Cambridgeshire & Peterborough Integrated Care System

Cambridgeshire County Council

PETERBOROUGH CITY COUNCIL

Joint Cambridgeshire and Peterborough Health and Wellbeing Board / Integrated Care Partnership

Date: Friday 22nd March 2024

Time: Venue: 14.00 hrs – 16.00 hrs

Red Kite Room, New Shire Hall, Alconbury Weald, Huntingdon PE28 4YE

Agenda

Open to the Public & Press

1.	Welcome & Apologies ▪ Declarations of interest: Guidance on declaring interests is available at: Declaration of Interest	Chair	14:00
2.	Minutes of the Cambridgeshire and Peterborough Health and Wellbeing Board / Integrated Care Partnership 19th January 2024	Chair	
3.	HWB /ICS Strategy Priority 4 Update ▪ ***For update***	Kathy Hartley	14:05
4.	Better Care Fund Q3 Reports ▪ ***For Update & Approval***	Caroline Townsend Leesa Murray Sandra Pedley	15:05
5	Joint Forward Plan - Refresh ▪ ***For Decision***	Kit Connick	15:20
6.	Learning Disability JSNA Action Plan ▪ ***For Update***	Emily Smith	15:40
7.	Healthy Places JSNA Consultation Briefing ▪ ***For Approval***	Iain Green Bryn Hilton	15:50
8.	Any other business	All	

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

Name/Post: Martin Whelan, Head of Governance and Data Protection Officer Email: cpicb.icsgovernanceteam@nhs.net

Joint Cambridgeshire and Peterborough Health and Wellbeing Board / Integrated Care Partnership

Date: Friday 19th January 2024
Time: 10.30 hrs – 12.30 hrs
Venue: Red Kite Room, New Shire Hall, Alconbury Weald, Huntingdon PE28 4YE

MINUTES

Present:

Members:

Cllr Saqib Farooq	Peterborough City Council Cabinet Member for Adults and Health (Chair)
John O'Brien	Integrated Care Board Chair (Co-Chair)
Cllr Susan van de Ven	Vice-Chair of Adults and Health Committee (lead member for HWB) – Cambridgeshire County Council (Co-Chair)
Jyoti Atri	Executive Director of Public Health, Cambridgeshire County Council and Peterborough City Council
Cllr Mike Black	Representative of the Chair of Adult and Health Committee, Cambridgeshire County Council
Cllr Ray Bisby	Peterborough City Council Cabinet Member for Children's Services
Kit Connick	ICB Chief Officer Strategy and Partnerships
Ged Curran	ICB Non-Executive Members
Julie Farrow	Voluntary and Community Sector Representative
Stewart Francis	Cambridgeshire and Peterborough Healthwatch Chair
Paul Medd	Chief Executive of Fenland District Council and District Council representative (North)
Dr Neil Modha	Primary Care Representative (North)
Stephen Taylor	Executive Director of Adult Services, Peterborough City Council
Piers Ricketts	Chief Executive, Eastern Academic Health Science Network
Patrick Warren-Higgs	Executive Director Adults, Health, and Commissioning, Cambridgeshire County Council
Liz Watts	Chief Executive of South Cambridgeshire District Council and District Council representative (South)

Present (Virtually):

Rob Bridge	Chief Executive, Cambridgeshire and Peterborough Combined Authority
Mary Elford	Chair of Cambridgeshire Community Services NHS Trust (CCS)
Anna Smith	Deputy Mayor of Cambridgeshire and Peterborough Combined Authority representing the Mayor of the Combined Authority

Apologies

Prof. Steve Barnett	Chair, North-West Anglia NHS Foundation Trust
John Gregg	Executive Director of Children's Services, Peterborough City Council
Claire Higgins	Voluntary and Community Sector Representative
Cllr Richard Howitt	Chair of Adults and Health Committee - Cambridgeshire County Council
Dr. Zoe Hutchinson	Primary Care Representative (South)
Dr Nik Johnson	Mayor of Cambridgeshire and Peterborough Combined Authority
Louis Kamfer	Managing Director Strategic Commissioning and Deputy Chief Executive, ICB
Dr Mike More	Chair, Cambridge University Hospitals NHS Foundation Trust
Darryl Preston	Police and Crime Commissioner
Jan Thomas	ICB Chief Executive
Prof. John Wallwork	Chair, Royal Papworth Hospital NHS Foundation Trust

Officers and others present:

Steve Bush	Director of Children and Young People's Services, Cambridgeshire Community Services NHS Trust
Iain Green	Team Manager Health in All Policies, Cambridgeshire County Council
Richenda Greenhill	Democratic Services Officer, Cambridgeshire County Council
Raj Lakshman	Consultant in Public Health, Lead for Children & Clinical Policies Cambridgeshire County and Peterborough City Council
Leesa Murray	Head of Adults Commissioning, Peterborough City Council
Jonathan Lewis	Service Director for Education, Cambridgeshire County Council
Kate Parker	Head of Public Health Business Programmes, Peterborough City Council and Cambridgeshire County Council
Sandra Pedley	Associate Delivery Partner Performance and Delivery, ICB
Naomi Siakpere	Corporate Governance Administrator, ICB
Caroline Townsend	Head of Partnerships and Programmes, Cambridgeshire County Council
Sati Ubhi	Chief Pharmacist, ICB
Martin Whelan	Head of Governance and Data Protection Officer, ICB

1 Apologies for Absence and Declaration of Interest

Apologies for absence were received from Jan Thomas (ICB Chief Executive), Dr. Nik Johnson (Mayor of Cambridgeshire and Peterborough Combined Authority), Darryl Preston (Police and Crime Commissioner), Mike Moore (Chair, Cambridge University Hospitals NHS Foundation Trust), Louis Kamfer (Managing Director Strategic Commissioning and Deputy Chief Executive, ICB), Dr Zoe Hutchinson (Primary Care Representative (South)), John Gregg (Executive Director of Children's Services, Peterborough City Council) , Prof. Steve Barnett (Chair, North West Anglia NHS Foundation Trust), Cllr Richard Howitt (Chair of Adults and Health Committee - Cambridgeshire County Council), Prof. John Wallwork (Chair, Royal Papworth Hospital NHS Foundation Trust), and Claire Higgins (Voluntary and Community Sector Representative).

The Chair, Councillor Saqib Farooq welcomed members and attendees.

There was no new declaration of interest.

2 Minutes of the Cambridgeshire and Peterborough Joint Health and Wellbeing Board and Integrated Care Partnership 20 October 2023

The minutes of the last meeting 20th October 2023 were subject to amendment of Item 7 - AOB, 2nd paragraph to state "with the implementation of the smoke free generation, any child who is 14 years will never be able to legally purchase cigarettes". In absence of any other amendment the minutes were agreed as accurate.

3 HWB ICS Strategy Priority 1 – Childrens Update

The Joint Health and Wellbeing Board/Integrated Care Partnership received the Priority 1 Children's update from the Consultant in Public Health, Lead for Children & Clinical Policies Cambridgeshire County and Peterborough City Council, the Service Director for Education, Cambridgeshire County Council, and the Director of Children and Young People's Services, Cambridgeshire Community Services NHS Trust.

The report provided a progress update against the 10 deliverables of the workstream about the system change, driving improvement for children and young people's services. It highlighted significant progress against actions, tangible outcomes, key deliverables, and engagement in education needs.

The meeting noted ongoing work to ensure children can enter education with a good level of development and exit prepared for the next phase of their lives. The demography of SEND children, children in care and those living in poverty in Peterborough, England and Cambridgeshire indicated a significant increase in provision is needed for increased healthcare and education services. The target is to improve the percentage of children who show improved progress in entering education, a reduction in the proportion of children who are not in education, employment, or training from 3% to 2% in Cambridgeshire and from 5% to 3% in Peterborough and to reduce inequalities in both outcomes.

The 10 deliverables were noted as:

- Increase uptake of the healthy start scheme
- Promote the start for life offer through health and community setting.
- Perinatal mental health & parent infant relationships:
- Infant feeding support.
- Provide families with support and advice to access early years and childcare opportunities.
- Ensure damp free accommodation for children with respiratory condition (ongoing in partnership with the housing and health priority).
- Improve immunisation rates at entry into and exit from school.
- Increase apprenticeship through anchor institutions (Councils, Combined Authority, NHS, Commissioned services etc).
- Improving mental health, emotional Wellbeing, and resilience among school age population.
- Establishing a mechanism to improve health outcomes for all school age population.

The meeting noted that the plan is to continue to embed the family Hubs and develop a pathway for new parents to perinatal mental healthcare, infant feeding, and delivery on school aged health improvement partnership.

The Chair invited comments and questions from attendees, where the following points were raised:

- Members suggested signposting, giving out leaflets and the dissemination of information on websites through colleagues and community to reach out to more people.
- It questioned how absenteeism is being addressed post Covid and how information is disseminated to parents for their children to return to school unless they are ill. In response it noted that there had been a lot of facilitation to encourage parents to send children back to school, and the Department for Education has set up attendance hubs to facilitate best practices on how to reassure parents and children to return to the classrooms post Covid. Attendees were advised that the public health is investing in a service to support the mental health of school children. To combat the issue of the child being absent from school due to healthcare service appointment, it was suggested that healthcare service is provided to children at school.
- A request was made to add to the challenges faced with children in need and the possible issue of housing infrastructure, transportation into the work programme.
- Members questioned whether there is enough attention on innovative thinking on housing. The importance of capturing the wider role of partners in this area was recognised by attendees.
- In terms of school readiness, an annual target was discussed that can be used to measure progress on a yearly basis. It was suggested that appropriate messages could be circulated to parents who want their children to return to school. That this should be scrutinised to gain the trust of the families and

innovative measures taken to reduce the number of people on the waiting list for school entry.

The Joint Health & Wellbeing Board and Integrated Care Partnership noted the progress update in relation to priority 1 Children's update, and unanimously agreed to support the recommendations.

4 Pharmaceutical Needs Assessment (PNA) - Supplementary Statement

The Team Manager, Health in All Policies, introduced the pharmaceutical needs assessment and supplementary statement, reminding members of the legal duty to keep the PNA up to date. It was highlighted that the Health and Wellbeing Board is required to review, agree on a supplementary statement and the production of a new PNA.

The following additional points were raised.

- A summary of the changes to pharmaceutical services both locally and nationally given the closure of Lloyds and Boots branches was reflected in the report.
- The Health and Wellbeing Board is required to assess the significant gaps in the provision of services.
- The supplementary report outlined changes arising from branch closures, reduction in opening hours of pharmacy services from 100hrs to between 72 and 79 hours a week.
- Despite the reduction in branches there is still accessibility to pharmaceutical services within 20 minutes in the area.
- A full PNA would take a minimum of 6 to 12 months to produce and adopt, therefore the supplementary statement approach was being proposed.
- It was highlighted that the PNA is used by commissioners in the decision-making process in determining whether to open pharmaceutical services or not.

The Joint HWB/ICP agreed:

- To consider the changes to pharmaceutical services across Cambridgeshire and Peterborough as contained in the report and supplementary statement attached.
- Approve supplementary statement and publish it as an addendum to the main PNA 2022 version.
- That producing a new PNA would be disproportionate at this time.
- That the provision of pharmaceutical services will be kept under review.

5 Update on Community Pharmacies

The ICB Chief Pharmacist provided the update on community pharmacies.

The presentation highlighted the significant changes currently taking place in Cambridgeshire and Peterborough, with the following additional points:

- Although the sector is faced with challenges of funding and workforce issues, the presentation demonstrated the scope and strategy of how pharmacies can improve the health and wellbeing of the population.
- Using the community pharmacist clinical skills, a range of services can be provided by the pharmacist such as undertaking vital checks, obtaining of oral contraceptives and treatment of other range of infections without having to visit the GPs, therefore reducing the pressure on general practice and hospital services.

Following the presentation, the following points were raised in the discussion:

- It was questioned how the ICB can continue to support the development of community pharmacy.
- Members commended the commitment by the pharmacy workforce in providing these services despite the various challenges faced by the sector.
- A suggestion was made (to avoid service user frustration) concise communication should be given as to what services or medication can be accessed at the pharmacy without the requirement to see your GP.

The Joint Health & Wellbeing Board and Integrated Care Partnership noted the update on community pharmacies.

6 Better Care Fund (BCF) Quarter 2 Report

The Head of Partnerships and Programmes, Cambridgeshire County Council, the Head of Adults Commissioning, Peterborough City Council and the Associate Delivery Partner Performance and Delivery, Integrated Care Board presented the BCF Q2 report.

An overview of the performance of the Q2 BCF was provided, based on the Q1 performance report. The following points were raised:

- Of the five metrics Cambridgeshire is on track for performance against the discharge place of residence, but faces challenges on falls metrics and avoidable admissions.
- The falls metric is due to a change in guidelines, particularly with head injuries relating to falls.
- In terms of residential admission to older people, there has been slight improvement in Q2 compared to last year. Admission to residential homes cumulatively is lower.
- There has been slight increase in the performance of enablement from 73.3% in Q1 to 76% in Q2.
- There is no waiting list as people are generally staying an average of 4 weeks.
- Good flow of service and independence outcome of 78% in the service as people no longer require further onward care, indicating a good service outcome.
- The falls metrics is a new metric for reporting. There have been changing guidelines to treatment to falls, particularly where a head injury is involved (indicating more conveyance to hospitals). The team is reviewing the data to see if head injuries can be treated within the community where people can stay at home without making the trips to hospital.
- Another metrics not covered in the BCF is reablement. Their target is 84%, with performance currently at 81%. There are higher acuity of people leaving the hospital which is impacting on the ability to rehabilitate and keep them at home after the 91-day period.
- On avoidable admissions, there is a difference in the metrics from Peterborough in comparison to Cambridgeshire.
- The Joint Health and Wellbeing Board and Integrated Care Partnership previously agreed to review the schemes under the Better Care Fund and align with the priorities as a system and meeting the objectives of the BCF. To achieve this, better care partners locally have appointed health integrated partners to undertake the review of the system and they have commenced work and gathering information at the completion; the BCF would present the recommendations to the Board in March or at the interim development sessions while the final recommendations would be presented in June.

The Joint Health & Wellbeing Board and Integrated Care Partnership noted the update BCF, and unanimously approved the quarter 2 return to NHS England.

7 Corporate Update

The Head of Governance and Data Protection Officer presented the report.

The Joint Health & Wellbeing Board and Integrated Care Partnership noted that the terms of references had been approved by the respective Full Council meetings of Cambridgeshire County Council and Peterborough City Council.

The Joint Health and Wellbeing and Integrated Care Partnership approved the meeting dates for 2024/25.

The meeting reviewed and considered the future agenda plan and made several suggestions, including a potential future item on the role on the interrelationship between health, with arts and leisure.

8 Any other business

In absence of any other discussion, the Chair thanked all members for their contribution and the meeting was declared closed.

9 Date of next meeting

The date of the next meeting was confirmed as Friday 22nd March 2024

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Agenda Item No: 3

Progress Report Priority 4: Promote Early intervention and Prevention Measures to Improve Mental Health and Well-being

To:	Cambridgeshire and Peterborough Health & Wellbeing Board / Integrated Care Partnership
Meeting Date:	22nd March 2024
From:	Vicki Evans Stephen Legood
Outcome:	This paper is to provide the Joint Health and Wellbeing/Integrated Care Partnership (HWB/ICP) Board with a progress update on the action plans for delivering the ambitions for Priority4: **Promote Early intervention and Prevention Measures to Improve Mental Health and Well-being** It will provide assurance that progress is being made against the objectives set for 2023/24.
Recommendation:	The HWB/ICP is asked to a) Consider the progress described in the report and agree the deliverable targets b) Identify how the Joint HWB/ICP Board and wider system can identify and support system-wide funding contributions to this programme of work and to provide support to some of the challenges and next steps described in the report.

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Member contacts:
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Susan.vandeven@cambridgeshire.gov.uk

1. Background

1.1.1 The Joint HWB/ICP Board has requested that each of the priority areas provide an update on progress against the delivery of their action plans.

1.2 This report describes the progress that has been made against the 2023/24 deliverables and actions plans for the delivery of Priority 4: '**Promote Early intervention and Prevention Measures to Improve Mental Health and Well-being'**. Presentations will made to the board and circulated beforehand

2. Main Issues

2.1 The long-term ambitions for Priority 4: '**Promote Early intervention and Prevention Measures to Improve Mental Health and Well-being'** have been defined and the following outcomes identified:

1. To increase the proportion of children and young people who score a high mental wellbeing score on the annual school survey from the 2022 level of 11% to 15% by 2030 and to bring down the proportion with a low mental wellbeing score from 8% in 2022 to 5% in 2030
2. To increase the proportion of children and young people who have a high measure of resilience from 14% in 2022 to 20% by 2030 and conversely to reduce the proportion who had a low measure of resilience from 36% in 2022 to 30% in 2030
3. To increase the proportion of adults who report a 'good' or 'very good' score for their life being worthwhile in 2030 from 81% in 2020/21 to 90%
4. To reduce the proportion of children and young people who need to be referred to mental health services by 10% by 2030

2.2 Upon careful consideration of the evidence, feedback and engagement from stakeholders and people with lived experience of mental health problems, data analysis and needs assessment, four themes were identified as areas of focussed work for priority 4 as listed below.

THEME 1 – Communications, information, and resources

No one should feel that they do not know what to do to support themselves or those they care for when struggling with mental health problems. No one should be unable to access support when needed. This workstream recognises that more needs to be done to support people of all ages to know what they can do and what choices they can make to best support their own and those they care abouts' wellbeing. The work will focus on how we communicate and inform people, their families, or the people they care for about where and how they can access help and information to prevent mental health problems escalating.

THEME 2 – Motivation

Feedback during consultation exercises consistently told us that lacking motivation was a block to engaging with activities or services that would support people's mental wellbeing. The work will understand, assess, map and provide tools and opportunities to encourage and motivate people to engage with activities and services that will support them or help them to promote better mental wellbeing.

THEME 3 - Relationships

There is a wide range of evidence showing our relationships with others are central to our mental and overall health. Relationships with others can provide emotional support

and promote positive health behaviours, whereas unhealthy relationships can have damaging impacts on mental health, particularly for children. The work will support and foster positive relationships across the life-course for better mental wellbeing and prevention of loneliness, but with a clear emphasis on 'the best start in life' approach for children and families.

THEME 4 – Wider determinants and leadership

There is strong evidence that mental wellbeing is affected by a wide range of environmental, structural, and social issues: poverty and financial issues, housing, health behaviours, drug/alcohol use, and employment are particularly important. The work under this theme will explore and strengthen the links with other HWB/ICS strategy priority areas that focus on wider determinants of health to ensure we work as a system, sharing resources to address the social and environmental factors that impact on mental wellbeing.

2.3 Achievements against 23_24 Deliverables and Action Plan

2.3.1 Steering Group

Priority 4 is overseen by a steering group chaired by the SROs and with members from the mental health and learning disabilities ABU. This places the work strategically within the mental health delivery model.The steering group meets regularly to review the progress of the workstreams under each theme and to provide guidance.
Recent actions have been on promoting and disseminating the priority 4 work across the ICS partner organisations, for example; the older people's mental health network.

2.3.2 Communications and Information workstream

The communications and information workgroup meets regularly and is currently led by a chair from Public Health. The workstream has identified the following deliverables:

Deliverable 1 - Review existing mental health website resources to improve user experience, data information and accessibility - This work focuses on refreshing the 'Keep Your Head' website that provides mental health information to residents and professionals in Cambridgeshire and Peterborough. In addition, the 'How Are You' map of community resources and assets that support mental wellbeing is being looked at in terms of accessibility. Both resources need to be promoted to the public and professionals through a communications campaign

Deliverable 2 - Ensure information on community assets is easily available and accessible to everyone, including those with significant mental health needs.

- Promote the development of 'easy read' resources, both within ICS materials and with external partners
- Understand, develop and deliver communications in tailored ways to different audiences, e.g. CYP, Older Adults and Neurodiverse People

Deliverable 3 - 'Align Mental Health Campaigns and Public Messaging Across the System' – achieved through the following actions:

- Conduct an evidence review of what works in terms of mental health and wellbeing communication and information

The evidence review was conducted by a Public Health Registrar in September 2023, with the following key findings and recommendations:

Key Findings	Recommendations
• Print media is less effective than other forms of interactive media • Evidence on social media is mixed but may be particularly effective with specific target audiences • Television programmes can increase intention to seek help, but there is limited evidence on long-term impact or targeting for specific populations • Trauma-informed and empathy-based approaches are important when communicating MH to CYP, families and schools • Evaluation of communication work is important but limited in practice	• Engage your target audience in development of successful communications • Use evidence-based approaches to guide communication development • Keep communications and messaging simple and readable • Consider framing around wider determinants of health • Consider the role of messengers and work with partners to use existing routes to underserved populations • Link to national campaigns where relevant

- Map existing and planned communication and information work
  A mapping exercise was conducted with the Mental Health Communications and Information Steering Group in winter 2023/24, with the figure below being the finished product of all ongoing campaign activity of which the ICS is aware.

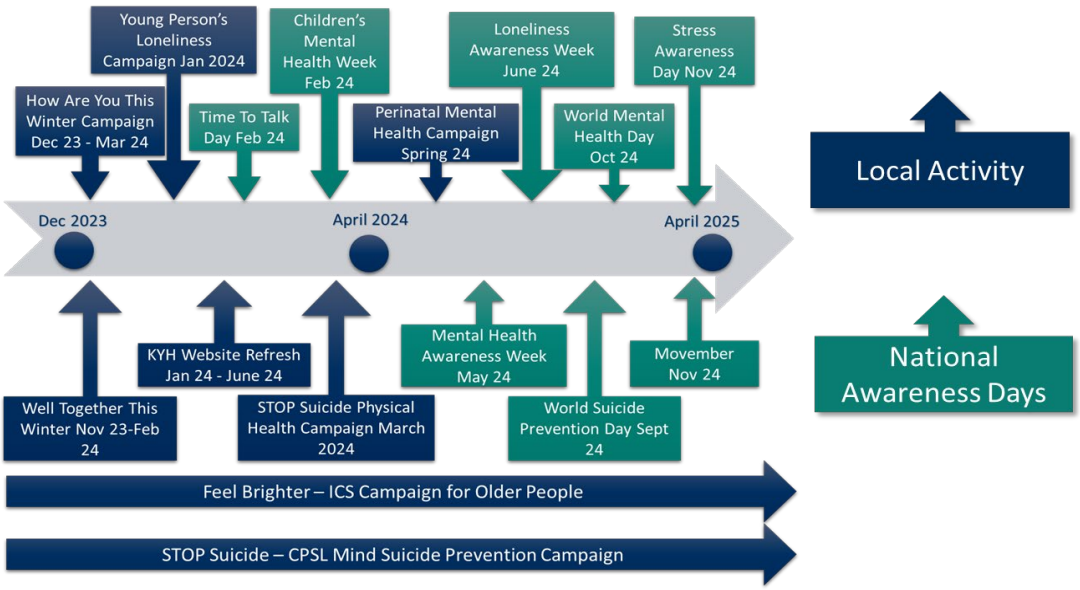


Figure 1 - Mapping of Existing and Planned Communications Campaigns

Whilst there is a lot of activity occurring across Cambridgeshire and Peterborough, there were two immediate conclusions that could be drawn here. The first is that there are many different short campaigns being led by several different agencies, each promoting slightly different messages. The second is that whilst there is

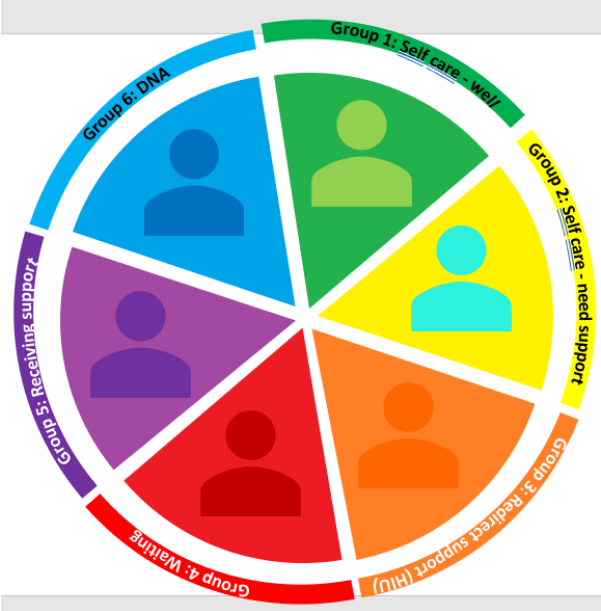
considerable activity planned up to six months in advance, this then fades significantly, with no campaigns planned for the latter half of 2024, suggesting that our approach to mental health communications in general is very much on a short-term basis.

