the Cambridgeshire Health and Wellbeing Board.

The Cambridgeshire Health and Wellbeing Board is required to:
"*…indicate whether, if the application were granted, in the opinion of the Health and Wellbeing Board the proposed removal of premises from the pharmaceutical list would or would not create a gap in pharmaceutical services that could be met by a routine application (a) to meet a current or future need for pharmaceutical services or (b) to secure improvements, or better access, to pharmaceutical services.*

Current Cambridgeshire Pharmaceutical Needs Assessment 2017.
The current Cambridgeshire Pharmaceutical Needs Assessment (PNA), published July 2017, states that:

Current provision of local pharmaceutical services
Key finding: There is currently sufficient pharmaceutical service provision across Cambridgeshire. No need for additional pharmaceutical service providers was identified in this PNA.

Cambridgeshire has one pharmaceutical service provider per 4,258 people, equivalent to 23 pharmaceutical service providers per 100,000 resident population in Cambridgeshire. This is the same as the national average of 23 per 100,000 resident population and slightly lower than the East of England average of 24 pharmaceutical providers per 100,000 resident population.

Estimates of the average number of people per pharmaceutical service provider across Cambridgeshire have remained relatively stable since 2011.

As of July 2016 there were:

- *110 pharmacies in Cambridgeshire (only slightly more than 109 in July 2013 and 101 in January 2011).*
- *43 dispensing GP practices in Cambridgeshire (unchanged from July 2013 and January 2011).*
- *One Dispensing Appliance Contractor (unchanged since 2011).*

Taking into account current information from stakeholders including community pharmacies and dispensing GP practices, the number and distribution of pharmaceutical service provision in Cambridgeshire is sufficient. The distribution of pharmacies and dispensing GP practices appears to cover the county well with few gaps and some concentrations. Some geographical gaps appear to exist in some of the less populated areas in the north and southern fringes of the county but these localities are served by suppliers from outside the county. In terms of postal addresses, across all of Cambridgeshire, there are only 67 postal addresses registered as a residential property that are located more than 20 minutes away by car from a pharmacy or dispensing surgery.

Review of the locations, opening hours and access for people with disabilities, suggest there is adequate access to NHS pharmaceutical services in Cambridgeshire. There appears to be good coverage in terms of opening hours across the county. Overall, out of 110 community pharmacies, 45 (41%) are open after 6pm and 26 (24%) are open after 7pm on weekdays; 90 (82%) open on Saturdays; and 22 (20%) open on Sundays. The out of hours service, Hertfordshire Urgent Care is required to arrange for the provision of a full course of treatment, if clinically necessary, before a community pharmacy is open.

Home delivery services can help to provide medications to those who do not have access to a car or who are unable to use public transport. Of the pharmaceutical providers who completed the questionnaire, 89 pharmacies (95.7%) and 21 dispensing GP practices (61.8%) have some form of delivery service in operation, which is more than in 2013.

The proportion of providers reporting that they have wheelchair access to consultation facilities has increased since 2013 from 80.4% to 93% of community pharmacies and from 86.8% to 88.2% of dispensing GP practices.

All community pharmacy and GP dispensing practices who responded to the questionnaire considered local provision to be 'adequate' or better, with 39% of pharmacies and 56% of dispensing GP practices reporting provision as 'excellent' and 55% of pharmacies and 41% of dispensing GP practices as 'good'.

Cambridgeshire PNA Supplementary Statement 2020

A Supplementary Statement was issued by the Health and Wellbeing Board in July 2020 reaffirms the position of the 2017 PNA, it states: *The current Cambridgeshire PNA expires in July*

2020 and the Cambridgeshire PNA Steering group started the production of the next version of the PNA. The steering group had produced a draft 2020 PNA and had consulted with pharmaceutical services as part of that process. The Draft PNA was due to be published for the 60 day statutory consultation in March 2020, in the light of Covid-19 the PNA steering group decided not to proceed with the public consultation and instead take the findings from the draft PNA and issue a Supplementary Statement reflecting the current position of pharmaceutical services in Cambridgeshire.