- Obtain funding from system partners to plan for a sustained mental health awareness campaign with accompanying resource (internal/external) for continued delivery. This is discussed in Section 4

- Improve collaboration between mental health and wider public health messaging to ensure that mental health is included wherever appropriate.

2.3.2 **Motivation workstream**
The motivation workstream group has met four times with two chairs leading the work covering both adults and CYP. The focus for the workstream is in the following areas:

a. Identifying the groups of people with differing needs in terms of engaging with mental health support as follows:



Group 1: No mental health challenge/ Not seeking support

Group 2: Some mental health challenge but are not seeking support

Group 3: Some mental health challenge - Seeking support from a source that doesn't best meet their needs (HIU)

Group 4: Mental health challenge - Waiting for support

Group 5: Mental health challenge – receiving support.

Group 6: Mental health challenge - Offered support but not attending.

b. Mapping interventions and understanding the evidence base for what is currently being offered system-wide to support people to access services or to engage in activities that promote mental wellbeing. An understanding of what works, who is being offered support, what the gaps are and opportunities to do more, particularly mapping these to the identified groups with need outlined above.

Examples of current system-wide funded programmes that support this workstream include:

- Peer Support and buddying programmes, particularly with high risk groups – offer support and encouragement to meet life choice-based goals and engage with services
- Follow-up phone call interventions after contact with services, particularly crisis

services to ‘check in’ and further support people who have had the strength to reach out.
- Life Coaching opportunities to offer goal-based encouragement to people who are struggling with engagement and motivation.
- Community connectors/ community navigators – working within Primary Care Networks and linked to social prescribing to support engagement and promote wellbeing, and act as role models.
- Social prescribing within primary care to support people with lifestyle choices and signpost to community interventions.
- ‘How Are You’ Resources and short videos to ‘introduce’ community services aiming to inform and reduce anxiety about engaging.

c. Improve motivation and engagement in interventions for the groups identified in ‘a’ and other high-risk cohorts

We need to understand the barriers to accessing services and interventions and the factors that would improve engagement. For example; reduce social anxiety about attending services or interventions. The work should include co-production to listen to the voices of people with lived experience to input in planning. To date the work has looked at the role within CPFT that ‘Lifestyle medicine’ plays to support people to engage with six lifestyle ‘pillars’; Healthy Eating / Nutrition, Physical activity, Mental wellbeing / Stress Reduction, Minimising Harmful Substances, Sleep, Healthy Relationships / Social Connection.

Motivation to improve physical activity for mental wellbeing has been supported over the winter through promotion of ‘RED January’, which is based on aspects of the ‘five ways to wellbeing’ by encouraging people to come together (Connect), use goal based methods to increase physical activity and to raise money (Give), while doing so for mental health charities.

d. A focus on Children and Young people

As mentioned above, the motivation workstream has two chairs, one of whom focuses on exploring the motivation for mental wellbeing factors that support children and young people. There has been some system-wide thinking to develop guiding principles in this area, based on some of the learnings from the best start in life as well as the thinking around universal, place based support for school aged children.

The work is assessing what is currently in place and effective and what the opportunities are to do more or to enhance programmes of work that are currently underway with a focus on motivation. In particular, opportunities to enhance the work being done through the family hubs and with families.

Examples of practice

- **Emotionally Based School Avoidance’ (EBSA)** Recent investment in a programme of work to address childhood social anxiety and EBSA in Peterborough and across Cambridgeshire. This will deliver a tiered model of interventions, working with schools but also engaging with families and including elements of enrichment to support motivation, resilience and confidence in young people to overcome anxiety and improve school attendance.
- **The wellbeing service**, hosted by centre 33 focuses on ‘guided self-help’ providing behavioural activation for CYP with low mood.

The web-resources support young people to engage in behavioural activities that are evidence-led to help mental wellbeing as shown on the left. Young people identify their own goals and the work needed to achieve the goals. Tasks are broken down into smaller, more manageable steps and support networks are utilised if required to support young people with strategies.

Co-production is an important aspect to the work as this not only supports engagement as CYP feel listened to and included, but ensures the resources are fit for purpose using appropriate and engaging platforms for the audience.

As such, 'bite-sized' Instagram wellbeing videos resources YOUtube wellbeing talks have been produced.

2.3.3 Relationships Workstream

The relationships workstream was launched on 29th February at a symposium event that brought together stakeholders from researchers, to colleagues working across the pathway of care from community sector organisations to secondary care, but also included people with lived experience of mental health problems and carers.

A best start in life for CYP and family relationships
The focus for this workstream is the evidence and best practice that facilitates better relationships from a 'best start in life' principle through children and young people and their families. It recognises the factors that negatively impact on mental wellbeing from an early age including difficulties in bonding between parent and infant, adverse childhood experiences such as trauma, abuse, parental relationship breakdown but also factors from wider social networks in childhood such as bullying and not being accepted or included in friendships.

The symposium reviewed the evidence and practice for what works in terms of interventions that promote or foster positive relationships or mitigate against the effects of adverse experiences due to poor relationships of all descriptions in early life. Examples of practice across Cambridgeshire and Peterborough that foster positive relationships for mental wellbeing in CYP and families include:

- Work being established through family hubs to improve parenting skills and bonding
- Programmes in schools around relationships and preventing bullying.
- Reducing parental conflict through tools and webinars that promote 'healthy arguing in relationships'

- Trauma informed approaches for professionals to understand the impact of trauma on mental wellbeing and to take this into account when supporting clients.
  Following the symposium, the workstream will identify opportunities for collaborative practice between academic research and community/public sector organisations to promote and develop interventions and activities that foster positive relationships and mitigate against adverse childhood experiences. This will allow the evidence base to grow and in turn, enable evaluative practice for the benefit of families and children.

Addressing loneliness

A second focus for the relationships workstream is addressing loneliness across all ages, building on work over several years prior to the pandemic, but learning from the last few years in terms of the impact of Covid-19 on social interactions and community responses.

The workstream recognises the challenges to both understand the scale and impact of loneliness but also the complexity of the response required at all levels and across all ages. The work will revisit the development of a strategy to address loneliness with deliverable actions. This will map and review the evidence base and practice examples, identifying gaps and opportunities for community-wide initiatives and resources required for effective translation.

Examples of good practice for addressing loneliness include:

- Promotion of How Are You (H.A.Y) resources to facilitate social connections across localities
- Promotion of good mood cafes
- Befriending services that support mostly elderly people who are isolated or feeling lonely
- Enabling community events such as ‘the big lunch and ‘great get together’
- Recognising that interactions needn’t be social to address loneliness and connecting with alternatives such as nature or art can alleviate feelings of loneliness
- Opportunities for enrichment and youth activities focussed on young people
- Opportunities for play and recreation that attracts families with young children

2.4 Next steps needing system support

- Ensure crossover conversations with other HWB priority areas - ensure the conversations are extended and crossovers mapped to avoid duplication and to increase awareness of each other’s plans. By working closely together we enhance our system-wide thinking and are better placed to identify opportunities as well as gaps in our support offer; for example, Priority 1 work to support the creation of a clear local pathway to support the wellbeing and mental health needs of new parents, and promote an associated local anti-stigma campaign in 2024. It will also be important to identify opportunities to work alongside colleagues responsible for Priority 3 - Reduce poverty through better employment and better housing as these are fundamental to promoting better mental wellbeing and preventing mental health problems from arising.

- Continue system-wide engagement to raise awareness of priority 4 and increase engagement with the workplans and themes

- Secure system-wide funding support for development of the work. This is discussed in section 4 but is particularly important to ensure a role out of a solid communications and information plan

- Consolidate links between the Faculty of Education and the local system partners to develop work focused on building positive relationships in CYP and families as well as mitigating against adverse childhood experiences. The academic support for the work will help to evaluate programmes and grow the evidence base as well as support to implement best practice and evidence based interventions

- Secure system-wide support for a strategy to address loneliness across all ages.

- Use system-wide experience, lived experience and co-production to both scope and evaluate interventions that support motivation. Cost-effectiveness analysis will support better understanding of where future investment should be made.

3. Alignment with the Cambridgeshire & Peterborough Health and Wellbeing Strategy

3.1 This recommendation covers work under priority 4 but is relevant to priority 1, 2 and 3 of the Cambridgeshire and Peterborough Health and Wellbeing Strategy.

- Priority 1: Ensure our children are ready to enter education and exit, prepared for the next phase of their lives
- Priority 2: Create an environment to give people the opportunities to be as healthy as they can be.
- Priority 3: Reduce poverty through better employment and better housing.
- Priority 4: Promote early intervention and prevention measures to improve mental health and wellbeing.

4. Significant Implications

4.1 Challenges : Resources

Currently no resources have been allocated by the system to deliver the work under priority 4. It will be difficult to fulfil the remit under this priority without system-wide commitment to funding. We can foster partnership working and support the good will of our community sector colleagues as well as develop relationships with the university academics specialising in mental wellbeing, but this will only enable a small proportion of the work that is needed in order to make a real difference to peoples' lives.

In order to effectively deliver Priority 4 and obtain the desired outcomes, significant investment is needed. The system has agreed this priority and should support its' implementation by committing to funding. The ask of the health and Wellbeing board is to identify and support system-wide contributions to this programme of work.

We need to obtain funding to deliver an effective communications and information programme of work. We know that people in Cambridgeshire and Peterborough do not know what mental health information is available to them or where is the best place to find it. In aligning mental health communications campaigns, key to this will be identifying a simple but engaging message that can be communicated to members of the public.

It is very difficult to estimate predicted costs for a marketing campaign as this heavily depends on the anticipated reach and desired outcomes. There are three key workstreams that will require funding consideration:

1. Planning – this is the human resource that will be needed to conduct market research, understand the audience, develop key messaging and design/production of marketing materials.
2. Delivery – this is the cost to get the message out to the desired audience, either through paid media, organic media or earned media.
3. Monitoring – evaluating the impact of the campaign through monitoring of metrics such as engagement with resources, stakeholder feedback and behaviour change

We also need to deliver an effective campaign that will reach out to all in Cambridgeshire and Peterborough, recognising that there would need to be adaptability to meet the diverse needs and age ranges of our population, communities and high risk/harder to reach groups. We do not have the in-house marketing and communication skills and expertise to design and deliver a sustained campaign that is intelligently designed to engage, reach and elicit a response from our diverse audience. To this end, we conclude that the best option is for us to work with external experts in marketing and communication to outsource the design and implementation of a system-wide communications campaign. This will require system-wide funding commitment.

Whilst we can outsource much of this work to an external agency, we will need to retain some capacity within the ICS to oversee this contract, provide expertise on the local mental health system, and lead stakeholder discussions. At present, there is no dedicated role within the system with a focus on mental health communications. For effectiveness, this role would need to be established for two to three years with funds to enable this. An average salary for a communications manager in 2024 is £46,000. With on-costs this is likely to cost the system approximately £60,000. Depending on the scale of work needed, the cost of outsourcing to a digital marketing agency would likely fall in the region of around £100,000 per year. However, in order to ensure that our campaign is inclusive of those with different accessibility needs, including digital literacy, it is important to consider alternatives, such as physical media, which would occur additional costs in the design, production/printing and delivery processes.

For the system to deliver a comprehensive and engaging three-year mental health Communications and information plan, the following is a guide to the costs:

£200K is required in year one
£120K is required in year two
£120K is required in year three

Long-term funding commitment needs to be identified for all the workstreams within priority 4. If we are serious about promoting mental wellbeing and preventing mental health problems. We need to invest ‘upstream’ in order to save on costs of treatment and the consequences of people living with long-term poor mental health. The scale of the investment required can be determined by the work underway in the workstreams as described in section 2.

4.2 Statutory, Legal and Risk Implications

There are no significant implications

4.3 Equality and Diversity Implications

There are no significant implications

This report has been signed off by the Executive Director for Public Health, Jyoti Atri.

5. Appendices

6. Source documents

It is a legal requirement for the following to be completed by the report author.

6.1 Source documents

Cambridgeshire and Peterborough Joint Health and Wellbeing Integrated Care Strategy. Priority 4 - Promoting early intervention and prevention measures to improve mental health and wellbeing Priority 4 - Promoting early intervention and prevention measures to improve mental health and wellbeing (cambridgeshire.gov.uk)

Centre for Mental Health – A manifesto for a Mentally Healthier Nation ManifestoforAMentallyHealthierNation_Digital.pdf

The case for investment in Public Mental Health and obtain parity with physical health funding: mental-health-parity-of-esteem-report-jan-2020-2.pdf (bma.org.uk)

A mentally healthier nation - AMentallyHealthierNation_Digital.pdf

Evidence describing the importance of relationships in mental wellbeing: The Contributing Role of Family, School, and Peer Supportive Relationships in Protecting the Mental Wellbeing of Children and Adolescents (nih.gov)
Relationships and community: statistics | Mental Health Foundation

If including an electronic link to documents this needs to be in the format of a description of the document, not a web address e.g: Cambridgeshire Health and Wellbeing Board 25 November 2020

7. Conflict of Interest

7.1 Conflict of Interest have been reviewed and addressed in line with the ICB Conflicts of Interest and standards of Business Conduct Policy

The ICB and HWB have agreed to joint Conflict of Interest register but with its respective members filling out separate forms.

The Head of Governance will handle any queries in relation to this (capccg.icsgovernanceteam@nhs.net

Agenda Item No: 4

Better Care Fund 2023-25 Quarter 3 Report

To:	Cambridgeshire and Peterborough Health & Wellbeing Board / Integrated Care Partnership
Meeting Date:	22 March 2024
From:	Head of Partnerships and Programmes, Cambridgeshire County Council Head of Adults Commissioning, Peterborough City Council Associate Delivery Partner, Performance and Delivery, Cambridgeshire and Peterborough Integrated Care Board
Outcome:	The approval of Quarter 3 returns enables us to comply with the national conditions associated with the Better Care Fund.
Recommendation:	The Cambridgeshire and Peterborough Health and Wellbeing Board / Integrated Care Partnership is asked to: a) Approve the Quarter 3 return to NHS England

Officer contact:
Name: Caroline Townsend, Leesa Murray & Sandra Pedley
Post: Head of Partnerships and Programmes (CCC), Head of Adults Commissioning (PCC), Associate Delivery Partner Performance and Delivery (ICB)
Email: caroline.townsend@cambridgeshire.gov.uk; leesa.murray@peterborough.gov.uk; Sandra.pedley@nhs.net
Tel:

1. Background

1.1 Both Cambridgeshire and Peterborough were required to submit quarter 3 returns to NHS England on 9th February 2024.The templates were issued at the end of December 2023 enabling a window of c. 5-6 weeks for the completion of this work. Whilst reports were submitted in line with this deadline, they were done so with the caveat that they were pending full HWB/ICP approval due to the timelines.

1.2 The returns included an update in relation to the following key areas:

- Performance against national metrics
- Compliance with national conditions
- Update on spend and activity

2. Main Issues

2.1 Performance to date at the end of Q3 against national metrics is summarised in the table below.

2.2 *Cambridgeshire Performance*

Metric	***Planned Performance***	***Q1 Actual Performance***	***Q2 Actual Performance***	***Assessment of Progress***
Avoidable admissions	Q1 – 173.2 Q2 – 172.1 Q3 – 181.1 Q4 – 175.1	201.3	215.8	Not on track to meet target
Discharge to normal place of residence	Q1 – 91.3% Q2 – 91.6% Q3 – 91.6% Q4 – 91.4%	91.48%	92.4%	On track to meet target
Falls	1,810 per 100,000	519.5 per 100,000	573.4 per 100,000	Not on track to meet target
Residential admissions	486 per 100,000	292.1 per 100,000	292.1 per 100,000	Not on track to meet target
Reablement	77.7%	73.3%	76.4%	Not on track to meet target

2.3 We continue to see avoidable admissions for unplanned hospitalisation for chronic ambulatory sensitive conditions continue at a rate above target. At the time of submission data for quarter 3 was not available, post submission data indicated an improvement in performance for quarter 3 at a rate of 206.1 compared to 215.9 for quarter 2, performance is not on track to meet the targets. The implementation of the cardiovascular strategy through primary care and development of ambulatory proactive care models will support delivery of this metric.

2.4 We have continued to see an improving position in discharges to normal place of residence into quarter 2 of 2023/24, with performance increasing to 92.4%. Data available post submission is indicating a decrease in performance for quarter 3 to 91.8%, but remains above the target of 91.6%. Thus, performance against this metric in Cambridgeshire is on track.

2.5 Comparing quarter 2 with quarter 1 data, admissions for falls increased. However, data available post submission indicates a slightly reduced rate of admissions in quarter 3. It

should be noted that a change in guidance relating to head injuries for falls is a possible driver for the increase. Action is being taken to review guidance and the possibility for a community solution to reduce admissions.

2.6 At the end of quarter 2, performance was 292.31 per 100,000, which equates to 370 admissions year to date. If this level of admissions continues throughout the remainder of the year, then we will not be on track to meet target. We are continuing to see a return to pre-pandemic demand for older people bed-based care. However, on a positive note, we have seen a slight slowing of admissions in quarter 2 (167) compared to quarter 1 (221), but it is too early to say if this trend will continue throughout the remainder of the year. When compared with last year, cumulative admissions year to date was 388, compared to 456 this time last year. This indicates that we are likely to end the year with lower admissions overall compared to 2022/23. This is alongside a continued increased demand for community care for older people, indicating that we are also continuing to support peoples' independence to remain at home.

2.7 Performance in quarter 2 in relation to the proportion of people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services was 76.4%. An improvement from 73.3% at quarter 1. Whilst not quite on track to meet target yet, if performance continues to improve, then meeting the target will be well within reach. The reablement service continues to have overall good capacity with no waiting lists and delivers good outcomes with 77.4% of people completing reablement not requiring any ongoing care. We have good flow through the service, with the average length of stay just over 4 weeks. Discharge funding has supported international recruitment into the reablement service and this has recently contributed to increased capacity.

2.8 *Peterborough Performance*

Metric	***Planned Performance***	***Q1 Actual Performance***	***Q2 Actual performance***	***Assessment of Progress***
Avoidable admissions	Q1 – 185.1 Q2 – 161.7 Q3 – 195.3 Q4 – 171.3	180.2	191.3	Not on track to meet target
Discharge to normal place of residence	Q1 – 92.3% Q2 – 92.7% Q3 – 92.6% Q4 – 92.2%	91.63%	92.8%	On track to meet target
Falls	Rate 1,559.0 per 100,000 population	398.3	490.1	Not on track to meet target
Residential admissions	630 per 100,000 population	176 per 100,000	176 per 100,000	On track to meet target
Reablement	81.0%	69.8%	68.4%	Not on track to meet target

2.9 For Peterborough, comparing quarter 1 data with quarter 2 the rate of avoidable admissions is increasing from 181.7 to 191.3. At the time of submission, the quarter 3 data was not available, post submission data is indicating a further increase in admissions in quarter 3 to a rate of 212.4.

2.10 The percentage of people being discharged to their usual place of residence remained stable in 2022/23 averaging at 92.1%. In 2023/24 performance has varied between quarter 1 at 91.63%, 92.8% in quarter 2 and data available post submission for quarter 3 at 92.1%, giving an average to the end of quarter 3 at 92.1%. This is slightly below target of a year-to-date average of 92.5%.

2.11 Residential admissions is based on an annual rate, quarter 3 data reports performance above target on a rolling 12-month basis. However, we continue to see an increase in residential placements and acuity of need. Since January 2023, monitoring of all placements has given assurance people are being placed appropriately.

2.12 In Peterborough, in relation to the proportion of people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services, performance in quarter 2 has decreased to 68.4%, from 69.8% in quarter 1. This metric is currently not on track to meet target. However, there are good outcomes with 83.6% of people completing reablement requiring no ongoing care. Similar to Cambridgeshire, the 91-day target excludes intermediate care data, which impacts on performance.

2.13 System Wide Developments Supporting Better Care Fund Performance

2.14 **High Impact User Model**

The High Impact Users model is a partnership approach which provides additional resource and capacity to better support our population and enable joint working between partners, to reduce the use of unplanned health & care services for those people with the highest intensity use of urgent and emergency services.

Following an Expressions of Interest process, Cambridgeshire County Council Communities service was successful in securing the opportunity to host a dedicated team to deliver the model across the Cambridgeshire and Peterborough Integrated Care System. The delivery model will particularly focus on providing better support to:

- People who have attended an Emergency Department 10 or more times within the previous 12 months.
- People who have attended an Emergency Department and have increasing social needs and vulnerability but not (yet) chronic health needs.
- People who are frequently accessing, or frequently trying to access urgent care through 999 or NHS111.

This initiative will identify people who may benefit from support, which will include undertaking a ‘What Matters to You’ conversation and co-developing a personalised care plan. People will be connected with relevant care and support as needed, to help the them transition away from needing more intensive support and coordination. This project is currently being implemented and is due to run as a pilot until March 2025.

2.15 Home First Programme Review of Pathway 1

The Cambridgeshire and Peterborough Integrated Care System Home First Programme has recently commenced a review of pathway 1 to support hospital discharge flow. The scope of this review covers reablement and intermediate care at home capacity and demand, with a focus on ensuring we are reducing unnecessary delays in hospital discharges, making the best use of resources across the system and ensuring that we are delivering the best outcomes for people. The review aims to develop a set of practical recommendations and case for change, which will incorporate the following elements:

- A review of local reablement and intermediate care capacity and demand
- Exploring new models of care, including good practice learning from other integrated care systems
- Collaborative and integrated ways of working
- Understanding lost capacity and opportunities to minimise inefficiencies
- Understanding digital capabilities and opportunities

2.16 Falls Prevention

To reduce the number of conveyances to hospital and admissions for falls, work is being undertaken in the following areas:

- A Task and Finish Group is being established to review the long-lie and head injury pathways, looking at areas of best practice the system can adopt to enhance opportunities to keep people at home where it is clinically safe to do so.
- A falls clinic proposal from the North Place Partnership Accountable Business Unit (ABU) is being considered as part of the broader Falls/Frailty programme, alongside further development of an Integrated Community Care Hub.
- An evaluation is being undertaken of the Care Homes falls lifting equipment pilot to inform if it is suitable for roll-out to all care homes.

3. Alignment with the Cambridgeshire & Peterborough Health and Wellbeing Strategy

3.1 This recommendation is relevant to priority 4 of the Cambridgeshire and Peterborough Health and Wellbeing Strategy.

- Priority 4: Promote early intervention and prevention measures to improve mental health and wellbeing.

4. Significant Implications

Report authors should evaluate any further significant implications using the following three sub-headings below. These significant implications should also be evaluated using the questions detailed below.

4.1 Resources
There are no significant implications.

4.2 Statutory, Legal and Risk Implications
There are no significant implications.

4.3 Equality and Diversity Implications
There are no significant implications.

This report has been signed off by the Executive Director of Public Health, Jyoti Atri

5. Appendices

5.1 Appendix 1 – Cambridgeshire 2023/23 Quarter 3 NHS England Return
Appendix 2 – Peterborough 2023/24 Quarter 3 NHS England Return

6. Source documents

It is a legal requirement for the following to be completed by the report author.

6.1 Source documents

None.

Better Care Fund 2023-25 Quarter 3 Quarterly Reporting Template

2. Cover

Version 2.0

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the Better Care Exchange) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

			Checklist: Complete:
Health and Wellbeing Board:	Cambridgeshire		Yes
Completed by:	Caroline Townsend		Yes
E-mail:	caroline.townsend@cambridgeshire.gov.uk		Yes
Contact number:	7565845158		Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No		Yes
If no, please indicate when the report is expected to be signed off:	Fri 22/03/2024	<< Please enter using the format, DD/MM/YYYY	Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. This does not apply to the ASC Discharge Fund tab.

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. Spend and activity	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Quarter 3 Quarterly Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Cambridgeshire

Has the section 75 agreement for your BCF plan been finalised and signed off?	Yes	
If it has not been signed off, please provide the date the section 75 agreement is expected to be signed off		

Confirmation of National Conditions		
National Conditions	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in the quarter:**
1) Jointly agreed plan	Yes	
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes	
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes	
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes	

Checklist Complete:
Yes
Yes
Yes
Yes
Yes
Yes

Better Care Fund 2023-25 Quarter 3 Quarterly Reporting Template

4. Metrics

Selected Health and Wellbeing Board: Cambridgeshire

National data may be unavailable at the time of reporting. As such, please use data that may only be available system-wide and other local intelligence.

Challenges and Support Needs Please describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans

Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics

Metric	Definition	For information - Your planned performance as reported in 2023-24 planning				For information - actual performance for Q1	For information - actual performance for Q2	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs in Q3	Q3 Achievements - including where BCF funding is supporting improvements.	Checklist Complete:
		Q1	Q2	Q3	Q4						
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	173.2	172.1	181.1	175.1	201.3	215.8	Not on track to meet target	Implementation of CVD strategy through Primary Care and development of ambulatory Proactive care models will support his metric.	The 23/24 Q1 and Q2 actuals of 202.4 and 216.7 are above plan, against a plan of 173.2 and 172.1. This equates to approx. 153 more admissions at 3106 to end of Q2. Q3 data not available	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	91.3%	91.6%	91.6%	91.4%	91.5%	92.4%	On track to meet target	Home First programme continues to recruit and train workforce, reducing spot purchase arrangements.	Continued improvement in 23/24 Q2 to 92.4% achieving above plan of 91.6%. Q3 data not available.	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				1,810.0	519.5	573.4	Not on track to meet target	Action being taken to review guidance and possibility for a community solution to reduce admissions.	Comparing Q2 to Q1, falls is increasing in Cambridgeshire. Change in guidance to head injury for falls possible driver for increase.	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				486	2022-23 ASCOF outcome: 502.3		Not on track to meet target	At the end of Quarter 2 performance was 292.31 per 100,000, which equates to 370 admissions year to date. If this level of admissions continues throughout the remainder of the year then we will not be on	We have seen a slight slowing of admissions in Q2 (167) compared to Q1 (221), but it it too early to say if this trend will continue. However, when compared with last year, we have had less cumulative admissions year to	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services				77.7%	2022-23 ASCOF outcome: 77.7%		Not on track to meet target	Performance at the end of Quarter 2 is 76.4% so is currently not on track to meet target. Local reported 91 day data only includes local authority reablement data, and not health intermediate care data 91 day performance, which impacts on performance. This is an issue we are exploring options to address longer term with the wider system.	Performance in Quarter 2 has improved from Quarter 1, which saw performance at 73.3%. Overall capacity in the reablement service continues to be good with no waiting lists. We have good flow through the service with length of stay just over 4 weeks and good outcomes with 77.4% of people completing reablement not requiring any ongoing care. Discharge funding has supported international recruitment into the reablement service and this has recently increased capacity.	Yes

Better Care Fund 2023-25 Quarter 3 Quarterly Reporting Template

6. Spend and activity

Selected Health and Wellbeing Board: Cambridgeshire

Checklist						Yes		Yes		Yes	Yes
Scheme ID	Scheme Name	Scheme Type	Sub Types	Source of Funding	Planned Expenditure	Actual Expenditure to date	Planned outputs	Outputs delivered to date (estimate if unsure) (Number or NA)	Unit of Measure	Have there been any implementation issues?	If yes, please briefly describe the issue(s) and any actions that have been/are being implemented as a result.
1	Promoting Independence	Assistive Technologies and Equipment	Assistive technologies including telecare	Additional NHS Contribution	£125,000	£93,750	580	228	Number of beneficiaries	No	
2	Intermediate Care and Reablement	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-	Bed-based intermediate care with rehabilitation	Minimum NHS Contribution	£4,119,498	£3,089,623	400	804	Number of placements	No	
4	Carers Support	Carers Services	Other	Minimum NHS Contribution	£345,770	£259,327	304	513	Beneficiaries	No	
5	Community Health	Home-based intermediate care services	Rehabilitation at home (accepting step up and step	Minimum NHS Contribution	£2,506,946	£1,879,745	1,916	5766	Packages	No	
6	Discharge to Assess	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-	Bed-based intermediate care with reablement	Minimum NHS Contribution	£2,209,743	£1,657,307	912	406	Number of placements	No	
7	Community Equipment	Assistive Technologies and Equipment	Community based equipment	Minimum NHS Contribution	£1,603,959	£1,202,969	14,700	5730	Number of beneficiaries	No	
8	Community Equipment	Assistive Technologies and Equipment	Community based equipment	Additional NHS Contribution	£663,049	£497,286	7,850	2457	Number of beneficiaries	No	
14	Support of Discharge	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	Additional NHS Contribution	£10,087	£7,565	144	75	Hours of care (Unless short-term in which case it is packages)	No	
18	Intermediate Care and Reablement	Home-based intermediate care services	Reablement at home (accepting step up and step	Minimum NHS Contribution	£8,798,111	£6,909,066	3,200	2795	Packages	No	
19	Carers Support	Carers Services	Carer advice and support related to Care Act duties	Minimum NHS Contribution	£1,584,900	£1,438,649	3,014	2230	Beneficiaries	No	
24	Disabled Facilities Grant	DFG Related Schemes	Adaptations, including statutory DFG grants	DFG	£5,069,550	£5,069,550	424	189	Number of adaptations funded/people supported	No	
27	Protection of Adult Social Care	Residential Placements	Care home	iBCF	£9,501,549	£9,501,549	251	251	Number of beds/placements	No	
28	Reablement	Home-based intermediate care services	Reablement at home (to support discharge)	iBCF	£300,000	£225,000	200	150	Packages	No	
29	Domiciliary Care	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	iBCF	£1,693,961	£1,270,471	281,554	211166	Hours of care (Unless short-term in which case it is packages)	No	
30	Protection of Adult Social Care - Uplift	Residential Placements	Nursing home	Minimum NHS Contribution	£1,072,125	£1,072,125	25	25	Number of beds/placements	No	
31	Pathway 1 - Home First	Home-based intermediate care services	Rehabilitation at home (accepting step up and step	ICB Discharge Funding	£2,461,970	£1,846,477	1,900	1986	Packages	No	
32	Pathway 2 - Delirium	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-	Bed-based intermediate care with reablement	ICB Discharge Funding	£0	£0	-	0	Number of placements	No	
38	Workforce development	Workforce recruitment and retention		Local Authority Discharge Funding	£174,172	£29,772		7	WTE's gained	Yes	Funding was not utilised as planned, but has been reallocated to other areas to support discharge flow, predominantly bed capacity.

41	Reablement capacity	Workforce recruitment and retention		Local Authority Discharge Funding	£120,185	£0		0	WTE's gained	Yes	Funding was not utilised as planned, but has been reallocated to other areas to support discharge flow, predominantly bed capacity.
42	Reablement and occupational therapy capacity	Home-based intermediate care services	Reablement at home (to support discharge)	Local Authority Discharge Funding	£186,752	£106,527	120	NA	Packages	No	
44	Community equipment	Assistive Technologies and Equipment	Assistive technologies including telecare	Local Authority Discharge Funding	£67,733	£67,733	3,543	2959	Number of beneficiaries	No	

Better Care Fund 2023-25 Quarter 3 Quarterly Reporting Template

2. Cover

Version 2.0

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- All information will be supplied to BCF partners to inform policy development.

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			Checklist: Complete:
Health and Wellbeing Board:	Peterborough		Yes
Completed by:	Leesa Murray		Yes
E-mail:	leesa.murray@peterborough.gov.uk		Yes
Contact number:	07881 922600		Yes
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No		Yes
If no, please indicate when the report is expected to be signed off:	Fri 22/03/2024	<< Please enter using the format, DD/MM/YYYY	Yes

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Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. Spend and activity	Yes

<< Link to the Guidance sheet

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Better Care Fund 2023-25 Quarter 3 Quarterly Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Peterborough

		Checklist Complete:
Has the section 75 agreement for your BCF plan been finalised and signed off?	Yes	Yes
If it has not been signed off, please provide the date the section 75 agreement is expected to be signed off		Yes

Confirmation of National Conditions			
National Conditions	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in the quarter:**	
1) Jointly agreed plan	Yes		Yes
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes		Yes
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes		Yes
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes		Yes

Better Care Fund 2023-25 Quarter 3 Quarterly Reporting Template

4. Metrics

Selected Health and Wellbeing Board: Peterborough

National data may be unavailable at the time of reporting. As such, please use data that may only be available system-wide and other local intelligence.

Challenges and Support Needs Please describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans

Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics

Metric	Definition	For information - Your planned performance as reported in 2023-24 planning Q1	Q2	Q3	Q4	For information - actual performance for Q1	For information - actual performance for Q2	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs in Q3	Q3 Achievements - including where BCF funding is supporting improvements.	Checklist Complete:
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	185.1	161.7	195.3	171.3	180.2	191.3	Not on track to meet target	Implementation of CVD strategy, development of ambulatory Proactive care models will support his metric. Reviewing how other UCR services can support to reduce admissions.	Q3 data notavailable. 23/24 Q1 actual of 180.2 achieved against a plan of 185.1, but Q2 actual of 191.3 is above plan of 161.7. Although across both quarters this equates to 50 fewer admissions. Investment in areas with high prevelance and deprivation is showing early signs of reduced admissions.	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	92.3%	92.7%	92.6%	92.2%	91.6%	92.8%	Not on track to meet target	Patients discharged with greater acuity, skill mix of workforce in community unable to meet needs.	Q3 data not available. Estimated Q3 performacne at 91.9%. Home First programme continues to recruit and train workforce, reducing spot purchase arrangements.	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				1,559.0	395.1	486.9	Not on track to meet target	Change of guidance relating to head injury resulting in more convayences. Action being taken to review guidance and possibility for a community solution to reduce admissions.	Annual metric, local data shows an increasing trend for falls admissions. Care Homes fall lifting equiment is currently being evaulated priror to planned roll-out.	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				630	2022-23 ASCOF outcome: 642.9		On track to meet target	We continue to see high levels of dementia combined with physical care needs necessitating 24 hour care	Despite high levels of acuity we continue to support indpendence at home for as long as possible and have seen admission rates reduce in 2023/24	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services				81.0%	2022-23 ASCOF outcome: 80.9%		Not on track to meet target	This figure only includes reablement data as rehabilitation is not extractable from our community health provider. Further options are being explored	Numbers receiving reablement overall have increased in 2023/24 due to successul recruitment campaigns lead by a dedicated recruitment resource.	Yes

Better Care Fund 2023-25 Quarter 3 Quarterly Reporting Template

6. Spend and activity

Selected Health and Wellbeing Board: Peterborough

Checklist						Yes		Yes		Yes	Yes
Scheme ID	Scheme Name	Scheme Type	Sub Types	Source of Funding	Planned Expenditure	Actual Expenditure to date	Planned outputs	Outputs delivered to date (estimate if unsure) (Number or NA)	Unit of Measure	Have there been any implementation issues?	If yes, please briefly describe the issue(s) and any actions that have been/are being implemented as a result.
2	Carers Support	Carers Services	Other	Minimum NHS Contribution	£65,581	£49,185	96	220	Beneficiaries	No	ICB Care Network & Caring Together
4	Community Equipment	Assistive Technologies and Equipment	Community based equipment	Minimum NHS Contribution	£439,249	£329,436	4,550	1540	Number of beneficiaries	No	ICB ICES
5	Community Equipment	Assistive Technologies and Equipment	Community based equipment	Additional NHS Contribution	£327,287	£245,465	3,430	1367	Number of beneficiaries	No	ICB ICES
8	Section 256 agreement: Care Placement Spend	Home Care or Domiciliary Care	Domiciliary care packages	Minimum NHS Contribution	£4,223,453	£3,304,216	235,079	212712	Hours of care (Unless short-term in which case it is packages)	No	LA
10	Reducing DTOCs/ 7 day serices	Home-based intermediate care services	Reablement at home (accepting step up and step	Minimum NHS Contribution	£250,000	£187,500	138	104	Packages	No	LA
11	Person centred care	Assistive Technologies and Equipment	Assistive technologies including telecare	Minimum NHS Contribution	£100,000	£75,000	238	179	Number of beneficiaries	No	LA
13	Care Act Implementation / Enhanced Offer	Carers Services	Carer advice and support related to Care Act duties	Minimum NHS Contribution	£407,000	£305,250	1,365	517	Beneficiaries	Yes	Numbers of carers conversations recorded on carers records have been lower than planned. There is a delivery plan in place looking to raise this number by taking more opportunities to have the right conversation at the right time.
14	Carers Support	Carers Services	Carer advice and support related to Care Act duties	Minimum NHS Contribution	£75,000	£56,250	241	164	Beneficiaries	Yes	Numbers of carers conversations recorded on carers records have been lower than planned. There is a delivery plan in place looking to raise this number by taking more opportunities to have the right conversation at the right time.
17	Disabled Facilities Grant	DFG Related Schemes	Adaptations, including statutory DFG grants	DFG	£2,236,384	£1,677,288	197	277	Number of adaptations funded/people supported	Yes	Cost of adaptations work frequently exceeds both discretonary and mandatory limits - discretionary limits currently under review. This is resulting in higher numbers of people are being supported with smaller adaptations.
18	Investment in Adult Social Care and Social Work	Residential Placements	Care home	iBCF	£306,276	£229,707	6	5	Number of beds/placements	Yes	There are demand and acuity pressures
21	Protection of adult social care	Residential Placements	Care home	iBCF	£5,483,734	£4,112,801	108	81	Number of beds/placements	Yes	There are demand and acuity pressures
22	Nursing home capacity	Residential Placements	Nursing home	iBCF	£793,661	£595,246	18	14	Number of beds/placements	No	LA
25	Pathway 1 - Home First	Home-based intermediate care services	Rehabilitation at home (accepting step up and step	ICB Discharge Funding	£886,287	£664,708	50	851	Packages	No	ICB CPFT P1 ICWs & Discharge Cars
27	Assistive Technology - levelling up	Assistive Technologies and Equipment	Assistive technologies including telecare	ICB Discharge Funding	£160,000	£160,000	72	0	Number of beneficiaries	Yes	Delay in receiving proposal, agreed and invoiced in December, Implementation to commence From January 2024 until March 2025.
28	Pathway 2 - Delirium	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-	Bed-based intermediate care with reablement	ICB Discharge Funding	£0	£0	-	0	Number of placements	No	ICB 24/25 plan
31	Additional Reablement Capacity	Home-based intermediate care services	Reablement at home (to support discharge)	Local Authority Discharge Funding	£376,365	£282,274	204	153	Packages	No	LA
32	Workforce recruitment and retention	Workforce recruitment and retention		Local Authority Discharge Funding	£49,000	£36,750		1.84	WTE's gained	Yes	Staff retention as with other front line care roles is a challenge.

Agenda Item No: 5

Report title: Refresh of the Joint Forward Plan (2024 - 2029)

To:	Cambridgeshire and Peterborough Health & Wellbeing Board / Integrated Care Partnership
Meeting Date:	22 March 2024
From:	Kit Connick, Chief Officer Partnerships and Strategy, ICB
Outcome:	That the refreshed Joint Forward Plan (2024–29) addresses the NHS operational priorities and the NHS long term plan, as well as the Cambridgeshire & Peterborough health and wellbeing integrated care strategy.
Recommendation:	The HWB/ICP is being asked to:

a) **note** the refreshed Joint Forward Plan, and the engagement with system partners to inform this annual refresh
b) **confirm** that the Joint Forward Plan has taken account of the health and wellbeing integrated care strategy
c) **note** that Hertfordshire & West Essex Health and Wellbeing Board will undertake the same duties at their meeting on 26th March 2024

Compliance with Accessibility Regulations
Complete

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1. Background

1.1 Integrated Care Boards (ICBs) and their partner NHS Trusts and Foundation Trusts are required to prepare a rolling five-year Joint Forward Plan (JFP) before the start of each financial year. There has only been nine months since the publication of the last JFP, given the nationally imposed delayed timings in 2023.

1.2 The Plan has been developed through system groups and via engagement of our delivery partners and takes into account the feedback received through this engagement process.

1.3 The refreshed Joint Forward Plan was presented to and approved by the Integrated Care Board on 8th March 2024. It is scheduled to be presented to the Hertfordshire & West Essex Health and Wellbeing Board (26th March) for confirmation that the JFP has taken proper account of the health and wellbeing strategy.

2 National Guidance

2.1 The five year Joint Forward Plan fits as part of the overall strategic framework within which the ICB operates. It addresses the NHS operational priorities and the NHS long term plan, as well as the Cambridgeshire & Peterborough Health and Wellbeing Integrated Care Strategy. Objectives of the Cambridgeshire & Peterborough Joint Forward Plan are to:

- Direct the collective endeavour of ICB & partner trusts towards system priorities (immediate priorities and longer-term ambitions)
- Offer assurance that the ICB is fulfilling its key functions and duties effectively, and that it is making a meaningful contribution to the achievement of the ICS's four core purposes (to improve outcomes in population health and healthcare; to tackle inequalities in outcomes, experience and access; to enhance productivity and value for money; and to help the NHS support broader social and economic development)
- Demonstrate how the ICB and partner trusts will meet the health needs of the population and the priorities of the joint local health and wellbeing and integrated care strategy
- Address the statutory duties of the ICB, the steps for implementing the HWB and integrated care strategy, and how the ICB and its partner trusts will meet the population's physical and mental health needs, including delivery of universal NHS commitments.

2.2 In developing the plan, the ICB and its partner trusts must:

- Involve each Health & Wellbeing Board within their area.
- Include a statement from the Health and Wellbeing Board as to whether the JFP has taken proper account of the health and wellbeing strategy.
- Develop the JFP with close engagement of partners, building on previous local patient and public engagement.
- Update the plan, with partner engagement, before the start of each financial year.

3 Development of the plan

3.1 System groups have played a key role in reviewing the priorities and plans for their areas of delivery. There has been close co-ordination with the development of the operational plan through a joint internal planning group, oversight from the System Strategy and Planning Group, alongside reporting to the ICB Executive group.

3.2 The focus for this work has been on refreshing the Plan in light of system learning and delivery over the past nine months, work on the Outcomes Framework (led by the Strategic Commissioning Unit) and maintaining our shared focus on delivery and clear accountabilities.

3.3 A comprehensive engagement programme was undertaken in 2023 with service users, carers and local communities via the 'JFP Lets Talk' campaign. Given the comprehensive feedback received in 2023, alongside the tight timescales for delivery in 2024, we have not undertaken a revised external engagement campaign for this refresh. We have used the information from the 2023 work, alongside other more recent engagement processes in specific work areas, for example maternity services, Royston Lets Talk etc to inform this refreshed Plan.

4 Key issues

4.1 This refreshed Joint Forward Plan sets out the ICB and partner trust's vision and priorities for how we will continue to improve services and meet the needs of our population. This includes learning from our operational and strategic focus throughout 2023:

- Commitment to the ongoing recovery of core services and productivity.
- Focus on advancing the realisation of key aspirations set out in the NHS Long-Term Plan (LTP).
- Progressive transformation of the health and care system, ensuring its resilience and adaptability to meet the demands of the future.
- How together we are taking collaborative action and focusing prevention at every level of health care delivery.

4.2 It describes how we are fulfilling our responsibilities against the four core purposes of the ICS (to improve outcomes in population health and healthcare; to tackle inequalities in outcomes, experience and access; to enhance productivity and value for money; and to help the NHS support broader social and economic development).

4.3 The key changes made to the refreshed plan include:

- The priorities now cover 2024/25 as year one, through to 2029 for the five-year horizon.
- Examples of delivery in 2023/24 have been included throughout the document.
- The high-level system outcomes framework, developed in 23/24 is included. Further work is ongoing on the programme-level measures, which will inform future updates to the JFP and delivery programmes.
- Where system groups in specific delivery areas have adjusted or refocused their priorities since the publication of this plan, this has been reflected in the document. Any changes to priorities have been through the relevant system governance and are not significant.
- Where there have been changes in structures or governance this has been updated

in the document accordingly.
- There are some updates to the data.

4.4 The detailed breakdown of the revisions made within each section are set out in Appendix 1.

5. Alignment with the Cambridgeshire & Peterborough Health and Wellbeing Strategy

5.1 The Joint Forward Plan is relevant to all four priorities of the Cambridgeshire and Peterborough Health and Wellbeing Strategy:

- Priority 1: Ensure our children are ready to enter education and exit, prepared for the next phase of their lives
- Priority 2: Create an environment to give people the opportunities to be as healthy as they can be.
- Priority 3: Reduce poverty through better employment and better housing.
- Priority 4: Promote early intervention and prevention measures to improve mental health and wellbeing.

6 Next steps

6.1 We will work with all our partners to review lessons learned from the process of developing the refreshed JFP to inform future work. This may include a rolling or early review approach to anticipate this yearly national ask.

6.2 Refresh and update of the JFP Delivery Plans to reflect any revised/additional milestones. This will be completed by the end of March and will form part of the progress updates to the Programme Executive, the ICB and wider system.

6.3 We will continue to work with our delivery partners on the JFP Delivery Plan, reporting progress against the high-level milestones in the Joint Forward Plan and ensuring these are linked to the ICB Outcomes Framework.