In addition the Department for Health and Social Security announced: "The Pharmaceutical Needs Assessments (PNA) are due to be renewed and published by Local Authority Health and Wellbeing Boards in April 2021, however due to current pressures across all sectors in response to the COIVD-19 pandemic, the requirement to publish renewed PNA's will be suspended until April 2022. Local Authority Health and Well Being Boards will retain the ability to issue supplementary statements to respond to local changes and pharmaceutical needs during this time. The NHS Pharmaceutical and Local Pharmaceutical Services Regulations 2013 will be updated in due course."

The supplementary statement therefore is an updated picture of pharmaceutical needs in Cambridgeshire, but still should be read in conjunction with the 2017 PNA.

The position at the July 2020 Supplementary Statement is that a review of numbers of community pharmacies from NHS Digital data[1] and dispensing general practices from NHS England data[2] shows that the total number of pharmaceutical service providers (community pharmacies and dispensing general practices combined) per 100,000 resident population in Cambridgeshire remained unchanged from the time of the 2017 Cambridgeshire County Council PNA, within which provision was deemed adequate. It concludes that: *Several large-scale housing developments are in progress in Cambridgeshire and have been considered when assessing the need for local pharmaceutical services.* ***The level of growth has not resulted in any need for additional pharmaceutical services.***

A review undertaken in January 2022 for this application of the numbers of community pharmacies from data provided by the Cambridgeshire & Peterborough Local Pharmaceutical Committee and dispensing general practices from Cambridgeshire & Peterborough Clinical Commissioning Group data shows that the total number of pharmaceutical service providers (community pharmacies and dispensing general practices combined) per 100,000 resident population in Cambridgeshire has reduced, from 23 to 22, compared to provision at the time of the 2017 Cambridgeshire PNA.

[1] Source https://digital.nhs.uk/data-and-information/publications/statistical/general-pharmaceutical-services/in-2008-09---2018-19-ns
[2] https://www.england.nhs.uk/mids-east/our-work/pharm-info/

Time of Review of Cambridgeshire Pharmaceutical Provision	Community Pharmacies	Dispensing General Practices	Total Pharmaceutical Providers	ONS Mid-Year Population	Pharmaceutical Service Providers per 100,000 Resident Population
January 2017	110	43	153	651,940 (mid-year 2016)	23
January 2020	108	40	148	651,428 (mid-year 2018)	23
January 2022	106	40	146	657, 204 (mid-year 2020)	22

Cambridgeshire now (January 2022) has one pharmaceutical service provider per 4,501, compared to 1 per 4,402 residents at January 2020, and one per 4,261 residents at the time of the 2017 PNA.

A reduction of one community pharmacy, from 106 to 105, as a result of this consolidation application being approved would result in the rate of pharmaceutical service providers per 100,000 resident population in Cambridgeshire remaining at 22/100,000.

Distance & Travel Times

In terms of the proposed consolidation of the pharmacies to the one site at 64 St Marys Street, Ely it is important to consider access to any existing pharmacy provision and any resulting gaps in provision from the loss of one location.

The 2008 White Paper 'Pharmacy in England: Building on Strengths, Delivering the Future' states that it is a strength of the current system that community pharmacies are easily accessible and that 99% of the population – even those living in the most deprived areas – can get to a pharmacy within 20 minutes by car and 96% by walking or using public transport.

The maps in **Appendix 1(A-D)** were created using the Strategic Health Asset Planning and Evaluation (SHAPE)[3] mapping tool and illustrate a travel times by cycling, walking, car and Public Transport, 20 minutes is recognised nationally as an acceptable journey time) from the closing and consolidated sites to identify any gaps in accessibility. The maps show that accessibility to pharmacy services in Ely by all modes of transport remain unaffected by the closure of the 50 St Marys Street site, the current pharmacy sites are only 50 meters apart with a journey time on foot between the two of a few minutes. Ely residents will still have access to a pharmacy within a journey time of 15 minutes by walking or 12 minutes by cycling, and all residents will have access to a pharmacy with 20 minutes by other modes of Transport.

[3] https://shapeatlas.net/

There are 4 other pharmacies in Ely (3 within the city centre) as shown in Appendix 2, the closest (Boots Pharmacy) is less than a ten minute walk from closing site

Opening times
The proposed opening times on the application form for the consolidated site leads to a reduction in opening hours as a result of the consolidation as the closing site is a 100 hours pharmacy.