6.4 Development of an updated Joint Forward Plan public-facing executive summary for publication.

7 Significant Implications

7.1 Where applicable, Resources, Statutory, Legal and Risk Implications and Equality and Diversity Implications have been assessed and addressed as part of the JFP programme of work. The combined impact assessment has been completed and updated at a strategic level on the JFP.

7.2 There is no direct financial impact. However, the delivery of the Plan will need to be within resources available, in line with the principles set out in the financial strategy section of the JFP and the NHS national financial planning guidance.

8. Appendices

This report includes the following appendices:

i. A summary of the changes made within the plan under each section
ii. Joint Forward Plan full narrative report

9. Source documents

NHS England » Guidance on developing the joint forward plan.

9.1 Location

Our Joint Forward Plan | CPICS Website

10. Conflict of Interest

10.1 Conflict of Interest have been reviewed and addressed in line with the ICB Conflicts of Interest and standards of Business Conduct Policy.

The ICB and HWB have agreed to joint Conflict of Interest register but with its respective members filling out separate forms.

The Head of Governance will handle any queries in relation to this (capccg.icsgovernanceteam@nhs.net)

Appendix 1

Changes to the Joint Forward Plan as part of the refresh for 2024 – 2029:

- The priorities now cover 2024/25 as year one, through to 2029 for the five-year horizon.
- Examples of delivery in 2023/24 have been included throughout the document.
- The high-level system outcomes framework which was developed in 23/24 is now included. Further work is ongoing on the programme-level measures, which will inform future updates to the JFP and delivery programmes.
- Where system groups in specific delivery areas have adjusted or refocused their priorities since the publication of this plan, this has been reflected in the document. Any changes to priorities have already been through the relevant system governance and are not significant.
- Where there have been changes in structures or governance this has been updated in the document accordingly.
- There are some updates to the data.

Detailed list of changes by section:

- Foreword: Minor updates to foreword to reference the annual updating of the plan.
- Section 1 Introduction: Look back section on 23/24 delivery.
- Section 2 “Our Integrated Care System”:
    - Updated description of the Strategic Commissioning Unit to reflect development in 23/24.
    - Updates to the data on health inequalities.
- Section 3 “Our population health challenges and outcomes”:
    - Updated life expectancy data.
    - New section on the system outcomes framework which was developed in 23/24.
- Section 4 “Delivering the ambitions and priorities of the Health and Wellbeing Integrated Care (HWBIC) Strategy”:
    - This section cross references the JFP delivery against the four priorities of the HWBIC strategy. Minor additions, including elective recovery for children and young people; waiting well and other pre-operative programmes, and delivery of the CORE20PLUS5 priorities.
    - Introductory paragraph on each of the integrated care strategy priorities has been updated for current status and progress made in 23/24.
- Section 5 “Reduce inequalities in health outcomes”:
    - Clarifies health inequalities and ICB focus in the context of wider inequalities.
    - Changes to reflect new programme structures.
    - Updated governance arrangements including new Inequalities Data and Insights Group.
    - CYP: Added focus on waiting lists for CYP, which impacts on their development and inequalities. Deep dives new focus for 24/25. Epilepsy nursing pilot removed as did not proceed.
    - Data updates, clearer on CVD mortality.
    - Examples of delivery throughout.
- Section 5, sub section on Population Health Management: Greater focus on the approach as well as the tools, with delivery examples.
- Section 5, sub section on CVD: expanded, around new programme workstreams.
- Section 5, sub section on “Babies, children and young people”:
    - Minor edits with more detail on SEND and safeguarding.

    - Restructured as a narrative with priorities grouped by theme (previously lengthy list of bullet points).
- Section 5, sub section on Mental health, learning disabilities and autism":
    - Amendments to priorities to make them more specific and updates on delivery.
- Section 5, sub section on place partnerships:
    - Delivery examples.
- Section 6 "Creating a system of opportunity":
    - Minor updates to EDI.
    - Minor updates to Healthier Futures Fund to reflect progress in 23/24.
    - Updated delivery focus for Armed Forces, following the establishment of the Armed Forces steering group.
- Section 7 "Giving people more control over their health and wellbeing":
    - Deliverables for years 1-5 updated to show completion in year 1.
    - Updates on delivery 23/24.
    - Updated look ahead paragraph for engagement, referencing developments in enabling mechanisms with the voluntary, community and social enterprise sector.
- Section 8 "Delivering world class services enabled by research and innovation":
    - Minor updates to the continuous quality improvement section, referencing the new NHS Impact approach.
    - Updated research section, with more emphasis on 23/24 achievements.
    - Updated innovation section with the new infrastructure and the transition of the Innovation Hub to the ICB.
    - Examples of delivery.
    - Minor edits and delivery example to digital section.
- Section 9 "Environmental and financial sustainability, with a resilient workforce":
    - Minor edits and look back 23/24 to Net Zero section.
    - In financial strategy, new paragraph on prioritisation framework which is in development.
    - Updates to efficiency and productivity work to capture progress in 23/24.
    - Updates to workforce section to reflect the refocused priorities agreed by the ICB People Board in September 2023, informed by the publication of the NHS Long Term Workforce Plan.
    - Minor updates to primary care sustainability to reflect developments in 23/24.
    - Minor updates to Estates to reflect work commenced in 23/24.
- Section 10 Implementation:
    - Edits to reflect updates in governance.
    - Updates to quality and safety to include 2024 focus.
    - Implementation of Patient Safety Incident Response Framework completed.
    - Edits to safeguarding, particularly on serious violence duty which was a significant new area in 23/24.
    - Clinical and care professional leadership 23/24 focus.

Cambridgeshire & Peterborough Integrated Care System

NHS Cambridgeshire & Peterborough

Joint Forward Plan 2024 - 29

cpics.org.uk

February 2024

Contents

Welcome

Thank you for taking the time to read this refreshed plan. It's called the Joint Forward Plan and is a requirement of each Integrated Care Board in England to produce and update on an annual basis. It has been written by a wide range of health and care professionals and partners who have spent time listening to what people say they want from local health and care services.

Over the next five years we will continue to work hard to make sure your experience of health and care services is simpler for you to access, more integrated, more local in your communities and continually improving. Service providers will listen to your feedback and learn from your experience. Where services can't be local, we will ensure you have the information you need to make the right choices about accessing services.

We will directly tackle some immediate priorities, such as reducing waiting times (including those for suspected cancers) and improving access to urgent care, as well as making progress on long term issues, like prevention of the most acute conditions such as cardiovascular disease and shifting our focus more towards helping people to live longer, healthier lives. These priorities aren't just aspirations on a page, they are achievable goals.

"These priorities aren't just aspirations on a page, they are achievable goals."

The NHS, local authorities, the voluntary, community, and social enterprise sector, faith groups and many more, will think creatively about the challenges ahead and keep productivity and efficiency at the centre of this reform. We will work together to improve the lives of the million people living across Cambridgeshire, Peterborough and Royston.

We know it won't be easy. We need to increase the number of people working in health and care, manage day to day services and shift the focus of our activity towards prevention, improve areas that are not working well and operate within a set budget. But, by focusing on what makes the biggest difference for the population, staying focused on what is really important and continually working with and listening to you, we can help people to live healthier lives.

It is by working together in a more integrated way that we can find better, more creative solutions to the challenges we face and help create healthier futures for all.

Jan Thomas, Chief Executive Officer, NHS Cambridgeshire & Peterborough ICB

John O'Brien, Chair of the NHS Cambridgeshire & Peterborough ICB

Section 1: Introduction

Purpose of this plan

We are a system with an ambitious vision for our services, local people, and workforce. We have committed to deliver this vision with our partners and our communities. The purpose of this Joint Forward Plan (JFP) is to set out how NHS Cambridgeshire & Peterborough Integrated Care Board (ICB) and its partners will achieve this, and in doing so meet the health needs of our population, by:

1. Setting out how we will support the delivery of our Health & Wellbeing Integrated Care Strategy (HWICS), published in December 2022.

As part of our joint HWICS we have agreed a shared vision with our local authority and other partners centred around four priorities:

The ICB, NHS Trusts and primary care are key partners in the delivery of these four priorities. Our Plan demonstrates how we are taking collaborative action on prevention at every level of health care delivery.

2. Describing how we are delivering on our key functions and duties, Throughout our plan we demonstrate how we are fulfilling our statutory duties and how our delivery priorities are actively supporting the four ICS aims:

- To improve outcomes in population health and healthcare.
- To tackle inequalities in outcomes, experience and access.
- To enhance productivity and value for money.
- To help the NHS support broader social and economic development.

Our areas of strategic delivery and reform

Improve cancer performance	Implement our cardiovascular disease strategy	Children and young people's mental health	Make best use of all public estate and capita	Make the best use of all resources
Reduce the time people wait for elective care	Identify and better support people with high/complex needs	In community care (incl. primary care)	Delegate delivery to our accountable business units	Live our leadership compact
Increase on-the-day urgent care performance	Stabilise and increase our workforce	Ensure services are as productive as they can be	Focus on prevention	Quality Improvement Framework
Focus on the basics	Always think ahead	Reform services	Make big moves	Lead well
Ensure our children are ready to enter education and exit prepared for the next phase of their lives	Create an environment to give people the opportunity to be as healthy as they can	Promote early intervention and prevention measures to improve mental health and wellbeing	Reduce poverty through better employment and housing	
Getting better outcomes for children	Reducing inequalities deaths in the under 75s	Increase the number of years people live in good health		
ALL TOGETHER FOR HEALTHIER FUTURES				

3. Directing the collective endeavour of the ICB and its delivery partners towards key system priorities.

Our Plan sets out the key delivery programmes and transformation priorities against which we will align our collective efforts and resources. It is particularly important (in the context of competing operational pressures and limited scope for new investment) to focus our resources and collective effort on shared objectives, where we can make a real and sustainable impact.

Over the next five years, we will directly tackle some immediate priorities, such as reducing waiting times (including those for suspected cancers), and improving access to urgent care, as well as making progress on long term issues, like preventing cardiovascular disease and helping people live longer, healthier lives, as well as supporting people and their loved ones at the end of life. Additionally, over the same timeframe there will be strategic decisions that we need to make together. We need clarity and focus for the former, which is set out in our delivery plans. For the latter, we need data to inform decision-making; a constant focus on the needs of our population; good governance; and diversity of perspectives to inform ICB decision-making. Collectively, this will increase our capability to identify, develop and recommend innovative solutions for implementation.

We have to increase the number of people working in health and care, manage the day to day services, improve areas that are not working well and manage within a set budget. Our health system has historically experienced severe financial challenges, which built up a cumulative deficit over a sustained period. Similar fiscal challenges have been experienced by our public sector partners over the same period.

However, at the end of 2022/23 our system was able to report a breakeven position, delivering our financial plan as well as our operational and strategic aims. We are working hard to do the same for 2023/24, despite the challenges that industrial action and other winter pressures have brought, and continue to bring, on operational, strategic and fiscal delivery.

There is still more to do. Our financial plan shows a continued commitment to deliver within our financial allocation. This will not be achieved in isolation, and particularly considering the ongoing challenges for local authorities and other public sector organisations, which will have a cumulative impact on services. It is for this reason we are committed to making financial decisions alongside, and in conjunction with, the delivery of our system ambitions, and where possible across health and care organisations.

Looking ahead, the ICB will transition towards a resource allocation process informed by a population health approach. This shift is driven by the need for a more effective, efficient and equitable distribution of resources, emphasising health economics insights in decision-making.

We know it won't be easy. But, by focusing on what makes the biggest difference for our local people, staying focused on what's really important and continually listening to feedback we can find better, more creative solutions by working together to create healthier futures for all.

Our principles and approach

The Hewitt Review (published in April 2023) and its challenge for all Integrated Care Systems to transform the model of health and care, provides six guiding principles that we will adopt to create a context where our ICS can thrive: collaboration within and between systems and national bodies; a limited number of shared priorities; allowing local leaders the space and time to lead; the right support; balancing freedom with accountability; and enabling access to timely, transparent and high-quality data.

We have applied NHS England's (NHSE) JFP principles of alignment, subsidiarity and focus on delivery. These directly correlate with our locally developed strategic planning principles:

Think Local

Development and ownership at a local level, with the right expertise and insight.

Keep it simple

Alignment across the integrated care strategy, joint forward plan, operational plans and local strategies.

Do it together

Collaborative planning and shared accountability through system groups.

Prove it

Delivery focused, with measurable outcomes and milestones.

Our delivery commitments

Focus on the basics: Over the past few years, we have seen unprecedented challenges across health and care, with significant workforce challenges and cost pressures. We remain committed to reducing waiting times for access to services and improving performance against core standards for quality and delivery across elective and urgent care, both in hospital and the community. Specific objectives and targets are agreed with NHS England through the annual operational planning round. We have a robust system in place for monitoring and managing performance, as set out in the implementation section of our plan.

Reforming services: Our plan sets out our key priorities for reforming services and improving access to integrated, person-centred care close to home, while ensuring these services remain as productive and efficient as possible. We are committed to putting people at the heart of everything we do and co-producing service developments with local people as equal partners in shaping the future services.

Tackling longer term challenges: We need to mobilise now to meet the growing health needs of our local people in the future. In particular, through preventing cardiovascular disease which is where the NHS can make the most impact over the next 10 years, and by providing earlier, better care for people with high and complex needs.

We need to take action to tackle climate change which is also a health emergency. We have a bold commitment to sustainability and achieving net zero, which is a specific workstream but also a theme throughout the plan, recognising that climate change poses a major threat to the health and wellbeing of our communities.

A key risk for our collective delivery is workforce capacity and productivity, as staff shortages, particularly in higher cost of living areas, lead to increased workload and impact staff wellbeing and retention. We need to stabilise and increase our workforce across all health and care sectors, through a continued programme of investment and transformation, new role development, upskilling our staff and creating opportunity and access for all who wish to work within the health and care sector.

Big moves: Major developments in our infrastructure will underpin service change. This includes significant capital projects, as set out in the estates and digital sections of our plan. It also includes fundamental changes to our planning and commissioning mechanisms, with the aim of delegating these functions to the most appropriate organisational level and embedding a Population Health Management approach and a culture of continuous improvement. This is reflected in our commitment to developing our Accountable Business Units (ABUs) as the key delivery and transformation vehicles for our system, acknowledging the relationship between the ABUs and ICB as an equal partnership that reaches across organisational boundaries and works towards common goals.

Lead well: Finally, we need to embed and live by the leadership values we have set ourselves: putting people and quality first; having honest relationships and acting with integrity; being transparent and inclusive when making decisions; doing what we say, celebrating success and learning from failure; and holding each other to account.

It is critical that our Joint Forward Plan is co-developed and co-owned by the ICB, its partner Trusts and delivery partnerships, and as such is informed by and responds to the needs of our communities. Through our Let's Talk campaign we engaged local people and communities in the development of this plan, with the majority of people agreeing with the priorities we have set. However, ongoing engagement is key, listening to our communities to understand what matters to them and being open and transparent in our decision-making. This underpins the need to continue to develop our co-production efforts to engage our local people in focus areas and how, together, we develop effective solutions to the challenges we face.

To deliver on our ambitious vision, this needs to be the plan that we will use to guide our decision-making, our progress and our performance.

Key operational performance and delivery highlights in 2023/24:

- During 2023/24 **Urgent Emergency Care** has remained a system priority. There has been further implementation and development of our Urgent Community Response (UCR) services to support patients to be treated in their own homes and reduce ambulance conveyances, attendances to ED and admissions to hospital. Work is continuing on how we enhance these services further and ensure the capacity is maximised across the system.
- **Virtual wards** have been embedded during the year across all hospital providers. These have supported patients to be discharged earlier whilst still receiving support and monitoring for their condition.
- Partnering with our **voluntary sector colleagues** has been a key focus for us, and investment has been made in a single point of access service with three local voluntary sector organisations. This service will support patients being discharged home with additional support where it has been identified as a need for the person.
- Work has continued across the system to reduce the overall **elective waiting list**. Whilst the waiting list has not reduced to the expected levels due to the impact of industrial action throughout 2023/24, substantial progress has been made in reducing the longest wait times with a continuing reduction of people waiting over 65 weeks and 78 weeks (in line with national guidance). Focused work has been undertaken to offer patient choice, mutual aid across providers and improve communication with patients to support this reduction.
- Across challenged **specialty services**, for example Dermatology, Ear Nose & Throat (ENT), Ophthalmology and Musculoskeletal (MSK), system-wide clinical and operational groups have been established to look at alternative ways of working, share best practice and develop services further, supporting the improvement in waiting times and in increasing elective activity which has now recovered greater than 2019/20, pre-pandemic levels.
- To support and **improve our cancer pathways**, during 2023/24 we have continued to work with all providers to deliver the best practice timed pathways. We have introduced a teledermatology pilot to ensure a timely response for patients needing to access skin cancer services. This service is proving successful as patients are accessing services quickly and hearing results faster. We have implemented a pilot for Targeted Lung Health Checks to support the earlier identification of lung cancer. This has been successful, and a business case has since been successful to roll this out across the system.

Statutory functions and duties

Patient choice	Obtaining appropriate advice	Innovation and research	Financial duties
Education and training	Climate change	Children and young people	Victims of abuse
Workforce	Performance	Digital and data	Estates
Procurement	Population Health Management	System development	Wider socioeconomic development

Across all the above areas there are a host of specific policies, regulations and quality standards where the ICB has responsibility for delivery or assurance.

Section 2: Our Integrated Care System

Cambridgeshire, Peterborough and Royston are situated in the East of England. The area is well connected in the south and east with major roads running through the county, and main train lines running through many of our towns and cities. However, there are also many rural communities experiencing geographical isolation.

Our area is home to circa one million people who live in diverse communities, from more deprived areas in Peterborough and Fenland, to the more affluent areas of Cambridge and Royston (although there are also pockets of deprivation in this area too). Across our area, 112,000 people live in the 20% most deprived quintile nationally; 95% of these people live in the North of our system.

We have significant health inequalities. For example, there is a difference in life expectancy between our most and least deprived areas: 7.5 years for men and 6.7 years for women across NHS Cambridgeshire & Peterborough. These differences in life expectancy are driven predominantly by conditions such as cardiovascular disease, respiratory conditions and cancer.

Our older population is also growing rapidly (particularly visible in more rural areas), with 18.4% of our population aged 65+. Our diverse population includes Asian/Asian British, making up 5.9% of our population, with 9.1% of the population using English as a second language (the most common other languages are European). In Cambridgeshire & Peterborough, we have over 77,000 unpaid carers including young people and parents. This number will grow as people grow older and develop more long-term conditions.

The area is home to a range of NHS services. They are:

3 Hospital Providers

- Cambridge University Hospitals NHS Foundation Trust, which is a regional centre for specialist services, comprising Addenbrooke's and the Rosie hospitals;
- North West Anglia NHS Foundation Trust covering Peterborough City and Hinchingbrooke hospitals;
- Royal Papworth Hospital NHS Foundation Trust which is a national heart and lung specialist centre.

Community provider: Cambridgeshire Community Services NHS Trust

Community and mental health provider: Cambridgeshire and Peterborough NHS Foundation Trust

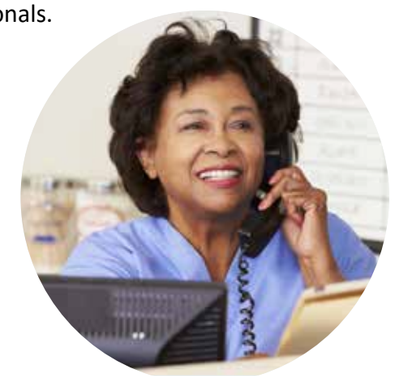
87 GP Practices (forming 21 Primary Care Networks)

East of England Ambulance Service NHS Trust

Hertfordshire Urgent Care (HUC - our NHS 111 provider)

145 pharmacies

Working in partnership are our expanding neighbourhood teams which comprise a range of staff such as community services, social care and the voluntary, community and social enterprise sector, including two adult and one children's specialist hospices, as well as medical professionals.



We are covered by two upper tier authorities:

- Cambridgeshire County Council
- Peterborough City Council (a unitary authority)

Five District councils:

- Fenland
- Huntingdonshire
- East Cambridgeshire
- Cambridge City
- South Cambridgeshire

Plus part of North Hertfordshire District Council area for Royston, as well as the Cambridgeshire & Peterborough Combined Authority.

Within the ICS, we have five Accountable Business Units that bring together health and care organisations with the voluntary sector to jointly plan and deliver services to meet the health needs of local people.

There are two place-based partnerships, one in the North, hosted by North West Anglia NHS Foundation Trust (NWAFT) and one in the South, hosted by Cambridge University Hospitals NHS Foundation Trust (CUH).

The Children's and Maternity Partnership is hosted by Cambridgeshire Community Services NHS Trust (CCS) and the Mental Health, Learning Disabilities and Autism Partnership is hosted by Cambridgeshire & Peterborough NHS Foundation Trust (CPFT).

The Strategic Commissioning Unit (SCU) is hosted by the ICB. It is designed to work as an independent unit offering services, guidance and support to the ICB, other Accountable Business Units, and the wider ICS. It provides collaborative leadership and oversight in relation to healthcare inequalities, population health management and the NHS long-term prevention agenda. It offers strategic insights into healthcare needs, risks and outcomes; supports decision-making on resource allocation using health economic analysis; and provides leadership on a pipeline of innovations that can improve healthcare delivery and outcomes.

Together, these partnerships are the key mechanisms for delivering population health outcomes and priorities within our system.

North Cambridgeshire & Peterborough Care Partnership

Population 586,049

Partnerships:

- Healthwatch Cambridgeshire & Peterborough
- Cambridgeshire County Council, Peterborough City Council, Fenland District Council, Huntingdonshire District Council
- Cambridgeshire & Peterborough Combined Authority
- 49 GP practices, 13 Integrated Neighbourhood Teams (INTs): A1 Network, Huntingdon, St Neots, St Ives, BMC Paston, Central, Thistlemoor & Thorpe, South Peterborough, Peterborough Partnerships, Bretton Park & Hampton, Peterborough & East, Wisbech, Fenland, South Fenland. 2 Primary Care Networks: Greater Peterborough Network (GPN), West Cambs Federation (WCF).
- Cambridgeshire and Peterborough wide Local Medical Committee, Local Dental Committee, Local Pharmaceutical Committee, and Local Optical Committee
- North West Anglia NHS Foundation Trust (NWAngliaFT)
- Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
- Cambridgeshire Community Services NHS Trust (CCS)
- East of England Ambulance Service NHS Trust (EEAST)
- Other partners including schools, parish councils, and local voluntary, community and faith organisations.

Cambridgeshire South Care Partnership

Population 445,420

Partnerships:

- Healthwatch Cambridgeshire & Peterborough
- Cambridgeshire County Council, Cambridge City Council, East Cambridgeshire District Council and South Cambridgeshire District Council
- Cambridgeshire & Peterborough Combined Authority
- 39 GP practices; 4 Primary Care Networks (PCNs): Cambridge Northern Villages, Cambridge City, Cambridge City 4 and Cam Medical; and 5 Integrated Neighbourhoods (INs): Granta, Cantab, Ely South, Ely North and Meridian.
- Cambridgeshire and Peterborough wide Local Medical Committee, Local Dental Committee, Local Pharmaceutical Committee, and Local Optical Committee
- Cambridge University Hospitals NHS Foundation Trust (CUH)
- Royal Papworth Hospital (RPH)
- Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
- Cambridgeshire Community Services NHS Trust (CCS)
- East of England Ambulance Service NHS Trust (EEAST)
- Other partners including schools, parish councils, and local voluntary, community and faith organisations.

Children's & Maternity Partnership

Population 1,031,469

Working with partners across Cambridgeshire & Peterborough to develop and deliver system-wide vision for children, young people and maternity services.

Mental Health, Learning Disabilities & Autism Partnership

Population 1,031,469

Working with partners across Cambridgeshire & Peterborough to improve care for people living with mental illness, learning disabilities and autism.

Section 3: Our population health challenges and outcomes

Population health needs

Our Joint Forward Plan seeks to address the growing health needs of our population.

Population growth of **1.5% - 1.8%** per year

- **One of our greatest challenges is the rate at which our population is growing** - between 1.5% and 1.8% per year - with significant future housing developments planned. Growth across the area is not even; we are seeing significant population growth in our urban areas which are also some of our most deprived areas. We are also expecting to see considerable growth in our older population which we anticipate will have grown by 128% by 2041. This is important because we know that 87% of those aged 85+ have a chronic condition, with 31% having five or more. We need to make sure our services continue to meet the needs of this growing population with a variety of health needs, some of which are complex. Meeting the needs of this growing and ageing population is key to delivering the NHS Long Term Plan. The risk of long term conditions, incurable cancer, frailty and dementia increase with age, so developing services now will help improve the outcomes for our population.
- **We have significant level of need** - our Population and Person Insight Dashboard shows that 27% of patients are living with a chronic condition i.e. long term conditions, disabilities, incurable cancer, organ failure, frailty or dementia. In the North, approximately 30% of people have chronic conditions compared to 24% in the South. Hypertension affects almost 10%, with asthma, diabetes, depression, cancer, osteoarthritis and coronary heart disease affecting between 3.6% and 6.0% of our local people. We also know that these people have comorbidities, for example 27% of our hypertension patients also have coronary heart disease and 29% have diabetes. Services that focus on a single condition aren't meeting the increasingly complex requirements of the population. The environment these populations live in further affects their ability to live with and recover from ill health, exacerbating inequalities.
- **There is a wide life expectancy gap across the whole system** - life expectancy in Cambridgeshire is higher than in Peterborough for both males and females. However, there is considerable variation across Cambridgeshire's districts, with life expectancy in Fenland very similar to Peterborough. There is also a life expectancy gap between individuals born in the most deprived communities compared to those born in the least deprived. The difference in life expectancy between the most and least deprived areas within NHS Cambridgeshire & Peterborough is 7.5 years for men and 6.7 years for women. Across the ICS, 50-60% of the gap in life expectancy between the most deprived and least deprived areas is due to circulatory conditions,

10 years in the life expectancy gap between the most and least deprived parts of our area

cancer and respiratory conditions, but there are considerable variations between Cambridgeshire & Peterborough and by sex. For example, in Peterborough, approximately 42.4% of the gap in life expectancy in men is due to circulatory conditions, compared to 18.6% in Cambridgeshire (Data source: Segment Tool (phe.gov.uk)). It is important to note that although deprivation is more widespread in the North compared to the South of our area, there are pockets of deprivation throughout, e.g. Cambridge and Huntingdon have lower super output areas (LSOAs) in the top 20% most deprived across our ICS.

Our health and wellbeing ambitions and health outcomes

Outcomes framework

Our Health & Wellbeing Integrated Care Strategy sets out our shared priorities, with outcomes aligned to the strategic priorities to define our focus, track our progress and chart delivery against ambitions.

Building on this foundation, we have developed an outcomes framework to demonstrate how the Joint Forward Plan supports the delivery of these high-level ambitions.

The framework provides a core set of measures that help us and our partnerships to measure our progress, ensure visibility and oversight at strategic level, and support collaborative working.

It does not replace existing quality, performance management frameworks and operational Key Performance Indicators (KPIs), which will continue to be delivered and monitored through the relevant governance mechanisms.

Working with our ICS partners and our ICB Board, we will continuously develop this framework so that it provides a clear overall picture of our progress against our strategic priorities and core purposes.

High Level Outcomes and Proxy Measures

The high-level outcomes of our framework measure the whole system's success in keeping the population well and reducing illness, covering both overall improvement in health and wellbeing, and reducing inequalities between different groups. Our intention is to measure improvement against each outcome and progress in reducing inequalities, looking at ambitions for 2030 and beyond.

In addition, we are using 'proxy measures' to help us understand in the short term if we are succeeding in our ambition. Most of these are linked to existing programmes of work included in our Joint Forward Plan. For example, our ambition is to reduce the impact of heart disease in terms of illness and premature death (high level outcome). Possible proxy measures to measure shorter term success include helping people to quit smoking, and actions to identify and treat more people with high blood pressure.

Development Process

As part of the development process, the Strategic Commissioning Unit Outcomes Team have undertaken extensive engagement with subject matter experts across the system. This includes ICB leads, Accountable Business Units leads, the Joint Clinical & Professional Executive Group, ICS Strategy & Planning Leads, provider colleagues, Public Health, local authority, Healthwatch, voluntary, community & social enterprise sector, and other stakeholders.

In developing the domains and measures, we have also taken into account the following factors:

- Demographic and disease forecasts to 2041, which show significant increases in our older population and signal challenges with preventing and treating age-related conditions and multi-morbidity.
- The relative burden of disease, which shows the impact of certain disease groups such as cancer, cardio-vascular disease and respiratory illness.
- Healthy life expectancy drivers, which suggest chronic health conditions and multi-morbidity are the clearest drivers of self-reported poor health, with conditions of the musculoskeletal system standing out due to its high prevalence in the population.
- Health inequalities, which are particularly severe for people with serious mental health illness and learning disabilities.
- The role played by the wider determinants for health such as housing, unemployment, education and social environment.
- Patient experience/user measures.

The ICS Outcomes Framework will guide our plans and agreements with delivery partners. We continue to work on how to make the data easily accessible for staff and public audiences.

High Level Outcome Domains & Population Health Metrics

Headline Outcome Framework domains based on Integrated Care Strategy, JFP and health economics modelling taking into account scale of potential impact on mortality and healthy life expectancy.

Tackling inequalities is cross-cutting for all outcome measures.

Better Outcomes for Children
(also reduces poor health in adulthood)

1. Increase % children achieving good level of development at end of Reception.
2. Reduce % 16/17 year olds NEET.

Reducing Inequalities Deaths in Under 75s

1. Reduce inequalities in preventable premature mortality <75.

Increasing Number of Years People Live in Good Health

1. Increase average years living in good health based on mortality rates and prevalence of self-reported good health.

Wider Determinants

Employment
Increase % in employment.

Housing
Percentage of people in fuel poverty.

Environmental
Carbon reduction linked to air pollution (PM2.5).

Social
Reduce % of adults who feel lonely all or some of the time.

Behavioural

Smoking
Reduce adult smoking prevalence to 5% by 2030.

Healthy Body Weight
Reduce adult overweight/ obesity levels to pre-COVID19 times by 2030.

Physical Activity
10% increase in adults who undertake 150 mins of physical activity per week by 2030.

Alcohol
Reduce alcohol related mortality rate (male/female).

Children

1. 5% decrease in childhood overweight/obesity by 2030 (year 6 prevalence).
2. Years 8 & 10 health related behaviour survey (LA). Reduction in reporting poor mental health.
3. Reduce health inequalities in under 19s (CORE20PLUS Measures).

Mental Health

1. Reduce premature mortality in adults with severe mental illness.
2. Reduce the gap in employment rate for those in contact with secondary mental health services and the overall employment rate (aged 18-69).
3. Increase adults in contact with secondary mental health services who live in stable and appropriate accommodation.

Musculo-Skeletal (MSK) Conditions

1. Reduce work related absences from MSK condition.
2. Increase the rate of Self-Reported Good Health linked to long term MSK Conditions.
3. Improve patient reported outcome measures (PROM) for MSK.

Cardiovascular Disease & Diabetes

1. Reduce mortality from CVD in under 75s per 100,000 population.
2. Reduce emergency admissions for diabetes / 100,000 population.
3. Decreased prevalence of type 2 diabetes.
4. Better diabetes management: reduced complications.

Maternity

1. Reduce still-birth (50% by 2025) & neonatal mortality rate.
2. Reduce number of birthing people who die during childbirth.

Learning Disabilities & Autism

1. Reduce % of deaths which are classed as avoidable among people with a LD.
2. Increase adults with learning disability who live in stable & appropriate accommodation.

Cancer

1. Reduce mortality from Cancer in under 75s ASR per 100,000 population.
2. Improve 5/10 year survival rates.
3. Patient's average rating of care scored from very poor to very good.

Respiratory

1. Reduce mortality in under 75s from respiratory diseases per 100,000 population.
2. Reduce non-elective admissions for COPD and asthma.

Ageing Well (including dementia, frailty & End of Life)

1. Ageing Well: % >55 years who are physically inactive (Active Lives).
2. Reduce emergency admission rate for >65s and (a) falls (b) dementia per 100,000 pop.
3. Reduce permanent admissions rate to care homes/ 100k pop.

Section 4: Delivering the ambitions and priorities of the Health & Wellbeing Integrated Care Strategy

Our joint Health & Wellbeing Integrated Care Strategy sets out a comprehensive explanation of how we will deliver our strategic priorities together as a system, based on evidence we have gathered and feedback from our people and communities.

We described how we plan to address our priorities using three clear phases and for all strategic priorities we are now in phase 3 as a system:

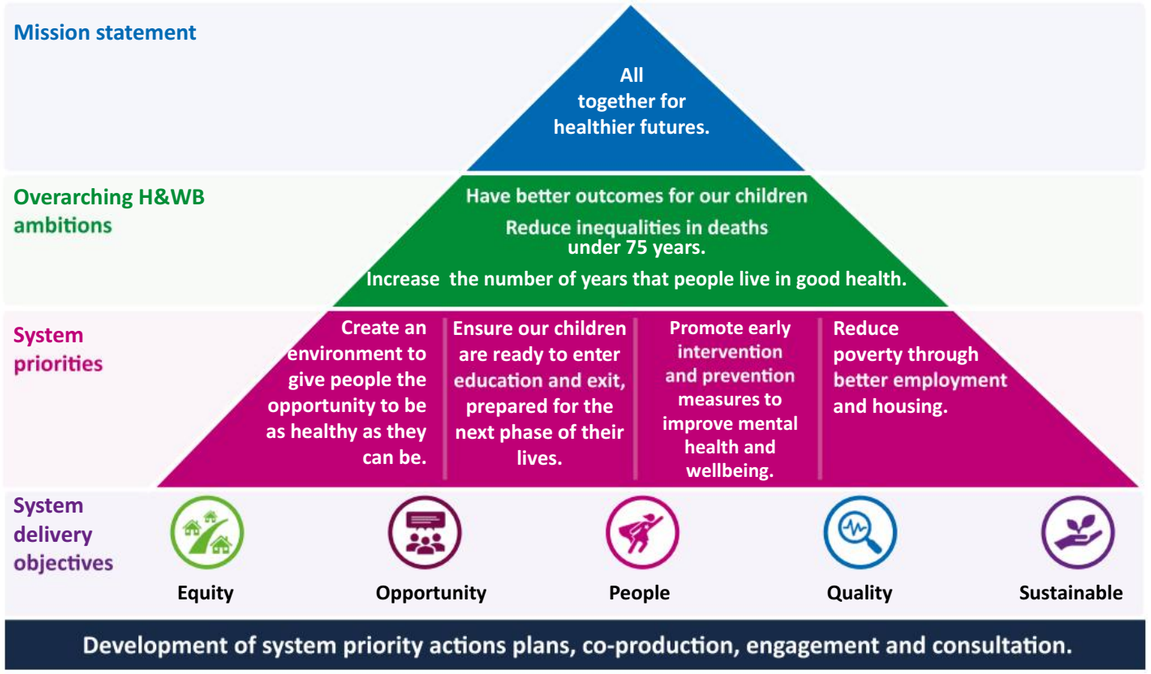
Phase 1 – Data intelligence gathering around priorities.

Phase 2 – Identification of gaps in action and activity for the priorities.

Phase 3 – Implementing programmes of activity to address these gaps.

Within our area, we are continue to work collaboratively to integrate our services, address inequalities and develop local solutions focused on prevention. This focus is embedded across all areas of health service provision.

As detailed in our joint strategy, Cambridgeshire & Peterborough have three clear overarching Health and Wellbeing ambitions, which align with both the system priorities and our mission, as illustrated within the diagram below:



These ambitions are jointly owned and were agreed across local authorities, NHS and wider partners in our system as they reflect the needs of our people and communities. All partners have committed to delivering on these ambitions and the joint action plans that underpin them. Prevention (including action on smoking; obesity; alcohol; hypertension, diabetes; hyperlipidaemia; NHS health checks) is covered within this Joint Forward Plan, in particular within our cardiovascular disease (CVD) prevention plans and the integrated delivery plans at place level. In particular, within our cardiovascular disease (CVD) prevention plans and the integrated delivery plans at place level.

The following four sections describe the current development of delivery plans for the four priorities of our Health & Wellbeing Integrated Care Strategy and the ICB aligned areas of delivery covered in the wider content of this plan:

Priority 1: Children ready to enter and exit education prepared for the next phase of their lives.

Implementation of the action plan across all 10 deliverables is underway. Connections have been made between district councils, primary care and schools, with work focusing on increasing uptake of Healthy Start vouchers and vitamins and childhood immunisations. For 'entering education' work is co-ordinated through the Family Hubs Board and for 'exiting education' work is co-ordinated through the School-Aged Health Improvement Partnership. Some deliverables are crosscutting with other priorities and also across the age ranges (e.g. improving immunisation uptake). Work is underway to complete a children and young people Joint Strategic Needs Assessment and Outcomes Framework.

ICB aligned delivery areas include: integrated family approach across perinatal and early years; emotional wellbeing and mental health; special needs, disabilities and neurodiversity; mental health transitions; ensuring elective recovery for children and young people keeps pace with that of adults. Further details are provided in the children and young people delivery plans.

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

This priority is focusing on the environments that impact on obesity and the clinical risk factors associated with obesity. Activities in the past year include a review of evidence, a school food survey, commissioning behavioural science research to identify behavioural barriers and incentives and the development of a pirmary care risk stratification programme for obesity and associated cardiovascular disease risk factors. An Obesity Summit (February 2024) will explore the evidence and identify priorities for the next phase of strategy delivery with support from experts and system leaders.

ICB aligned delivery areas include: Identification of risk factors through primary care (this will aim to target obesity in year one but may also include smoking and harmful alcohol consumption and onward referral); Empowering people to manage and live well with their health conditions through personalised care and supported self-management; Regular medication reviews, social prescribing and shared decision-making; Identification and treatment of hypertension, high blood sugar & cholesterol; Embedding the prevention offer in secondary care – stop before the op, get fit before the op, hospital cessation support and onward referral to sustain quit. Actions to deliver on environmental sustainability (including waste, travel and energy efficiency) are also critical for preventing ill health.

Supporting high risk groups is another key ICB intervention, including people with mental illness and supporting pregnant smokers to quit and addressing inequalities. Furthermore, the role of the ICB as an anchor institution and its wider influence within our system is aligned to this work.

Finally, actions to improve the management of long-term conditions including asthma, diabetes, epilepsy, mental health and oral health, in line with the Core20PLUS5 priorities.

Priority 3: Reduce poverty through better employment, skills, and better housing.

A housing and health summit was held in 2023 to support completion of the action plan focusing on identification of immediate deliverables for 2023/24. The Employment and Health workstream is continuing to progress the Cambridgeshire & Peterborough Work, Health and Wellbeing Strategy and its action plan. The Strategy Oversight Group is well established and involves public health, district council, upper tier local authority, ICB representatives and wider partners. The group has shifted to delivery through a trial hub and spoke approach overlaying work and health support into existing community hubs. Other areas in development include a Good Work Charter sponsored by Cambridgeshire & Peterborough Combined Authority and work to support employers.

ICB aligned delivery areas include: The People Plan promise, workforce retention and training; Affordable housing for health workers; Integrated local approaches to provide person centred support. This will be covered primarily in the workforce and opportunities sections of the Joint Forward Plan and in Place-based delivery plans.

Priority 4: Promote early intervention and prevention measures to improve mental health and wellbeing.

We have established a mental health oversight group that provides guidance on the development of the following three workstreams: motivation for mental health; information and communication; and relationships for mental wellbeing. The first two workstreams meet regularly with stakeholders and have identified short and longer term deliverables within action plans. The relationships for mental wellbeing workstream will be launched at a symposium event, which will bring together a wide range of stakeholders, including academics and community sector groups, to review the evidence and best practice on children, young people and family relationships for mental wellbeing and work to address loneliness across all age-groups. A fourth workstream focussed on the wider determinants of mental wellbeing is being considered in relation to cross-over work with Priority 3.

ICB aligned delivery areas include: Increasing access to Talking Therapies and community mental health services; Providing employment support to enable people with mental health conditions, learning disabilities and autism to return to the labour market; Improving dementia diagnosis and support; Development of the Learning Disabilities and Autism Partnership and implementation of its work programmes, with increasing focus on prevention and early intervention, particularly for children.

Section 5: Reduce inequalities in health outcomes

Our approach

Health inequalities are systematic, avoidable and unfair differences in health outcomes that exist between different groups or populations. These inequalities arise from the unequal distribution of social, environmental, and economic conditions within societies (poverty, education, housing, employment, and access to green spaces, clean air and transport). They can significantly impact an individual's overall health and wellbeing and disproportionately impact people from a range of demographic groups.

Healthcare inequalities are related to inequalities in the access people have to health services, their experiences of using such services, and the outcomes they receive.

Addressing health inequalities requires a coordinated, cross-sector approach that, alongside the improved delivery of care, addresses the wider social, economic, and environmental factors that contribute to poor health outcomes. Our vision, and one which is shared with our ICS partners, is to deliver the best possible health outcomes for everyone living in Cambridgeshire & Peterborough. The following sets out the ICB's contribution to delivering against this vision and our commitment to improving access, experience and outcomes for our local population.

Our overarching ambition is to increase the number of years people live in good health and reduce premature mortality. We will support this through a renewed focus on primary and secondary prevention, partnership work to address the root causes of health inequalities and promoting Population Health Management approaches.

Targeting health inequalities is also a core focus of our innovation agenda covered later in our plan. We will continue to build on early successes, such as the Innovation for Health Inequality programme and the Adopting Innovation Hub's work on inequalities in line with Core20PLUS5 priorities, to ensure innovation is specifically adopted to support underserved communities.

Our overarching objectives are to:

- Ensure reducing health inequalities is a priority for everyone and embedding a 'Core20PLUS' approach.
- Be informed by our data and wider insights and be evidence-led in our approaches.
- Promote healthy lifestyles and behaviours and increase access to early intervention services.
- Improve access to healthcare services for vulnerable and marginalised populations.
- Improve the quality of care and patient experience across the ICS.
- Ensure resources are allocated based on need.
- Work closely with research and innovation functions to adopt and implement both clinical and non-clinical best practice to better support our underserved communities.
- Work with local people and communities to better understand the challenges they experience and co-produce solutions that best meet their needs.

The key areas of focus that we will seek to embed across all areas of delivery are aligned to the NHS England's five key priorities for tackling health inequalities, the Core20PLUS5 (adult and children and young people approaches), and our Health Inequalities Strategy, published in 2020.

In 2023, we undertook a review of our governance arrangements to support delivery. We have since established a Health Inequalities Strategic Oversight Group which reports into a new Population Health Improvement Board, providing a system-wide approach to help drive the ICB's ambitions in improving population health outcomes.

Core20PLUS5 approaches

Core20PLUS5 is an NHS England national approach designed to help support efforts on reducing health inequalities. The approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' clinical areas in which rapid improvements should be made for the target population.

'Core20' – this describes the most deprived 20% of the population nationally as identified by the Index of Multiple Deprivation (IMD). For Cambridgeshire & Peterborough, 62 Lower Super Output Areas (LSOAs) are in the 20% most deprived nationally; 46 are in Peterborough, while 11 are in Fenland. In total, 13% of our population live within the most deprived area with the geographical distribution varying considerably: 95% (107,000) living in the north compared with 5% (5,000) in the south.

'PLUS' population groups – these are ICS-determined population groups experiencing poorer than average health access, experience and/or outcomes, but who may not be captured in the 'Core20' population alone. Across our area, these groups have been identified as:

- People from minority ethnic communities.
- Rural communities.
- People or groups experiencing, or at risk of experiencing, greater health inequalities (including disadvantaged groups or inclusion health groups), e.g. migrants, asylum seekers, travellers, those experiencing homelessness or rough sleeping, sex workers, those in contact with the judicial system.
- People with learning disabilities and/or autism.
- People with Severe Mental Illness (SMI).
- Armed Forces community.

It is important to note that this is not an exhaustive list of 'PLUS' groups and that those experiencing poorer than average health access, experience and/or outcomes are likely to vary depending on the clinical priority and the geographical footprint being considered.

There are five clinical priorities across two areas of focus, adults and children and young people.

For adults, the five areas of clinical focus include:

- **Maternity** – Ensuring continuity of care for women and birthing people from Black, Asian and Minority Ethnic communities and from the most deprived groups. We will continue to develop our partnerships and integration with community partners to triangulate and address the inequalities that exist, through delivery of the ICS's Equity and Equality Plan. As part of this ambition, during 2023-24 we supported the launch of a new maternity equity hub pilot Mothers United for Maternity and Mental Health Action (MUMMA). The hub is a joint venture between Barnardo's Childrens Charity and local VCSE groups which support Black, Asian, and Mixed Ethnicity women and birthing people to help improve their experiences of maternity care and support them and their families throughout the perinatal period. This is covered in more detail in the Children and Maternity section and in the Maternity and Neonatal Services delivery plan.
- **Severe Mental Illness (SMI)** – Over the next two years, we will expand the specialist SMI Annual Health Check (APHC) programme via our GP Federations to increase the number of health checks completed, with the ambition of achieving 80% completion year-on-year by March 2028. Additionally, by March 2025, we will enhance our community stop smoking service provision amongst SMI patients, in collaboration with wider ICS partners, as an extension to the NHS Long Term Plan Treating Tobacco Dependency Programme (TTDP).
- **Early cancer diagnosis** – To diagnose 75% of cancers at stage 1 or 2 by 2028. To meet this ambition, over the next five years, we will continue to focus on those more deprived communities through targeted Lung Health Checks which we were able to commence during 2023 with a pilot in Peterborough. We have now developed our plan to expand the services across Cambridgeshire & Peterborough to ensure all eligible people are invited to a lung health check by March 2029.
- The establishment of **Community Diagnostic Centres (CDCs)** to provide diagnostic services closer to patients who need it most (covered in more detail in the Community Diagnostic Centres delivery plan); and develop **faster diagnostic pathways** for population cohorts who are most disadvantaged (for example previous work has focussed on the Gypsy, Roma and Traveller populations and non-English speaking population groups in Fenland). Also to build upon the lessons learned from the **cancer screening projects**, which were designed to increase screening uptake in more deprived areas of higher deprivation by allocating resources on an deprivation-weighted basis.
- **Chronic respiratory disease** – To focus on Chronic Obstructive Pulmonary Disease (COPD) driving uptake of COVID-19, flu and pneumonia vaccines. Over the next five years we will continue to promote recommended vaccinations for eligible respiratory patients. Building on the COVID-19 vaccination outreach programme, we will continue to monitor vaccination uptake by deprivation, ethnicity and other protected characteristics and respond to such variations by ensuring future delivery approaches are co-designed with those populations and communities to maximise uptake.
- **Hypertension case finding and optimal lipid management** – To allow for interventions to optimise blood pressure and lipid management to minimise the risk of myocardial infarction and stroke. This work forms part of the wider cardiovascular disease strategy (see Cardiovascular Disease Delivery Plan for more information). We will continue to develop programmes of work that specifically target our Core20PLUS population groups, for example through the establishment of a new lipid management pathway utilising the Innovation for Healthcare Inequalities Programme (InHIP) funding. An evaluation of this programme will be carried out and will be used to expand the investment and pathway across our area in 2024/25 and beyond.