The total opening times as stated on the application form are as follows:

Site 1 (64 St Marys Street Ely – Consolidated Site)		**Site 2 (50 St Marys Street, Ely – Closing Site)**	
Monday	09:00-19.00	Monday	12.00 – 18:30
Tuesday	09.00-18:00	Tuesday	12.00 – 18:30
Wednesday	09:00-19.00	Wednesday	12.00 – 18:30
Thursday	09.00-18:00	Thursday	12.00 – 18:30
Friday	09.00-18:00	Friday	12.00 – 18:30
Saturday	09.00-17:00	Saturday	09:00 – 16:30
Sunday	Closed	Sunday	Closed
	55 Hrs		100 Hrs

100 Hour Pharmacies
100 hour pharmacies are pharmacies which are contracted to open for at least 100 hours per week for the provision of pharmaceutical services).
The closing site is a 100 Hour pharmacy, and the proposed consolidated site is not proposing to continue the 100 hours service, therefore if the consolidation is approved it would lead to a loss of a 100 hour pharmacy in Ely, however, there are two remaining 100 Hour pharmacies (Tesco and Sainsbury's) Tesco is a 6-10 minute drive from the closing pharmacy and Sainsbury's is 5-6 minutes away by car. This is shown in Appendix 2.

Primary Care Network (PCN) Profile
Both pharmacies (closing site and consolidated site) are located in the "Ely North PCN), the PCN has the following characteristics (reported in the 2019 PCN Profile):

- There are almost 37,900 people registered with Ely North PCN, with higher proportions of the population aged under 18 years and over 65 years compared to the South Alliance, CCG and England. The population is estimated to increase by almost 25% between 2021 and 2036.
- The PCN has a higher proportion of White British ethnic group compared to the South Alliance, CCG and England.
- Relative deprivation is higher for the PCN compared to the South Alliance but lower than the CCG and England. Approximately 9% of children and 10.3% of older people live in poverty.
- Recorded obesity in adults is statistically significantly higher than the South Alliance.
- It is estimated that 15% of adults smoke, which is statistically significantly higher than the South Alliance.

- Estimates of people reporting long-term activity-limiting illness and being in Good or Very Good health are statistically worse than the averages for the South Alliance, which may be a reflection of the relatively older population.
- The PCN has statistically significantly high recorded prevalence of CHD, hypertension, stroke, asthma, COPD, diabetes and cancer compared to the South Alliance averages. This may relate to the relatively high older people population in the PCN.
- The PCN has statistically significantly higher rates of Children's early help cases than the South Alliance
- Overall adult social care rates are statistically significantly higher than the South Alliance
- The first outpatient attendances, elective admissions and emergency admission rates are statistically significantly higher than the South Alliance

Changes to Service Provision
There are no proposed changes to the dispensing of appliances and no change in advanced and enhanced services across the two sites the consolidated site already provides all the services currently provided at the closing site and continue to do so.

Premises Facilities (Access)
The consolidation removes a site which has limited car parking which is on street, to one closer to public parking, there is no change in access to car parking for existing users of the consolidated site (64 St Marys Street) and little change for current users of the closing site.

Housing Growth in Ely
There are concerns that the consolidated site may not be able to cope with the additional growth due to housing growth. Ely is an area for Housing growth identified in the East Cambridgeshire Local Plan and referenced in the current Pharmaceutical Needs Assessment. The consolidated site is not proposing any enlargement of space, the current waiting area, consulting room, storage and staff areas etc. will have to take on the existing clients from the closing site as well as any from the planned growth in Ely. The documents provided don't give an indication of current numbers of people served at the closing site and the expected extra demand that will transfer to the consolidated site.

There will be additional pressure on staff at the consolidated site to deliver vital public health services including flu vaccines, LFT distribution and pandemic delivery services at a time of high demand on these services, and an increasing reliance on community pharmacies generally. Therefore the Health and Wellbeing Board is concerned at the consolidation of demand on a pharmacy that does not propose to expand its capacity, serving a high growth area.

Summary and Conclusions
In summary:

- Cambridgeshire now (January 2022) has one pharmaceutical service provider per 4,501, compared to 1 per 4,402 residents as at January 2020, and one per 4,261 residents at the time of the 2017 PNA. A reduction of one community pharmacy as a result of this consolidation application, from 106 to 105, would result in the rate of pharmaceutical service providers per 100,000 resident population in Cambridgeshire remaining at 22/100,000.