For children and young people, the five areas of clinical focus include:

- **Asthma** – To address the over-reliance on reliever medications and decrease the number of asthma attacks. We will achieve this ambition by 2028 through the increased partnership working and targeted interventions such as the Digital Health Passport to promote asthma self-care, which commenced in 2023, and the 'Ask about Asthma' campaign targeting high-risk children with asthma.
- **Diabetes** – To increase access to real-time continuous glucose monitors and insulin pumps across the most deprived quintiles and from ethnic minority backgrounds; and increase the proportion of those with type 2 diabetes receiving recommended NICE care processes. In 2023, access has increased by 19% through the additional supply of information and education to support those for whom English is not their first language.
- **Epilepsy** – To increase access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism, as set out in our delivery plan for children and young people.
- **Mental health** – To improve access rates to children and young people's mental health services for certain ethnic groups, age, gender and deprivation, as set out in our 2022/25 children and young people's mental health strategy. This is covered in more detail in the Babies, Children and Young People delivery plan.
- **Oral care** – To address the backlog for tooth extractions in hospital for the under 10s. Our analysis from 2022 has shown that Peterborough has the highest prevalence of dental decay in five-year-olds, while East Cambridgeshire had the lowest, although there is an increase in prevalence over the last three-years. In terms of the tooth extraction index in five-year-olds in lower tier local authorities in 2022, Huntingdonshire had the largest extraction index at 2.6%, followed by Cambridge City and then Peterborough. The ICB has provided additional funding into the Starting Well programme which links system partners to facilitate the identification of children and provide additional dentist sessions for check-ups, treatment and prevention advice.

Deep Dives into each of the clinical priority areas will be undertaken throughout 2024/25, which will identify additional opportunities and help inform a refresh of our Health Inequalities Strategy.

We know that long waits before accessing planned care can have detrimental consequences on the development of children and young people impacting on their ability to access education and lead full and active lives. Longer term, this can exacerbate existing inequalities and lead to life-long consequences on the development of children and young people. In light of this insight, during 2023/24 work on wider childrens and young people's waiting lists within secondary care has progressed with an action plan focusing on reducing overall wait times and ensuring that recovery of elective waiting list comparable to adult recovery, with focused work on ENT and ophthalmology.

In addition to the Core20PLUS5 approaches, we will continue to take system-wide action to address health inequalities that are aligned to the NHS England five priority areas:

Priority 1: Restoring services inclusively

During 2023/24 there has been continued focus to drive and accelerate long wait recovery for all our patients, whilst reinforcing the national Choice agenda. Focused work on evaluating our waiting list data by ethnicity and deprivation is progressing and further work is planned in 2024/25. The 'Waiting Well' programme and resource expanded to provide relevant information, opportunities, and access to a broad range of services in the local area to empower patients to optimise their health whilst awaiting treatment and is being rolled out across various platforms to promote to all.

We will:

- Continue to monitor and evaluate waiting list data by ethnicity and deprivation to help identify and address any differences of access between groups. A new Health Inequalities Data and Insights group has been established which will allow for greater analysis of waiting lists to be carried out.
- Develop and implement innovative initiatives that improve access to healthcare services for vulnerable and marginalised populations, including developing targeted interventions for disadvantaged and inclusion health groups such as the homeless, asylum seekers, and people with disabilities.
- Continue to develop our data sources to help identify health inequalities within elective care and work with our communities to co-produce different ways to deliver services.
- Further develop our "waiting well" initiatives and to work with local people to develop wraparound services.
- Improve diagnostic wait times across the system, ensuring equitable and timely access for all.
- Redesign pathways for key specialities (ENT, dermatology, urology, endocrinology, MSK, ophthalmology and cardiology) ensuring each is impact assessed from a health inequalities perspective.
- Improve elective waiting times for children and young people, ensuring that elective recovery rates for children and young people do not fall behind recovery rates of adult services.

Priority 2: Mitigate against digital exclusion

We will:

- Ensure that our providers offer face-to-face care to people who cannot use remote services.
- Monitor digital inclusion and work with partners to help overcome the barriers to accessing online healthcare services or provide accessible alternatives.
- Continue to expand our data collection to help identify who is accessing face-to-face, telephone, and video consultations, broken down by relevant protected characteristics, such as ethnicity.
- Ensure we support people to become digitally included as part of our wider Cambridgeshire & Peterborough digital strategy.
- Help people to use technology to improve outcomes, by empowering them to control their own health through efficient and joined up services.

Priority 3: Ensuring data sets are complete and timely.

We will:

- Work across the system to continue to improve the collection and recording of ethnicity data as well as other protected characteristics.
- Utilise the information on the Health Inequalities Improvement Dashboard as part of individual programme development.
- Implement a new Shared Care Record and analyse the information to help address variances such as discrepancies in patient ethnicity coding.

Priority 4: Accelerating preventative programmes that proactively engage those at greatest risk of poor health outcomes:

Cardiovascular disease (CVD) is one of the biggest drivers of health inequalities in our area, accounting for approximately one-fifth of the life expectancy gap between our most and least deprived communities. In Peterborough, the under-75 mortality rate from CVD considered preventable is significantly higher than the England average, with it being ranked the highest in the East of England region.

Preventing cardiovascular disease and addressing the associated behavioural risks (including excess weight, obesity, alcohol consumption and smoking) are priorities for the ICB and wider system. We will build upon work already underway in the delivery of primary and secondary prevention and work across the system to address such behaviour risk factors that drive health inequalities.

Our prevention plans for smoking, alcohol and obesity are set out in the cardiovascular disease section of this chapter.

In addition to preventative lifestyle programmes, the ICB is working closely with ICS partners to establish and embed new approaches to address high intensity use of services. The effective identification and management of those who utilise NHS services more frequently is vital in terms of reducing demand and increasing capacity across the system, while ensuring individuals receive the wider care and support they require.

High intensity use of services is linked to health inequalities with those attending A&E on a more intense basis likely to experience a host of wider socio-economic problems, including unmet social needs such as housing, loneliness, employment, debt, as well as having chronic health conditions, mental health issues, and drug and substance misuse problems. Taking a targeted and personalised approach to supporting these individuals is an important part of the wider prevention agenda, improving health outcomes amongst this population cohort, reducing health inequalities, and helping to reduce avoidable A&E attendances and admissions over time.

Priority 5: Strengthening leadership and accountability

We have established a new system-wide Population Health Improvement Board which aims to provide a collaborative systems approach to drive the ICB's key ambitions in improving population health outcomes while addressing healthcare inequalities in terms of access, experience, and outcomes.

In addition, we will:

- Continue to ensure the ICB, and its partners, have named Senior Responsible Owners who will be responsible for tackling health inequalities.
- Ensure all ICB programmes of work have a focus on tackling health inequalities and the appropriate impact assessments have been carried out as a part of the Strategic Commissioning Unit.

We will utilise the Population Health Improvement Board and wider ICB committees to seek and commit additional funding, drawn down from the national health inequalities funding allocation.

Over the next five years we will measure improvement against the following:

- A reduction in the number of deaths in under 75s considered preventable, reducing inequalities in our most deprived areas and amongst our most disadvantaged groups.
- Vulnerable and marginalised populations will experience improved access to healthcare services, such as treatments, diagnostics, primary care, and community services, as measured by reductions in waiting times, improvements in patient satisfaction, and reductions in missed appointments, leading to better health outcomes and quality of life.
- Improvements in the quality of care and patient experience, as measured by a range of indicators including patient feedback, patient outcomes, and compliance with national quality standards.
- Effective allocation of resources, as measured by the development of an outcomes delivery framework and the use of appropriate measures and evaluation criteria, contributing to better outcomes, reduction in health inequalities and improved financial sustainability for the ICS over the longer term.

To support our ambitions, the Strategic Commissioning Unit (hosted by the ICB) will continue to develop the ICB's capabilities to analyse data and intelligence (at system, Place and Integrated Neighbourhood level) to provide actionable insights into the key drivers of cost and risk. The unit will expand its capabilities to identify, develop and recommend innovative solutions which reduce health inequalities and improve patient outcomes.

Our two place partnerships will ensure people receive care as close as possible to where they live through the evolving neighbourhood teams and support integrated place-based approaches to prevention, early intervention and addressing the social determinants of health to help tackle health inequalities.

The Mental Health, Learning Disability & Autism Partnership and the Children & Maternity Partnership will play a key role in improving health outcomes for these population groups through transformation and integration, alongside other system partners including VCSE and district councils.

For example, with investment from the ICS Health Inequalities Fund, the North Care Partnership are creating case finding teams, which aim to engage people with underlying long-term conditions or vulnerability in health and wellbeing activities, and to increase uptake of immunisations, health screening and support among target groups. The target areas include CVD; high blood pressure; respiratory health; childhood and adult immunisations; people with learning disabilities; people who are housebound; new patient registrations for people who have not been assessed and may be at risk (e.g. people in temporary housing); long-term condition optimisation (e.g. diabetes); and safe housing (including damp and cold environments).

In addition, there are a number of opportunities for us to use the skilled workforce we have working across primary care providers - including optometrists, dentists and community pharmacists - to enhance closer to home access to preventative care, supporting the work already done in General Practice to identify patients for whom early identification and intervention can prevent longer term problems emerging.

By embedding a focus on prevention and equity through these structures and across all aspects of service delivery we will make a measurable and sustainable difference to outcomes for all our local people and tackle the health inequalities that currently exist in our area.

Population Health Management

Population Health Management (PHM) is an important methodology to support our goals on prevention of ill-health, tackling health inequalities, improved outcomes, and quality of care.

PHM is an approach that enables local areas to deliver the most appropriate services for local people. It uses linked datasets from health, care, and other services to plan and deliver proactive and preventative care. Using a PHM approach drives a change in culture towards more integration, more prevention, and more provision, based on need rather than service use.

Our vision is that all organisations within the ICS will have the skills, resource, and information they need to use PHM approaches, with all partners using the same database to align priorities and operationalise PHM. Most operational PHM will happen at Place and Integrated Neighbourhood level, but we will also use a PHM approach at system-level overseen by the Population Health Improvement Board to allocate resource, manage risk and identify system priorities. As part of our commitment to sharing intelligence across organisations, we know that PHM data can be further enhanced by qualitative information incorporating voluntary, community and social enterprise sector and feedback from local people. This ensures it reflects community insight and knowledge, bringing rich qualitative feedback alongside quantitative data.

We will develop a PHM platform and support provider partnerships and Integrated Neighbourhoods in using high-quality PHM approaches. Examples of progress to date:

Case study

Population Health Management in action: Eclipse

- Across Cambridgeshire & Peterborough, we have rolled out the Eclipse tool (provided by Prescribing Services Ltd). Eclipse combines Primary and Secondary Care data to segment the population into Population Health Management pathways which align with either long-term conditions e.g. diabetes, COPD or with high-risk users such as those with multi-morbidities or high usage of services.
- It allows GP practices to understand variation in their patient groups. An example of this is diabetes where current achievement of the Care and Treatment targets can be compared to other practices across PCNs, the ICS and nationally.
- It has been used to improve the care for patients with diabetes by identifying their unmet needs.
- Evidence shows that early identification of people who are in their last years of life improves their and their loved one's experience at end of life. We are using Eclipse to support GP practices to identify and plan with patients who are end of life.

Case study

Population Health Management in action: North and South Partnerships

- Practices in the North Partnership have used the PHM methodology to support patients who receive multiple Fit Notes. They have worked with their patients to understand their needs and identified musculoskeletal and mental health as the two leading drivers of requests for Fit Notes. They identified language as one of the key factors in accessing support so ran drop-in sessions with local voluntary services and the local college to link the patient up with language or employment advice.
- Integrated neighbourhoods within the Cambridgeshire South Care Partnership have used PHM methodology to bring together a wide range of system partners to look at the needs of their population in their most deprived areas. This brought together health, local authority as well as Citizens Advice and the local food bank to understand the services the population were accessing and what else they needed. This has led to more residents accessing the support and care they are entitled to, for example health checks and personalised care budgets.

How we will develop our infrastructure:

- We will create a linked dataset spanning social care, secondary care, primary care, community and mental health. This will build on the data warehouse currently commissioned by the ICB from North of England Commissioning Support Unit (CSU).
- We will add additional data sources (e.g. wider local authority, police, fire, VCSE) to the capability iteratively as and when technical capability, information governance and organisational alignment activities allow.
- We will procure and generate the tools to carry out the analysis we need to understand our population e.g. R, PowerBi, Python.
- We held four workshops across the ICS to understand the tools needed by each of our partners. We are now running a procurement to acquire those tools.
- As the capability increases, we will use it to redesign services and evaluate their impact iteratively. We will ensure our clinical community develop the skills to harness and understand these rich data sources so they can maximise its use in the clinically led redesign of care pathways.

As part of the wider PHM programme we are looking at the resourcing required to embed PHM as an approach and not just a tool. We have a PHM strategy in development that shows resourcing options across the ICS down to Integrated Neighbourhood level to support the PHM rollout to ensure it is used as a methodology for change across our system.

Each Primary Care Network (PCN) working with their Integrated Neighbourhood is developing a plan to address the needs of their population. Those plans will align to the data tools and PHM methodologies described above. Plans were submitted in September 2023 in preparation for full implementation from April 2024.

PHM will enable us to direct resources and interventions to target key risk and inequality areas at system, place and PCN level. Ensuring 'top down clarity' and 'bottom up agency' will lead to the best solutions for our population being proposed and enacted. We will come together as a partnership to plan how incentives can be best used as part of this approach.

Cardiovascular disease (CVD)

Heart and circulatory disease, also known as cardiovascular disease (CVD), causes a quarter of all deaths in the UK and is the largest cause of premature mortality in deprived areas. This is the single largest area where the NHS can save lives over the next 10 years.

Modifiable risk factors explain 90% of CVD incidence, and up to 80% of premature deaths (those who die under 75 years of age) from CVD are preventable. Obesity is closely associated with three of the main clinical risk factors for cardiovascular disease (CVD) – hypertension, hypercholesterolaemia, and hyperglycaemia, as well as many cancers.

Locally, CVD is among the largest contributors to health inequalities, accounting for one-fifth of the life expectancy gap between the most and least deprived communities. If we look at the period 2017-2019 the preventable CVD related mortality in those under 75 years of age in Peterborough is significantly worse than the England and regional averages. It is ranked the 26th highest district in England, with an increasing trend. Preventing cardiovascular disease and addressing the associated behavioural risks (including excess weight, obesity, alcohol consumption and smoking) are priorities for us now and in the longer-term.

Our overall ambition is to reduce rates of CVD in our area through preventative lifestyle changes whilst optimising diagnosis and treatment and thereby tackling health inequalities.

Our CVD strategy 2021-26 specifically aims to achieve the following outcomes:

- 5% reduction in deaths from cardiovascular disease.
- 5% reduction in acute admissions with heart failure.
- reduction in death from cardiovascular disease by 10% for PCNs within the worst quintile of death rates from cardiovascular disease.

To support the delivery of our CVD objectives, the programme is comprised of four key workstreams:

Workstream 1 – Population Awareness and Insight

- Review and update CVD prevention data to risk stratify patients and to target populations with unwarranted variation and inequalities.
- Increased awareness of behavioural, clinical CVD risk factors, type of CVD and its consequences through national and local campaigns.
- Increased awareness of the importance of early identification and checks available: NHS health checks, community health checks, annual reviews and self-assessment.
- Engage patients to improve their understanding of their condition and how to manage it.
- Support patients to manage their condition effectively, through self-care and use of digital technologies.

Workstream 2 – Behavioural risk factor detection and management

- Reduce prevalence of smoking in deprived communities.
- Reduced prevalence of obesity in adults.
- Reduced number of residents drinking to harmful levels.
- Reduce low rates of physical inactivity.

Smoking cessation

Smoking remains the leading preventable cause of illness and premature death. Since 2011, there has been a downward trend in smoking rates nationally. However, around 5.4million people (13%) continue to smoke nationally. The adult smoking prevalence in England is 12.7%, while in NHS Cambridgeshire & Peterborough the rate is 11.4%. Despite overall smoking prevalence being lower than the England rate, we see a marked difference in current smoking rates across our six districts, with rates highest in Fenland (14%) Cambridge City (13.8%) and Peterborough (12.2%) compared with East Cambridgeshire (7%).
Source: OHID Fingertips.

Improving smoking cessation rates is a core part of our CVD prevention strategy and forms a key part of our approach to tackling health inequalities. We will continue implementation of the NHS Treating Tobacco Dependency Programme (TTDP) building on the successful implementation of smokefree pathways within each of our maternity providers and mental health inpatient services. We will also incorporate into future plans the learning from local authority commissioned Behavioural Insights research that commenced in 2023, which will include insights into smoking behaviours amongst our Core20PLUS population groups.

- By March 2025, we will have piloted and commenced a new community mental health tobacco cessation pathway aligning this to the annual physical health checks for those with Severe Mental Illness (SMI).
- By March 2026, we will have fully implemented the TTDP across all acute inpatient services.
- We will introduce new technologies (e.g. digital applications and disposable carbon monoxide monitors) to support quit attempts as well as widen the incentives on offer to support pregnant women and mental health inpatients.
- We will focus on increasing uptake of stop smoking services in our Core20PLUS population through our integrated care partnerships and in collaboration with Integrated Neighbourhood teams.
- By March 2026, we will expand our offer of stop smoking support to NHS staff through the introduction of a stop smoking app.
- We will continue collaborating with the local authority to implement a sustainable tobacco control plan and contributing towards the Government's ambition to become a smoke free generation by 2030.
- We will collaborate with the local authority to implement a cessation of smoking trial in the emergency department (CoSTED) in 2025/26.
- We will continue to offer maternity specific stop smoking support to enable our women and pregnant people to have smoke free births.

Obesity

The prevalence of obesity in our area is influenced by various factors, including lifestyle choices, access to healthy food options, the availability of fast-food outlets and access to safe green spaces and active travel options. The percentage of adults (aged 18+) classified as obese in Peterborough (32.2%), Huntingdonshire (27.0%) and Fenland (40.1%) is higher compared to other areas of Cambridgeshire & Peterborough and higher than the national average (25.9%). Source: OHID Fingertips.

Tackling obesity is a key shared priority as part of our Health & Wellbeing Integrated Care Strategy. We aim to reduce childhood obesity to pre-pandemic levels by March 2026. We will work proactively with the local authority, public health and other partners on the delivery plan.

We will increase the identification of obesity in local people through increased opportunistic engagements and increase referrals from areas of high deprivation and obesity prevalence through targeted promotion of weight management programmes, complementing other prevention work. We also need to consider, with our local authority colleagues, planning decisions and the implications these have on population obesity.

Alcohol treatment

In 2023/24, we carried out an initial evaluation of the Alcohol Care Team (ACT) at Cambridgeshire University Hospitals NHS Foundation Trust, which has been established to provide a 7-day-a-week service. An Alcohol Care Team Innovation & Optimisation Network (ACTION) peer review carried out in 2023 found that CUH met 90% of standards expected of ACTs.

We will evaluate the feasibility of establishing other ACTs across the system by 2028 to support implementation of the wider Cambridgeshire & Peterborough Drug and Alcohol Strategy. We will also increase the integration of alcohol care services between primary, secondary and community services. We will continue to support the work of the local Combatting Drugs Partnership (CDP) and delivery of Cambridgeshire & Peterborough's Drug and Alcohol strategy, including the prevention and risk reduction of alcohol harm at a primary care level, as well as increased screening in secondary care, building upon the ACT optimisation programme within other acute sites.

Workstream 3 – Clinical risk factor detection and optimal management

Improve treatment and identification rates of:

- atrial fibrillation
- hypertension
- hyperlipidaemia
- chronic kidney disease
- pre-diabetes and diabetes.

Atrial fibrillation

We will work with primary care providers to develop a community palpitations pathway, ensuring early detection of atrial fibrillation through the use of remote technologies.

Working in collaboration with public health and primary care providers, we will increase the number of patients who are identified and optimally treated in relation to specific clinical risk factors such as, hypertension (high blood pressure) and hyperlipidaemia (high cholesterol). We will work towards the targets outlined below over a two-year programme. We will deliver this using a Population Health Management programme of work, which will detect patients at risk and seek to optimise their treatment to reduce that risk.

Hypertension (high blood pressure)

The Public Health England (PHE) ambitions for hypertension are that by 2029:

- 80% of the expected number of people with hypertension are diagnosed.
- 80% of the total number of people diagnosed with hypertension receive treatment, according to the target in NICE guidelines.

Hyperlipidaemia (high cholesterol)

- 75% of people aged 40-74 have received a formal validated CVD risk assessment and cholesterol reading recorded on a primary care data system in the last five years by 2029.
- 45% of people aged 40-74 identified as having a 20% or greater 10-year risk of developing CVD in primary care are treated by statins by 2029.

The programme will seek to gather information relating to patients' weight to ensure GP records have a weight measurement within the last three-years thus supporting the detection of obesity in our population.

Additionally, the programme will seek to increase the uptake of NHS Health Checks (available to those aged between 40–74 years who do not have a long-term condition) to meet the PHE ambition of 75% of eligible adults receiving a check. This will further support the detection of CVD risk across our population.

The CVD Population Health Management programme uses an iterative approach to make multiple contacts with patients through a range of means, ensuring those most underserved are identified through the programme and supported into appropriate treatment pathways.

Through 2023 and into 2024, Cambridgeshire & Peterborough ICB commissioned Eclipse to conduct a prototype model of this programme focusing on lipid management across practices in the most deprived communities, identifying key areas of improvement with a view to ensuring the learning could be taken into a universal approach. Key improvements identified throughout this programme have been built into the CVD Population Health Management programme with final evaluation due to be undertaken in the coming months.

Diabetes

People with diabetes are at a higher risk of developing CVD, particularly coronary heart disease and stroke. Effective management of diabetes, alongside lifestyle changes, is important to reduce the risk of CVD and improve health outcomes. We will ensure appropriate monitoring and screening for co-morbidities and complications for patients with a diagnosis of diabetes, and appropriate management in line with NICE treatment targets.

Workstream 4 – Identification and optimised management of established cardiovascular conditions including heart failure

- Provision of acute services closer to populations, particularly through the delivery of services within community settings. The following workstreams are driven by strong evidence based tertiary preventative interventions for the prevention and treatment of CVD:
  - Optimisation of heart failure treatment and pathways
  - Cardiac rehabilitation for patients post-ACS (acute coronary syndrome) and diagnosis of heart failure

Case Study

ACS pathway nurses at RPH now have access to the Epic electronic record system to review diagnostic results and relevant medical history. This has resulted in a smoother and more efficient pathway for CUH patients awaiting transfer to the RPH urgent cardiac pathway, impacting positively on waiting times and patient experience.