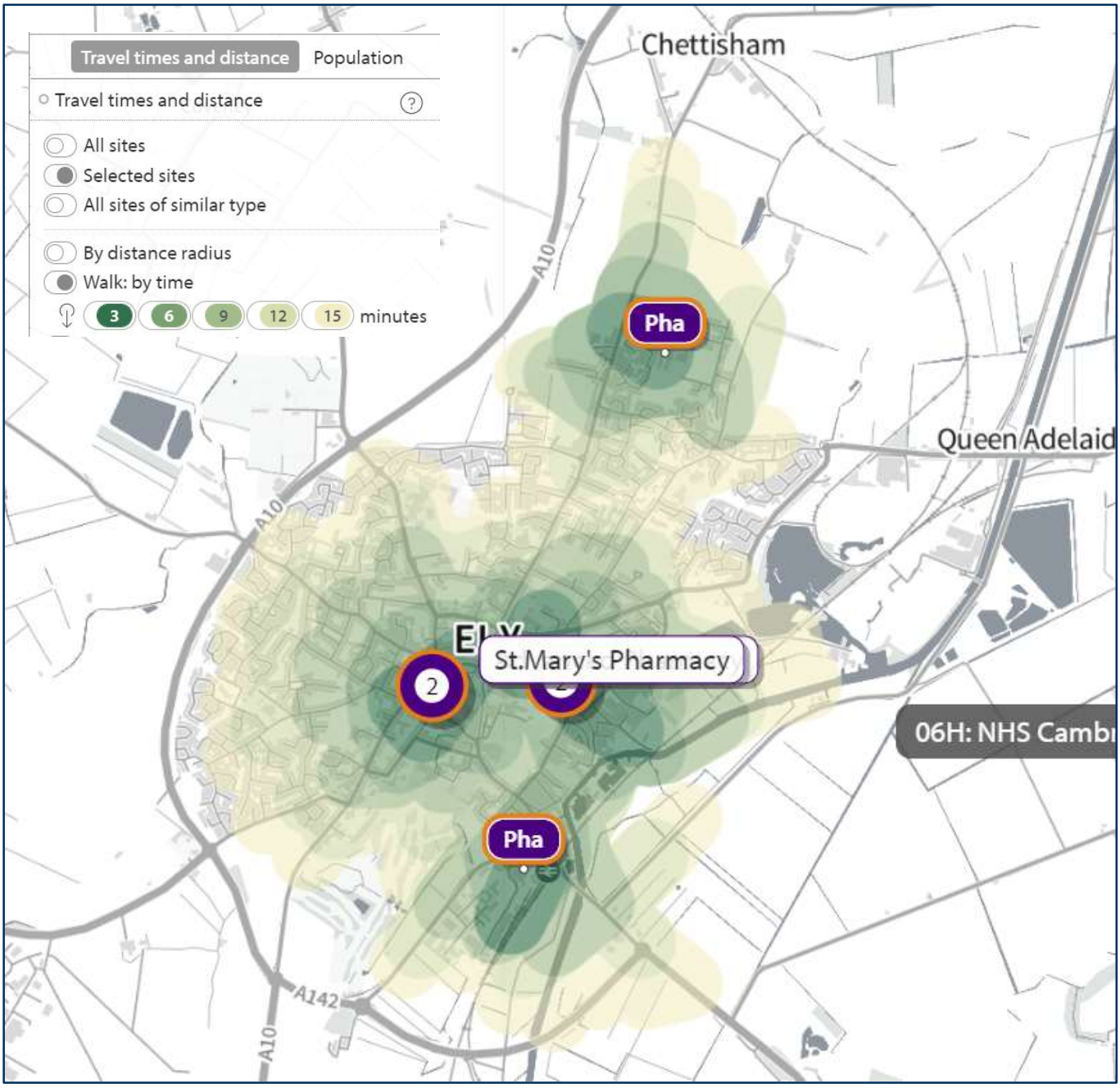
- Accessibility to pharmacy services in Ely by all modes of transport remain relatively unaffected by the closure of the 50 St Marys Street site, the vast majority of Ely residents will still have access to a pharmacy within a journey time of 15 minutes by walking or 12 minutes by cycling, and all residents will have access to a pharmacy with 20 minutes by other modes of Transport.
- The proposed opening times for the consolidated site do lead to a reduction in opening hours compared to the current actual opening hours as the closing site is a 100 hours pharmacies, however there are two remaining 100 Hour pharmacies (Tesco and Sainsbury's). Tesco is a 6-10 minute drive from the closing pharmacy and Sainsbury's is 5-6 minutes away by car.
- There are no proposed changes to the dispensing of appliances and no change in advanced and enhanced services provided.
- The Health and Wellbeing Board is concerned that the consolidated site does not propose to expand its physical capacity, and therefore there may be additional pressures resulting from increased use of the consolidated site from former customers of the closing site, in addition Ely is a high growth area.