Heart failure

The ICB will support providers to develop new pathways based on established ambulatory models by providing insights and data. An integrated team across the ICS will start to address the whole heart failure pathway. This approach will then be adapted, tested and evaluated in parts of Cambridgeshire & Peterborough.

There are opportunities for better outcomes through pathway changes and the adoption of innovation and the system has prioritised the CVD pathway as a priority pathway for improvement. As part of this work there will be a focus on diagnostics (especially echocardiograms) being able to be delivered more locally and having sufficient and alternative workforce to support. We will continue, with acute providers across Cambridgeshire & Peterborough, to drive improvements in cardiology pathways, optimising the expert specialist care available at Royal Papworth Hospital.

Children and young people

Our Health & Wellbeing Integrated Care Strategy identifies the improvement of outcomes for children as a top ambition, with a specific priority to ensure children are ready to enter education and exit, prepared for the next phase of their lives. Our partners are committed to working together to build strong families and communities, build capacity and take a whole family approach, with early intervention to address specific needs and reduce inequalities.

To tackle inequalities and improve health outcomes for babies, children, young people and families we will continue to co-produce quality improvements of services, with a commitment to always listen, discuss and act on the voices of children, young people and their families, ensuring all communities feel able to contribute. We aim to improve access by joining up services through Integrated Neighbourhoods. Where it makes sense, we will continue with joint commissioning arrangements enabling children, young people and their families to have seamless pathways of care across health, care and education.

Maternity and neonatal services remain a NHS priority. The Local Maternity and Neonatal System (LMNS) is the maternity and neonatal arm of the ICS, bringing together providers, commissioners, local authorities, service user voice representatives and other local partners to support improvements in care in accordance with the national priorities. The system's three-five year maternity strategy has been co-produced and is due to be approved by the ICB Board in March 2024.

Focusing on babies, we will promote the Healthy Start Scheme and Best Start for Life Programme to support a healthy pregnancy for all and tackle health inequalities through early identification and support for vulnerable parents. Our local midwifery, health visiting and community partners have an aligned approach to support new families to enable them to develop good parent/infant relationships. As well as face to face visits, we will introduce a digital offer through the Family Hubs programme promoting good attachment and bonding and infant feeding support as well as information on early childhood development.

For our children and young people, we will continue to support their mental health, emotional wellbeing and resilience by continuing to deliver on the priorities in the Cambridgeshire & Peterborough Children and Young People's Mental Health Strategy by:

- Improving access and equity to emotional wellbeing and mental health help and treatment for 0–25-year-olds.
- Targeting children and young people who are at increased risk of developing mental health issues.
- Improve the safety and experience of young people transitioning from children's service to adult mental health services.

For children and young people with a disability we will continue to embed our Special Educational Needs and Disabilities (SEND) Strategy. We want to make SEND everyone's business to enable children and young people to access a wide range of health services as well as those more specialist services as clinically required. We will continue with jointly commissioned services, where it makes sense to deliver an integrated and high-quality SEND Local Offer to support children to flourish and achieve their potential.

Focusing on children and young people who are neurodiverse, we recognise there are long waits for access to diagnostic and post diagnostic support. Throughout 2024/25 we will work with system partners to focus on children's and young people's needs, using quality improvement methodology to simplify neurodevelopmental diagnostic processes and provide better post diagnostic support to reduce long term poor health outcomes.

We will reduce health inequalities for children and young people with a learning disability. With a specific improvement programme over the next two years for all people with a learning disability. The programme will draw together the outcomes from the Learning from Lives and Deaths (LeDeR) reviews and recently published learning disability specific Health Needs Assessment, with the aim of:

- Improving uptake of Annual Health Checks and comprehensive co-produced annual health plan.
- Increased access to mainstream services by ensuring appropriate reasonable adjustments are in place.
- Upskilling of the workforce to support the specific needs of people with LD&A.
- Promoting the Homes Not Hospitals programme, by expanding the Dynamic Support Register through the Keyworker Collaborative, and ensuring every learning disabled or autistic child or young person on the Dynamic Support Register is offered the support of a keyworker.
- Improving system-wide knowledge of the Care Education and Treatment process to enable children and young people to access their care and treatment in their community and avoid unnecessary mental health admission.
- Developing a pilot programme to enable children and young people attending a special school to access their routine health review appointments at their school rather than in a hospital when this is clinically appropriate.

Over the next two years we aim to improve access to NHS dentistry for children and young people to improve oral health and reduce tooth extractions in young children, Our focus will be in areas of deprivation where rates of tooth decay are highest, along with our children in care who are amongst our most vulnerable children and young people in our community.

For our children and young people with a long term condition, we are focusing on improving the access and pathway in epilepsy, asthma and diabetes. We will:

- Improve access to Children's Epilepsy Specialist Nurses to decrease emergency epilepsy admissions to hospital and improve mental health and provide better continuity of care for children with learning disabilities and autism who have epilepsy.
- Improve outcomes for childhood asthma through community respiratory services.
- Ensure improved monitoring and treatment of diabetes, in line with NICE recommended care processes, leading to better outcomes and reduced complications from excess weight. We aim to work towards holistic individualised plans for children and young people with obesity.

For our more vulnerable children and young people we are focusing on improving the health of our children in care by improving access and timeliness of initial health assessments and by developing a targeted programme of support for children in care for their emotional health and wellbeing.

We are working with system partners to support our children and young people with complex or high-risk behaviours, offering more choice about different approaches for help near to where they live.

We will continue our journey to prepare for the Cambridge Children's Hospital by joining up health pathways and transitioning more care to being delivered in community settings, ensuring that children, young people and families only need to attend hospital to access the types of intervention that can only be delivered in a hospital setting.

Children and young people engagement

We will work in partnership with young people who have lived experience as well as their parents, carers and support networks, to ensure that improvements are led by communities and their needs. We will build on existing partnerships, such as the Parent Carer Forum and the networks built through the co-production of the Children and Young People Mental Health (CYPMH) and SEND strategies and will develop a system-wide approach to co-production and engagement, in which power and decision-making are shared. We will continue to ensure strategies and service developments are co-produced.

In our Let's Talk campaign, where we asked for views on this plan, when asked about where they would go for mental health support for young people or children, 70% would go to their GP, 41% would search online and 41% would phone a mental health helpline whilst 31% would talk to a friend or family member. There were concerns about waiting lists and additionally 77% of people thought easier access to counselling and 51% thought further education about mental health at school, would help young people to look after their mental health. All of this is useful intelligence that will be built into our strategies and our ongoing engagement and co-production with our population on the solutions to these challenges.

Children and young people safeguarding

Safeguarding remains a golden thread throughout our work. Protecting a person's health, wellbeing and human rights, enabling them to live free from harm, abuse and neglect is integral to all we do. We will strengthen our commitment to safeguarding by working collectively to increase momentum and by standardising our policies, training, commissioner visits to children and young people in inpatient settings and audit processes. Reporting for safeguarding has already been standardised with agreed metrics and a dashboard for visibility on where we are doing well and areas where we need further development. We are focusing on making incremental improvements to our Multi-Agency Safeguarding Hub (MASH) and to the provision of Child Protection Medicals.

We will build on our child protection medical service to ensure our most vulnerable children have appropriate access to medical assessments close to where they live.

Children facing additional adversity, vulnerability or risk

We know that children and young people in care or leaving care can face increased risks to their health and wellbeing. This is why these children and young people remain a priority group in our pathways focused on preventative universal interventions as well as targeted and specialist input. We will continue to maintain a priority focus on this cohort, continually challenging ourselves to ensure we are doing everything we can to support equitable access, experience and outcomes, with particular focus on improving the timeliness of Initial Health Assessments for Children in Care.

We will bring a similar focus to young carers, young offenders, young parents, children with SEND, children in alternative education provision, children who identify as LGBTQ+, children from Traveller or other minoritized communities and children facing socio-economic deprivation. This reflects our commitment to working to address inequalities and promote inclusion across our communities.

Preparation for adulthood

We are focusing on preparing children and young people with ongoing healthcare needs to move well into their adult life. We are developing a systemwide framework for good and safe transitions, that is person-centred and adopted by all healthcare services across our area so that young people feel safe, included, informed and in control of their transfer from children to adult healthcare services. We have created a Healthcare Transitions Community of Practice to support co-production, engagement and monitoring which will enable services to work together with people with lived experience to make transitions better and safe. Both Cambridgeshire & Peterborough Preparing for Adulthood Leads have co-produced Post-16 tool kits to support young people in their transitions.

Achieving this requires integrated working across agencies as well as clear accountability and focus on performance. The programme of work is developed and overseen by the Partnership Executive Group, which is a multi-agency group across our system that promotes collaborative working.

Mental health and learning disabilities

Mental health challenges can affect anyone and have a significant effect on the lives of individuals, their families, communities and wider society. Together with substance misuse, mental illness accounts for 21.3% of the total morbidity burden in England.[1] Mental illness is closely associated with many forms of inequalities and people with severe mental illness or a learning disability experience some of the worst inequalities, with a life expectancy of up to 20 years less than the general population.[2]

The importance of good mental health care for the population has never had such a high national profile and is widely recognised, partly due to the impact of the pandemic. It has been observed locally, and widely reported nationally, that the detrimental effect of COVID-19 has seen unprecedented levels of people experiencing a mental health crisis. This has resulted in significant pressures on existing care provision alongside an increased anticipation of future additional need. Our engagement with local people as part of "Let's Talk: Your Health & Care" indicated a high level of need for mental health support and the importance of timely access to high quality services. We also know that people with a learning disability experience significant health inequalities. It is therefore important to retain a dedicated focus on mental health and learning disabilities across our system to ensure that health and social care planning for delivery of services are integrated across all sectors and pathways to meet the demand, both now and in the future.

The Mental Health, Learning Disabilities & Autism (MHLDA) Partnership has been set up to drive the development and the delivery of improved care and outcomes for our local people who receive mental health, learning disability and autism services. The vision of the MHLDA Partnership is to embed collective responsibility for mental health, learning disabilities and autism across our ICS, and together with partners drive transformation for improved service provision; ensure delivery of the Long-Term Plan; and reduce the gap in life expectancy between people with mental illness, learning disability and autism and the rest of the population

The MHLDA Partnership will play a key role in supporting delivery of the MH and Wellbeing priority of our joint Health & Wellbeing Integrated Care Strategy.

Development of an all-age mental health and health needs assessment, led by public health, has progressed and has been used to inform the partnership priorities. Panels of experts have been established as part of this process to inform each chapter of the needs assessment, including people with lived experience. An adult learning disability health needs assessment has been completed3, and work is currently taking place to consider its recommendations.

Engagement and co-production have been embedded in the development and improvement of mental health, learning disabilities and autism services across our system over many years. The MHLDA Partnership continues to build upon this strong foundation, ensuring the voice of service users and their carers is integral to planning and service improvement.

[1] "Health matters: reducing health inequalities in mental illness" Public Health England, December 2018

[2] NHS Long Term Plan, 2019

We also recognise the value and contribution that voluntary, community, faith and social enterprise (VCFSE) organisations bring to deliver support and treatments for mental health, learning disabilities and autism across our system. We are continuing to strengthen their role in the partnership and in enhancing care within local communities, which in turn will also help reduce the burden on primary and secondary care services. The role of our VCFSE partners has been key in all areas of 2023/24 delivery, a summary of which is provided below.

What we achieved in 2023/24:

1. The completion of the Joint Strategic Needs Assessment (JSNA) for Learning Disabilities (LD). This has led to the LD inequalities working group and projects addressing improvements in respiratory pathways with community acquired pneumonia.
2. Ongoing production of the Joint Strategic Needs Assessment for mental health.
3. We have increased access for mental health intervention in the community through the rollout of the stepped care model for adult mental health and increasing access to Talking Therapies.
4. We have convened system partners in the delivery of the Autism Strategy with the shared commitment to coproduce the work together to develop a 'bubble of support' and a 'Needs Led Autism pathway' under a neurodiversity umbrella.
5. We have improved access for children and young people with new pathways in child and adolescent mental health and early intervention services and delivering above plan with Single Session Therapy delivery model.
6. Building on the CYP mental health strategy to address provision of mental health services for young people up to 25, co-producing recommendations for change. It will support system thinking about the needs of young adults with mental health problems and consider how the local mental health system can respond to this challenge, with a strong focus on engaging stakeholders in coproduction of solutions.
7. We have commenced engagement in the transformation of our services for people with a learning disability so that they better match the needs of our local people, working towards a well-connected model of support with seamless transitions between services and embedding the voice of service users, carers and families.
8. We are working with 40 primary schools across Cambridgeshire & Peterborough to take part in a new pilot, bringing together health, education staff and parent/carer forums to develop innovative ways to support the education and health needs of neurodiverse children in schools.
9. We are coproducing a plan, as part of the new Mental Health, Learning Disability and Autism Inpatient Quality Transformation Programme, which will support cultural change and a new model of care for the future across all NHS-funded mental health, learning disability and autism inpatient settings.
10. We have reduced inpatient admissions for children and young people with a learning disability or who are autistic through roll-out of the key worker programme to support families navigate holistic care in the community.
11. We have recruited a VCSE sector Influence and Participation Manager, established a board with eight VCSE partners and are currently embedding members across our governance and programme of work.

Our forward plan priorities for mental health, learning disabilities and autism include:

- Continued drive for the integration of mental and physical healthcare – embedding our Enhanced Primary Care Scheme to ensure physical health checks for people with severe mental illnesses, as well as ensure pathways of aftercare when physical health issues are identified.
- We will continue to embed our transformed model of community mental healthcare, focusing on neighbourhood models, ease of access, choice of therapies and interventions, and ensuring no gaps between primary and secondary care services.
- We will drive up access to NHS Talking Therapies, embedding this in a wider programme of early intervention, as well as focusing on removing barriers to access for local populations such as older people who would benefit from the support offered by Talking Therapies.
- We will embed high-quality community and crisis care to prevent avoidable admissions to mental health inpatient settings, and work more closely with social care colleagues to ensure rapid pathways of care for people who are ready for discharge (thus reducing length of stay and the need for out-of-area placement).
- We will ensure people with learning disabilities and/or autism have access to timely treatment.
- We will continue to invest in employment services and take opportunities to work with our partners to expand and integrate evidence-based approaches for both mental health and learning disability cohorts.
- We will encourage the use of Personal Health Budgets, allowing people to manage their healthcare and support such as treatments, equipment and personal care, in a way that suits them.
- More children and young people will have timely, co-ordinated access to NHS funded mental health support care and treatment including through mental health support teams in schools
- We will ensure Learning Disability Mortality Reviews are a continued focus for the system and learning is implemented to reduce mortality rates for people with a learning disability and autism.
- We will engage in a Quality Improvement Programme, using co-production to revamp access to health services for people with learning disability.
- Collaborating to review and remodel pathways to reduce waiting times, particularly for assessment and diagnostic services.
- Implementation of a three- year quality improvement plan for inpatient units.

The following are key areas of action for tackling inequalities for people with mental illness, learning disabilities or autism:

- Building integrated community mental health via a stepped care model, which will increase access to mental health services by 5%, improve treatment options and seek to address the wider determinants of health.
- Collaborating with voluntary organisations that support people with mental health, learning disabilities and autism, to strengthen their engagement and involvement in the MHLDA Partnership and system structures and to shape mental health support for our communities.
- Delivering targeted mental health programmes for rough sleepers to improve access to treatment and ongoing support.
- Implementation of the 2022/25 priorities of our Children and Young People's Mental Health Strategy, including:
  - improving transition pathways between children and young people's and adult mental health services; and
  - ensuring effective access to and choice of mental health support, which is developmentally appropriate for 16 – 25 year-olds.
- Ensuring reasonable adjustments as a legal requirement is utilised to ensure all people with assessed needs receive the appropriate services to meet those needs.
- Improving pathways for older people with focus on reducing waiting times and ensuring the dementia diagnosis rate is increased to at least 67% of the estimated prevalence of dementia based on GP registered populations, ensuring individuals and families receive early treatment and support.
- Ensuring system effectiveness in the delivery of responsibilities under the Mental Health Act, through a joined-up system response with effective use of resources.
- Reduce health inequalities for people with a learning disability and serious mental illness through improved quality and delivery of health interventions such as vaccination programmes, the "Sit and See" checks and completion of annual physical health checks.
- Embedding the five key principles to discharge to support people with LDA to leave hospital.
- Ensuring the digital reasonable adjustment flag is rolled out.
- Roll out of Oliver McGowan training.
- Enacting the recommendations from the All Age Autism Strategy to transform adult autism services and improve access and treatment options.
- Taking forward the learning disability health needs assessment through the system-wide learning disability health inequalities group.

Place partnerships

Our place-based Accountable Business Units (North Cambridgeshire & Peterborough Care Partnership and South Cambridgeshire Care Partnership) have brought together health and care organisations at a local level to plan and deliver more joined up care to improve outcomes for their populations.

Key areas of action for tackling health inequalities and improving health outcomes through local partnership approaches:

- Building community-based infrastructure to enable support and care to be provided at home or in a neighbourhood setting, e.g. through Integrated Neighbourhoods teams and a care co-ordination hub.
- Embedding an integrated proactive and personalised approach to reduce inequalities and increase years people enjoy good health.
- Enabling "home first" through optimising and integrating community/intermediate care, improved discharge co-ordination and optimising community-based pathways.
- Identifying and supporting at risk groups through population health analysis and targeted interventions.
- Optimising and improving equity of prevention services such as health checks and screening, through partnership working, utilising the full Primary care team including local GP's, community pharmacists, dentists/dental care professionals and optometrists. These professionals and their teams working in the heart of our communities can be resourced to work outside their traditional roles to maximise provision of preventative services within neighbourhoods, be that screening, lifestyle modification, medicine optimisation or disease monitoring services.
- Working together to developing person-centred care models, underpinned by local insights, co-production, data, and best practice evidence.

Both place-based partnerships continue to expand their role in leading and supporting many of the population health outcomes that are described throughout this plan, working with system partners and also on pan-system opportunities. Specific examples of cross-border work include the focused work on Royston services in the South, and in the North embedding relationships with eastern Leicestershire and southern Lincolnshire via system governance in the North Care Partnership to ensure the local communities' needs are met regardless of where they receive their health provision.

Case study

North Cambridgeshire & Peterborough delivery examples:

The A1 Integrated Neighbourhood ran a 'What Matters to Me' survey throughout August 2023, which was promoted by various community partners, along with local schools, with a view to understanding what local residents enjoy about their community, where they go for support, and what they'd like to see in their area.

The Integrated Neighbourhood received valuable feedback from nearly 100 survey responses and held the Spotlight on Sawtry event in October 2023 with the support of Sawtry Parish Council and library. Residents were able to make the most of a free NHS Health Check, with instant results. They were able to connect with a Social Prescriber, and Digital Champion from their Primary Care Network - learning more about other roles within the GP Surgery and the different ways that they can support patients.

The expanded proactive care approach (tier 2) is a service for those people viewed by their Integrated Neighbourhood Team as being vulnerable and at risk of being admitted to hospital or long-term care in the coming 12 months. Launched in November the Integrated Neighbourhoods have identified 7,580 people, contacted 1,490, taken 1,098 onto their caseloads and completed a Personalised Care Plan for 557 residents. The Integrated Neighbourhood Team are working with partners to ensure that wrap-around support for these residents is in place to avoid admissions to hospital or bed-based care.

Case study

Pooling budgets

East Cambridgeshire East Cambridgeshire Neighbourhood partners have pooled a total of £462,000, bringing together both transformation and business as usual funding to meet local priorities. This has included:

- Recruiting new jointly funded Integrated Neighbourhood roles including an Integrated Neighbourhood Carers Lead, an Integrated Neighbourhood Drug and Alcohol Recovery Coach, and an Integrated Neighbourhood Practice Lead.
- Outcomes based commissioning at a neighbourhood level such as increasing access to psychologist support, funding Community Living Rooms and increasing access to activities and support for people.
- Neighbourhood personal budgets to address health inequalities and meet needs where there are service gaps.
- Aligning funding locally and making joint decisions through the Integrated Neighbourhood Board has brought partners closer together and increased the scope and sustainability of neighbourhood work.

Section 6: Creating a system of opportunity

Equality, diversity and inclusion

We are committed to promoting Equality, Diversity and Inclusion (EDI) outcomes, with a focus on ensuring that all staff, patients and carers are treated fairly and with dignity and respect, regardless of their background or identity. To achieve this, we will continue to integrate the NHS East of England Anti-Racism Programme (alongside other areas of best practice) into our EDI strategy and developing targeted interventions that address the needs of all protected groups, as defined in the Equality Act 2010.

To ensure focus upon the various facets of EDI work, we target patient and community focused inequality through a wide and comprehensive range of health inequalities programmes which are overseen by the Health Inequalities Board for performance and assurance. To reduce inequality of outcomes for our population we must also ensure equality of opportunity for our staff.

Inequalities relating to workforce are overseen through a system network of EDI leads representing various partner organisations across the system. Assurance and performance are managed via the Local People Board.

To identify and achieve our objectives, it is essential to understand the current level of staff experience in our area.

According to the latest available NHS Staff Survey (2022), we have a higher percentage of staff from a Black, Asian and Minority Ethnic (BAME) background compared to the national average. However, the survey also highlights that BAME staff are less likely to feel they are treated fairly, with respect and dignity at work, compared to White staff. There is more work to be done to ensure that all staff feel valued and included, regardless of their ethnic background.

Furthermore, the survey shows that staff with disabilities are also less likely to feel their employer values their contribution, compared to non-disabled staff. This highlights the need for targeted interventions and initiatives that address the needs of staff with disabilities, to ensure they are supported to reach their full potential.

Addressing the gender inequality in the workforce is another important aspect of our EDI plan. The latest data from the survey shows that the gender pay gap in our ICS is 13.5% for median earnings. We are committed to ensuring that our staff are paid fairly and equally, that structures are developed to ensure equality of opportunity, regardless of gender. This includes ensuring there are no disparities in pay based on gender and promoting career development opportunities for all staff. Additionally, we will also work to address any other forms of pay discrimination, such as those related to race or disability.

Key improvements to support the EDI plan over the next five years:

- Targeted interventions to address the needs of BAME staff which include:
  - Establishing a consistent approach to dealing with violence and aggression targeted toward BAME staff.
  - Supporting the training of managers to ensure a wide range of knowledge across senior leaders in our organisations.
- Increasing the diversity of our system workforce, particularly at senior levels, to ensure our organisations reflect the communities they serve.
- Improving the physical and emotional environment in which staff work and patients are treated to ensure a compassionate and inclusive culture is central to the delivery of care. This includes investing in staff wellbeing initiatives, such as access to counselling services, and reviewing the physical environment to ensure it is accessible for all.
- Developing targeted interventions to improve health outcomes for under-represented and marginalised communities through our health inequalities programmes.
- Embedding EDI into all policies, procedures and practices, including our leadership compact, recruitment, procurement and service delivery, to ensure that all decisions are made with EDI principles in mind. This could involve reviewing existing policies and procedures to ensure they are inclusive and accessible for all, and developing new policies and procedures as required.
- Continuing to seek regular feedback from staff, patients and local communities to ensure that the EDI plan remains relevant and effective, and to measure progress against key objectives. This feedback will be used to inform ongoing development of the EDI plan, and to identify areas where further improvements can be made.