Therefore in conclusion, it is the opinion of the Cambridgeshire Health and Wellbeing Board that the proposed removal of premises from the pharmaceutical list (the consolidation of the 50 St Marys Street site and 64 St Marys Street site) would **not** create a gap in pharmaceutical services that could be met by a routine application (a) to meet a current or future need for pharmaceutical services, or (b) to secure improvements, or better access, to pharmaceutical services, but is concerned that the consolidated site may not be large enough to cope with the pressures put on it by the consolidation and transfer of clients and the anticipated growth in Ely.

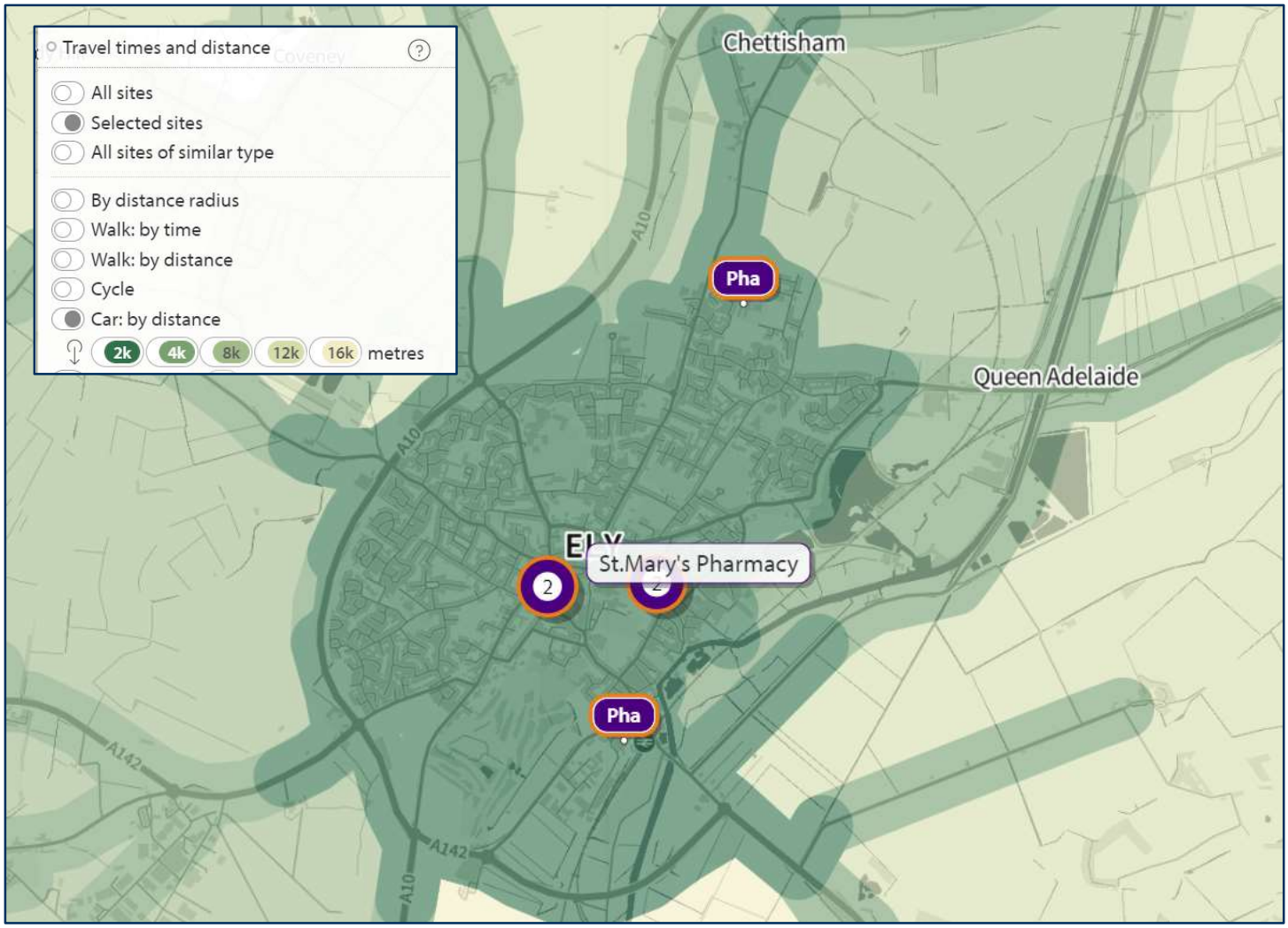
Yours sincerely

Iain Green
Team Manager Health in All Policies, Cambridgeshire County Council
For and on behalf of the Cambridgeshire Health and Wellbeing Board

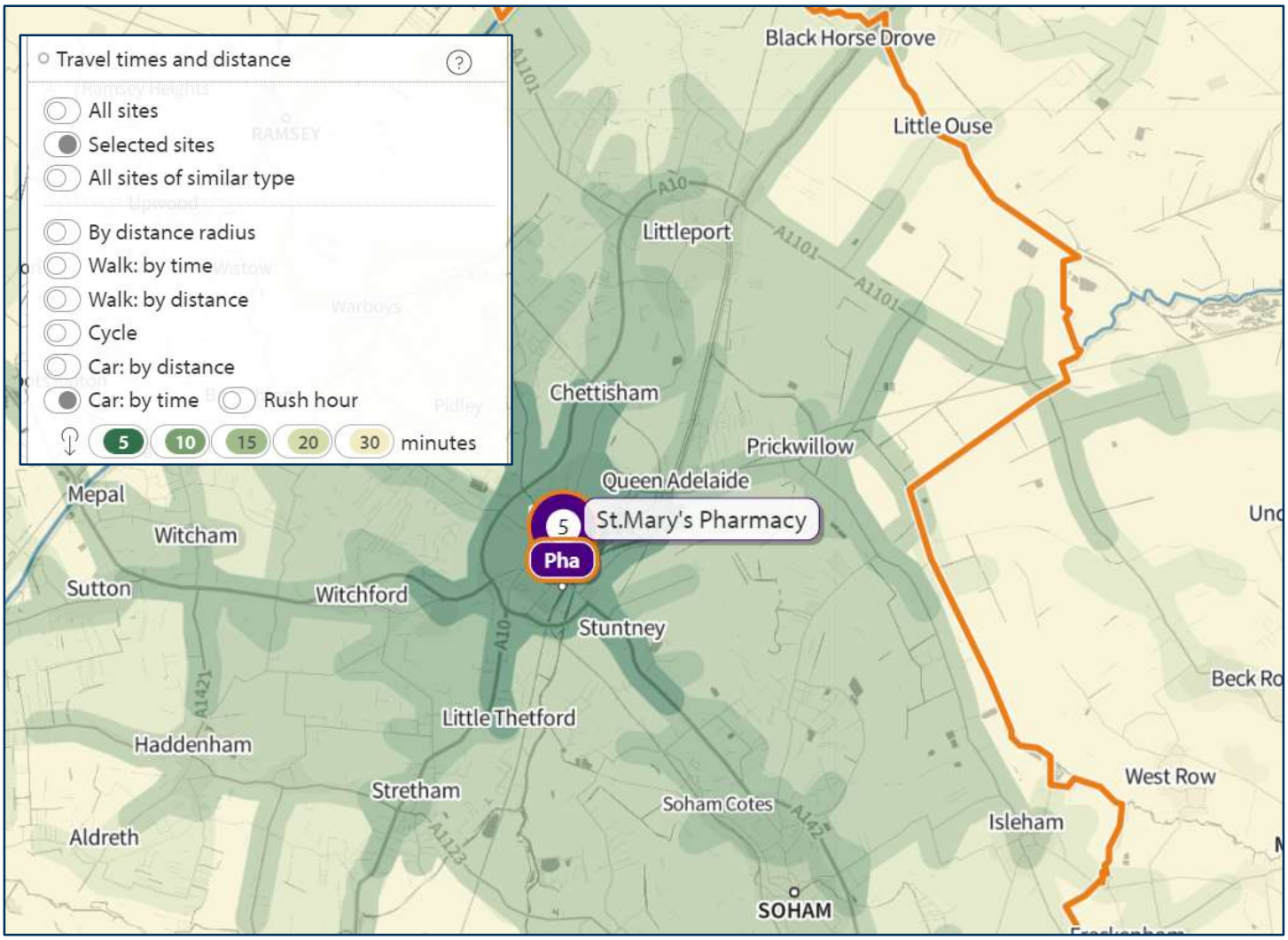
Appendix 1A – Travel Time by Walking



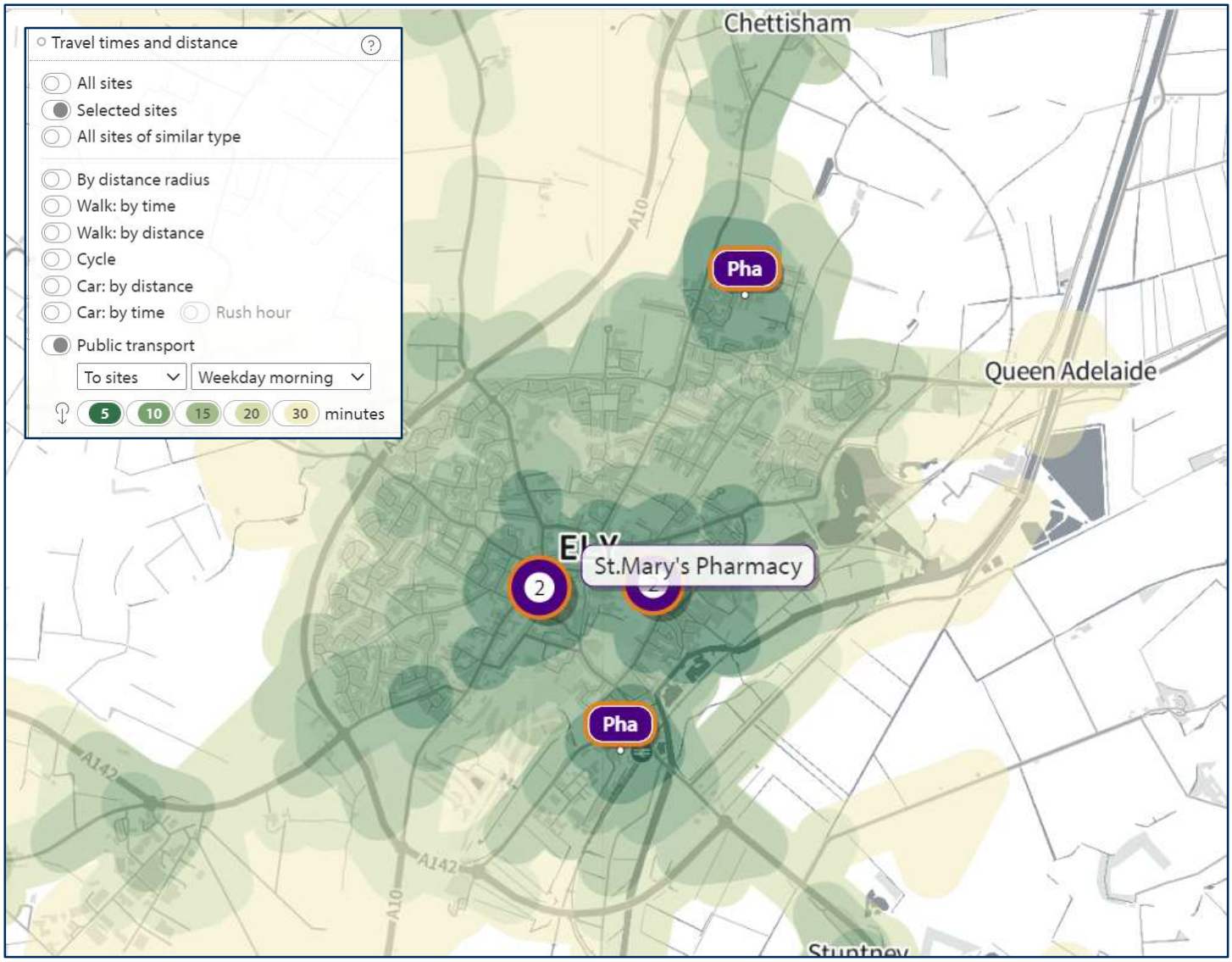
Appendix 1B – Travel Time by Cycling



Appendix 1C – Travel Time by Car

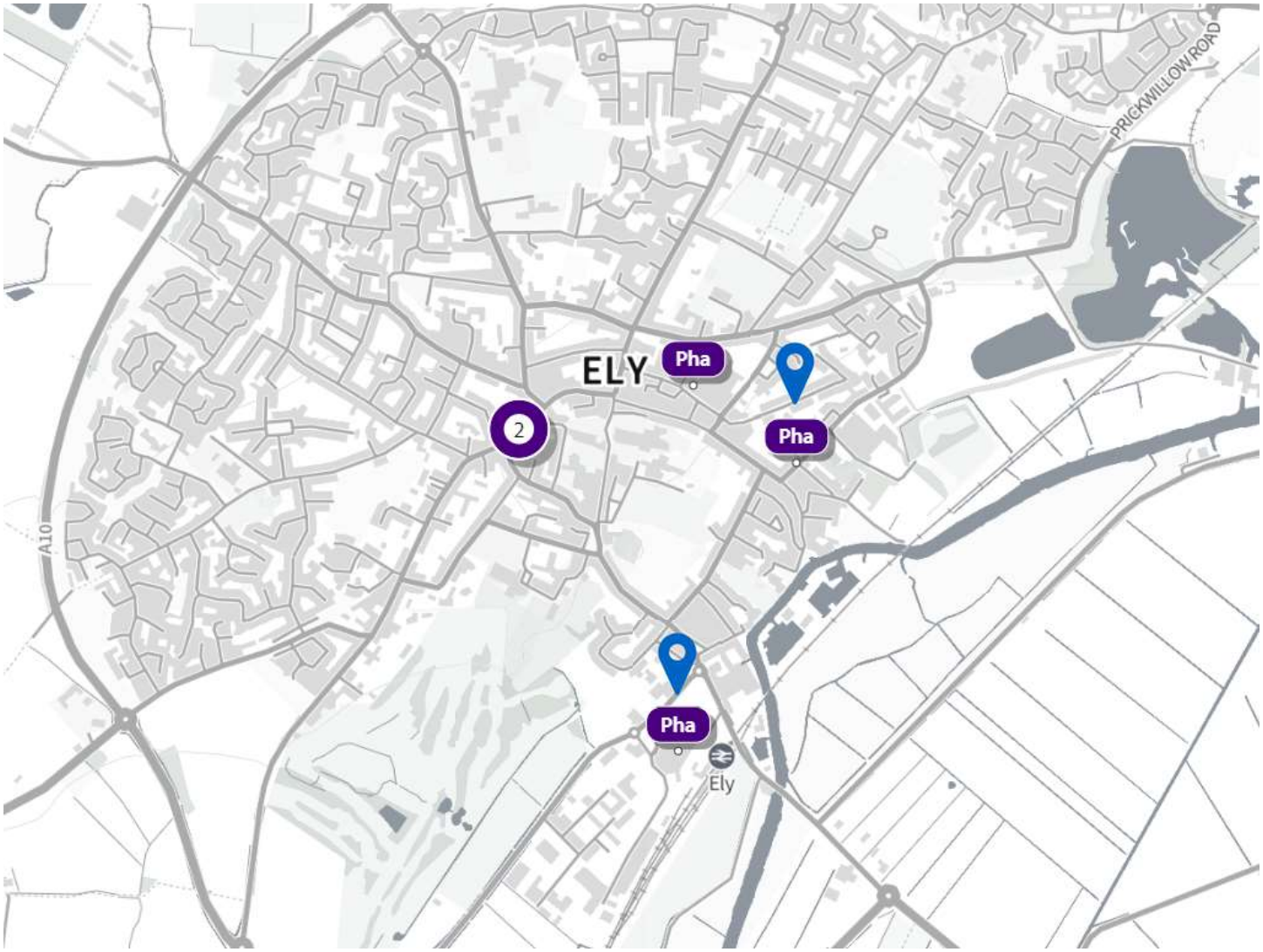


Appendix 1D – Travel Time by Public Transport



Appendix 2 –Closing and Consolidated sites

Appendix 3 – 100 Hours Pharmacies



100 Hours Pharmacy