Anchor system

In our Health & Wellbeing Integrated Care Strategy we clearly set out the importance of our anchor approach, not just as individual anchor institutions, but how we can enhance social value by working together as an anchor system. By creating an anchor-based infrastructure, we are better positioned to develop programmes and initiatives that support the reduction on inequalities across our system.

As a collection of larger employers with significant budgets, we can have a positive impact on our communities that extends far beyond the health and care services we deliver. This anchor role is one we take seriously. We think carefully about the ways we can add to value to our local communities through the decisions we make, whether this is as employers, purchasers of local products and services or as a visible presence in local communities.

We have already undertaken several anchor initiatives which include the Health Inequalities Challenge Prize and the District Council innovation programme. These are funded by the ICB but generate initiatives from within and across our communities that address inequalities and support prevention. These have covered a range of areas that aim to keep people active and well, pump-prime hyper local initiatives and support groups of people within communities that are often marginalised.

Case Study

Tackling Health Inequalities in communities

Investing £1.2 million additional funding in local council grassroot projects to make positive health, wellbeing, and social changes in the local communities.

From warm hubs and strength and balance classes to tuberculosis treatment support and art classes, new solutions to hyperlocal challenges were enabled by this ICB funding.

The Warm Hubs programme in East and South Cambridgeshire saw community-led hubs set up in 38 locations to tackle social isolation, help people stay warm, and build new connections and friendships. They were open for over 5,000 hours, supported by more than 150 volunteers and welcomed over 16,500 visitors over the winter, with almost 11,000 regular visitors. An analysis of the social return on investment shows for every £1.00 invested in Warm Hubs across East and South Cambridgeshire, £4.50 of social value was generated.

Over the next five years we will build our anchor system approach. This will include providing dedicated programme management support to help coordinate anchor activity across our area, learn from other areas and maximise our opportunities as an anchor system in areas such as employment, inequalities and environmental agendas. We will also develop a key anchor database that enables us to better understand our baseline anchor indicators and measure success, again learning from others. This may include data around how many people the anchor system employs from deprived areas in our communities, for example, and its combined carbon footprint.

We will also formalise our approach in an anchor charter that will be proposed to our joint Integrated Care Partnership and Health & Wellbeing Board, for partners to sign up to, unifying our approach and embedding it into our governance.

Aligned to our strategic priority around addressing poverty, we have finalised our Work and Health Strategy and support integrated pathways across our system which support more people with a long-term condition or disability to stay in and enter work. This is supported by our bid for WorkWell funding to accelerate our progress in this area over a two-year period.

In 2023/24 the ICB have funded further innovation initiatives, building on the success of the Health Inequalities Challenge Prize by repeating the programme with a new area of focus; providing another district council innovation fund to target prevention initiatives through integrated approaches; and mobilising a substantial VCSE Healthier Futures Fund. This work will help to support infrastructure and projects within our VCSE sector through a grant-based approach which generates innovative and locally developed and owned approaches to prevention.

We believe that this work will consolidate Cambridgeshire & Peterborough as a strong anchor system that consistently considers and takes action in our decision-making processes to enhance social value for our population through real and measurable action.

Case Study

Healthier Futures Fund

We have committed £2.25 million to support our voluntary, community and social enterprise (VCSE) sector across Cambridgeshire & Peterborough. Our VCSE organisations support thousands of local people, and have incredibly strong connections with our communities, but often lack the funding to do more.

Through this money, we are enabling VCSE organisations to trial new approaches that address our joint priorities of children's and young people's mental health, frailty, people who use health services very frequently, people who have an irreversible progressive diseases or medical condition, cardiovascular disease and supporting people who are medically fit to leave hospital.

The ICB funding is available to VCSE organisations of all sizes to make a positive impact on the health and wellbeing of our local people in a way that would otherwise not be possible, with projects starting work later this year.

Triple aim

The triple aim is a framework that seeks to achieve three key objectives in healthcare:

- Better health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing).
- Better quality of health care services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services).
- More sustainable and efficient use of resources by NHS bodies.

Integrated Care Systems are instrumental in improving coordination and integration across all our different stakeholders. We are committed to embedding the triple aim within our decision-making and governance structure, so all stakeholders have a shared understanding of the triple aim and its importance in guiding decision-making.

We have worked closely with all stakeholders in the system to develop our Health & Wellbeing Integrated Care Strategy which demonstrates how we will work together with all partners to deliver better outcomes for the population. All key partners in the system are represented on the Integrated Care Board, and so in approving the strategy have committed to the triple aim.

As an ICB the alignment of the organisational priorities with the triple aim is a key priority in decision-making. Organisational priorities are reflected in the Board Assurance Framework which outlines the key strategic risks for the organisation, and all decisions are linked to specific elements of that framework. The triple aim is also embedded through the use of community stories at the ICB Board meetings to inform decision-making and provide a clear, practical link to the three aims.

We have a formal Impact Assessment (IA) process that underpins our decision-making and commissioning process. All centrally funded projects are required to undergo a set of impact assessments: Health Outcomes (HIA), Health Inequalities (HIIA), Equality (EIA), Quality (QIA) and Sustainability Impact Assessment (SIA).

We have taken the opportunity to refine and remodel the existing IA procedures and integrate them into a coherent process across the ICS that operates under a common standard and guidance. To this end we have identified three core strategic actions, which our ICS impact assessment strategy group will lead on:

- Embed the impact assessment process across the lifecycle of ICS decision-making.
- Tackle the wider determinants of health by collaborating with ICS partners to measure and assess the health impacts of actions taken outside the NHS.
- Remove existing service inefficiencies and inequities by empowering staff.

Armed Forces

In line with our commitment to tackling inequalities, we need to ensure that our Armed Forces population should not experience disadvantage or inequity in outcomes when accessing health services where they live. We have identified leads for Armed Forces including military veterans. In the development of this work, we consider patients from the following groups to be part of the Armed Forces Community: Serving Personnel; Veterans; Reservists; Spouse or Partner (including those of reservists); Child of a veteran, a service member or reservist aged 25 or under.

GP practices have the option to voluntarily sign up to become an Armed Forces Veteran friendly accredited GP practice. Similar accreditation exists for NHS Trusts to become Veteran aware and for all NHS organisations to achieve bronze, silver or gold awards through the Defence Employer Recognition Scheme. Our Local Authority partners have identified leads to support veterans and are linked with the work within the ICS.

Key objectives and delivery focus for our system:

- Encourage and enable system partners to progress their accreditations related to the Armed Forces (Patient accreditation, e.g. Veteran Aware and Veteran Friendly; Defence Employer Recognition Scheme and Step into Health).
- Enable improved information sharing across the system to tackle the health inequalities.
- Utilise Healthwatch and Armed Forces organisations to enable partners to listen to the Armed Forces community voice, understand their requirements and work together to develop a better understanding of any change requirements.
- Review and enhance the accessibility and visibility of linkages to services that would support the Armed Forces community.
- Develop awareness of health impacts and share resources to support the system (tools, insights, templates, policies etc).

Section 7: Giving people more control over their health and wellbeing

Personalised care

Our Personalised Care Strategy, developed using engagement and co-production, sets out our vision for how we plan to deliver the NHS Long Term Plan (LTP) commitments, implement the comprehensive model of personalised care and deliver our local priorities.

We will work alongside partners to deliver person centred, personalised care for everyone living in our area that respects personal choice, addresses inequalities and increases independence and wellbeing.

Our vision is that personalised care becomes “mainstream” by delivering a fundamental shift in how we work alongside the individual, families, communities, and system partners recognising that the importance of ‘what matters to someone’ is not just ‘what’s the matter with someone’.

We will measure our impact through four measures:

Engaging people, integrating healthcare and wellbeing.

Enabling people to stay independent and have increased control over their own lives.

Empowering people to build knowledge, skills, and confidence and to live well with their health conditions.

Enabling people to stay well and building community resilience, enabling people to make informed decisions and choices when their health changes.

We plan to deliver the six components of personalised care in the following way:

Shared decision-making (SDM): SDM will be embedded into all clinical situations in primary care and secondary care where it will have the greatest impact on experience and outcomes. Validation and quality outcomes measurement tools will be used, and audits conducted. An awareness campaign will be delivered to make sure people are aware of their choice. “What are my options, what are the risks and benefits, and what help may I need to make my decision.”

Personalised Care Support Planning (PCSP): We continue to encourage the implementation of PCSPs for people with long term health conditions, end of life, maternity, cancer, mental health, learning disabilities and autism care.

Enabling choice: Good quality information and training will be available for people, health and care referrers to facilitate informed choices about care, treatment and support. There will be one central depository of services via a digital software solution called JOY, that will be accessible for everyone.

During 2023/24 the system has rolled out the national expansion of patient choice at point of referral where possible and implemented the first stage of the Patient Initiated Mutual Aid System (PIDMAS) programme, which supports patients already on a waiting list and waiting over 40 weeks to move providers if alternative provision is available.

Social prescribing: Is available to the local people via primary care, local authority, and voluntary services. This model is being expanded with pilots commenced in the acute setting. Population Health Management tools will be used to support proactive social prescribing. Community support groups and their capacity to take referrals is managed via JOY, this enables commissioners to assess the pattens and gaps in services, and to ensure support and funding is directed to build new groups in the areas of need.

From our Let’s Talk feedback we know that just over half of respondents, 53%, would take up an offer of social prescribing instead of medication to help with a medical condition. We are keen to increase this figure.

Supported Self-Management: We are actively supporting people who are on waiting lists with supported self-management through our local plan, with links from My Planned Care to supported self-management tools and a programme of Waiting Well support providing access to a broad range of information, opportunities and services local to people that will optimise the time they are waiting for treatment. Health coach training is being delivered and embedded across community services. Patients can access health coaching services via primary and community care and can be supported to learn the benefits of setting goals and using outcome measures.

Personal Health Budgets (PHBs): PHBs are offered to people who have a legal right to have one. (https://www.england.nhs.uk/personalisedcare/personal-health-budgets/). We are also piloting the use of small flexible personal budgets through Integrated Neighbourhoods as part of new Personalised Models of Care.

Co-production and peer leadership: Training is available to everyone, and it is our aim to have people with lived experience support board level delivery and decision-making across the ICS. Leaders will have the knowledge and tools required to embed personalised care at system, place and neighbourhood levels.

By 2028 we aim to have all services co-produced, with continued expansion of personalised care roles via all pathways.

We understand from our Let's Talk feedback where we targeted the topic of cancer that concerns about not being taken seriously (45%) was the main reason preventing people from seeking help if they felt they might have symptoms associated with cancer. Fear of the unknown (23%) and time to make or go to an appointment (27%) were also higher scoring reasons. When asked to give 'other' reasons the main themes were overwhelmingly being able to get an appointment, followed by waiting time for referrals/testing; getting time off work; transport and travelling; and worried about wasting time. The personalised care approach, offering shared decision-making, helps us to have better conversations with individuals that help better address some of these concerns.

The personalised care model of delivery will be supported by Population Health Management. This includes a prevention approach that will help anticipate needs and outcomes of our local population and align with the personalised care approach.

We take our duties to actively promote and engage with our patients on the personalised care agenda seriously. How we are achieving this:

In 2023/2024 we delivered the following:

- A public awareness campaign (BRAN) to ensure local people are aware of their choices. 'What are the Benefits, what are the Risks, what are the Alternatives, what if I do Nothing'.
- A marketplace of services was made available through the JOY App for self-referrals.
- Development of knowledge and tools required to embed personalised care at system, place and neighbourhood levels.

By 2026:

- We will increase the uptake of personalised health budgets by 4% for adult social care via the Caring Together programme by 2025/26.

By 2029:

- Personalised Care Support Plans will be routinely in place for people with long-term conditions.

Patient choice

In our area we are fully cognisant of the legislative duty enabling patient choice. The Complex Cases Team (CHC), in line with national direction, approach personalisation with both a Settings of Care Policy and Personal Health Budgets (PHB) as the default method of care provision. This means that anyone made eligible for continuing healthcare following a full assessment will be offered a PHB. Where a PHB is not accepted or not appropriate the ICB works with people to determine their wishes in regard to how and where their care is provided.

Engagement with people and communities

We have a shared vision of 'working together to improve the health and care of our local people throughout their lives'. We want to co-produce decisions about what services and support is needed locally with local people and communities, because life experiences and patient views can help us to make better choices.

We have an incredibly diverse local population, and our area is home to some of the most affluent and most deprived wards in the country. This diversity can bring challenges, but also opportunity to improve services to meet the needs of our entire community, particularly those whose voices we hear from less frequently.

Our People and Communities (Engagement) strategy, published in September 2022, was developed collaboratively with our partners and sets out how we will achieve the following aims:

- Help people to sustain and improve their health and wellbeing.
- Involve local people in developing our plans and priorities for the future.
- Listen to patients' views on how we can continually improve our services.

Engagement and involvement is a commitment that goes far beyond our legal and statutory duties to consult with our local stakeholders and communities on key matters, such as a significant service change or closure as set out in the Health and Care Act 2022, or our duty under section 244 of the Consolidated NHS Act 2006, amended in 2012, to consult the local health Scrutiny Committee on any proposal for 'substantial development or variation of health services'. It is how we work as a partnership; it is how we listen and respond to what our communities tell us matters to them.

Underpinning this approach is our commitment to transparency and involvement. Our ICB meetings are held in public, with papers available online a week beforehand and the opportunity for people to ask questions at each meeting either in person or in writing. We also ensure when we are developing strategies, such as this Joint Forward Plan, we build in opportunities for local people and communities to share their views before we write the plan and then again on the draft version. We will continue to do this and want to make it easier via a single system engagement and listening platform that we hope to implement in 2024.

Our work with Healthwatch is ongoing throughout the year, and we have co-funded community researcher roles to ensure we have a continuous dialogue with our local communities about what matters to most to them when it comes to health and care services. We have also worked closely with Healthwatch on projects such as our Integrated Urgent Care survey, to ensure we hear from a wide and diverse range of voices that are representative of our communities, for example where there may be a language, literacy or digital barrier to engaging.

Building strong relationships with ICS partners and voluntary, community and social enterprise (VCSE) organisations is key to increasing the breadth and depth of our conversations with local people. Our VCSE partners are well established and trusted within their communities and can help to facilitate and amplify voices that are seldom heard while playing a key role in ensuring healthier communities. These relationships are being formed and strengthened through our Voluntary Sector Network (formerly Health Alliance), a collaboration designed to build relationships, strengthening the voice and influence of the VCFSE sector in health and care decision-making and governance. Following publication of the ICS VCFSE Strategy in 2022, the ICB has worked closely with the Network to deliver on the strategic goals and develop the Network further, ensuring clarity of purpose, brand, delivery and reach.

In total, we heard from 2,315 people

Representatives from the Network have been recruited to the ICS Partnership Board and have seats on all ICB Committees. The Network has also delivered a number of projects and initiatives over the past year including the development of a Safeguarding Best Practice Statement for VCSE organisations to sign up to, supported by safeguarding training and guidance to help organisations meet the standards. The Network has also begun the development of a data catalogue to enable VCSE organisations to identify and share data more easily, across the ICS.

57% felt timely access to care and advice in the community through GP and other primary care services, such as pharmacists, was the most important.

48% prioritised reduced waiting times for appointments.

40% Ensuring that from birth right through to the end of life, people receive high quality care that is fair and reduces health inequalities was the third highest priority.

The ICB jointly funded the new system-wide volunteering platform that matches volunteering opportunities with individuals and organisations. In the first two months of launching, 912 VCSE groups had signed up to promote their volunteering opportunities, with training provided across the county to ensure organisations make the best use of the platform. Further promotion and training is planned over 2024 ahead of a public launch in the summer.

Our new Quality Champions will also bring a fresh perspective to our work around the quality of services we provide, and further embed the voice of local people into our governance and review processes

As an example of these commitments in action, in October 2022 we launched our first large engagement campaign, 'Let's Talk', to ask local people and communities to share their views and insights about health and care services in advance of our first ever Health & Wellbeing Integrated Care Strategy and Joint Forward Plan. We reached out to 400 different groups, from sports clubs and libraries to faith groups and charities, to ask them to share their views with us. We regularly reviewed our responses and targeted areas with lower responses rates to ensure we gathered insights from the widest range of communities possible, including working with the Think Communities team at the local authority to build on the partnership work undertaken during the response to COVID-19.

In total, we heard from 2,315 people via our online survey, through social media, at face-to-face meetings and via the post. These insights have shaped the document you read today.

Building on these insights we have had more focused conversations with specific groups to delve further into topics, such as conversations with organisations and people with lived experience of sexual abuse who shared their insights relating to our new duties, and reaching out to people who smoke to ask them to share what the key barriers to giving up smoking are for them.

We will also be taking our plans and strategies back out to our local people and communities to ask them if we've got our priorities and approach right. This gives us the opportunity to dig deeper into key areas of focus around access to services, diagnostics, prevention, mental health and social prescribing. These insights have helped us to refine, amend and shape this final Joint Forward Plan and the services and strategies described within it.

Initial feedback from the second phase of our Let's Talk campaign, targeted on our draft Joint Forward Plan, provided 225 responses to a detailed questionnaire that delved deeper into key elements of this plan. The majority of respondents agreed with our priority areas of focus, but a significant proportion were still unsure, indicating there is more work to do in engaging our people and communities in our plans including co-producing the solutions.

When asked what priorities from the Joint Forward Plan should be the top three:

When asked about key areas that needed strengthening, the most common themes were support people who have left hospital; access to NHS dentistry; digital exclusion; more support for carers; dementia care support; more face-to-face GP appointments; more flexible (not 9-5) services; more/better mental health support for young people. Another reoccurring theme was about NHS staff – improving staff experience, investing in workforce, staff retention, and staff recruitment. These are key considerations that will flow into our delivery and prioritisation.

Looking ahead, we are continuing to identify opportunities to work in partnership across ICS organisations to share resources, best practice, opportunities for collaboration and reduce duplication. We have established a system-wide Participation and Involvement Network and have agreed a number of priorities we aim to tackle together. We are also assessing options for an online platform to enable regular ongoing conversations with a broad cross section of local people and communities to continually shape, test and (when needed) course correct our plans.

We are also developing plans for an insight bank to bring together the feedback gathered at Place, via our Children's & Maternity and Mental Health & Learning Disabilities Partnerships, through our NHS Trusts, local authority and VCSE partners and beyond.

These insights can then be coupled with specific engagement work to support service development. They will also help us to be clearer about the local people and communities we are not currently hearing from through our current engagement routes, particularly service users or those who could benefit from services that they are currently not engaging with. As noted in our Equality, Diversity and Inclusion section, we need to continually seek regular feedback from staff, patients and local communities to ensure we have diversity representation, which we know is critical to successful service development and service change.

When we said to local people 'Let's Talk', we didn't mean just once, or just on our terms – we want to have an ongoing open dialogue to help us understand and improve the work we do on a continual basis to deliver better health and care services to our local people, and better quality of care and outcomes in the longer term.

Case Study

Healthier Futures Fund

We have been working closely with the local community in Sutton, in particular the Patient Participation Group (PPG), since early 2023 about their views for the future provision of primary care services. Whilst an immediate solution for the ongoing provision of primary care services in Sutton was secured, we worked with the local community to ensure Sutton and the surrounding areas continue to have a suitable building to house primary care services.

We held engagement events, working with local councillors, partners and the Patient Participation Group to gather their views. It was clear from this work that local people were keen to have a medical facility in the centre of Sutton with good access and parking, in a building that is accessible and meets the needs of community members. They also welcomed the opportunity to create a health hub which hosts a wider variety of services, such as community services and midwifery clinics.

The community engagement showed a preference for the surgery to remain close to the centre of Sutton alongside easy access to the pharmacy and consideration of the environment to be suitable for those with disabilities. As a result of this engagement work a business case was developed and approval given by the ICB to purchase the practice building from the landlord to enable the local needs to be met. This work is in progress and we hope to secure the site and ongoing primary care provision in 2024/25 for the local population, now and in the future.

Section 8: Delivering world class services enabled by research and innovation

Deliver improvements in service access, experience and outcomes

As we reimagine and redesign services truly fit for the future it is important that we focus not only on improving quality, but also on the experience of being a provider or recipient of care. As we strive to meet the changing needs and expectations of our population, we must be cognisant that the world around us, the technological solutions and the opportunities for accessing and delivering care will also change.

We will harness digital technologies to provide easy to use, intuitive solutions that allow local people to access information about care options and services. It is important that we offer not just equity of provision but also equity of access to our virtual and real-world care solutions. People will be able to access care from the comfort and security of their home and be linked into community, primary and secondary care providers' electronic patient records empowering them to 'own' their health and control their own healthcare journeys. Importantly, we need to ensure these opportunities are available and accessible to all communities.

We will bring together world leading research, academics, health services and industry to ensure a pipeline of new ideas and improvements to benefit our patients and continuously improve the care that we deliver.

It is important that we also maintain the human element of 'caring' and ensure that all groups in our society have access to well-trained health and care staff working in a supportive environment conducive with the provision of high-quality care; the type of care our staff are proud to deliver.

Case Study

Cambridge Movement Surgical Hub

CUH opened the new Cambridge Movement Surgical Hub in November 2023. This specialist facility provides an extra 40 beds and three dedicated state-of-the-art operating theatres for orthopaedic and spinal neurosurgical patients, with an anticipated capacity to treat around 70 patients per week. The Hub will also help those with bone and joint disease more widely, by greatly facilitating our research and innovation into current and future treatments.

Whilst the ability to easily access services, from a place of our choosing, at a time that is convenient to us is an admirable aspiration, when it comes to our health it is outcomes that really matter. Through using new science, new ideas and developing a culture of continuous improvement we will design health and care services that will ensure equal opportunities for all our local people to improve their chances of leading healthy, happy, fulfilling lives, encouraging lifestyle changes which are proven to increase years lived in good health. Where illness is unavoidable, we will ensure that treatments and interventions have proven benefits and lead to improvement in physical and psychological well-being.

The personal, social and societal costs of our care will be carefully considered to ensure benefits for the individual and the population as a whole are balanced. The following describes key enabling plans that will support the delivery of the above.

Learning and continuous improvements in quality – CQI approach

We have developed our first system-wide Continuous Quality Improvement (CQI) Strategy, which sets out our aspirations and approach for improving quality of care through a more consistent and joined-up approach to continuous improvement across all our health and care sectors. The implementation of this strategy will be overseen by the system-wide Quality Improvement & Transformation Group using a clear delivery plan.

The strategy outlines the ICB's responsibility to support all our partners across care and health to adopt a quality improvement (QI)/continuous improvement (CI) culture that is lived and owned from the Board and our most senior leaders to those delivering care or support services to individuals. The strategy does not mandate a specific tool/methodology to be used but focuses on the elements of a good QI culture. The aim is to support and empower our teams to deliver improvements to achieve high quality care, embed more efficient processes and, share and celebrate learning.

We will achieve this by building both individual, team and therefore system capacity and capability, through a systematic approach to using improvement science tools and techniques. We will also support system partners to utilise existing CQI training capacity or embed their own as appropriate. However, CQI is not simply about training. We need to see CQI as part of all our roles to help transform our organisations and system to achieve our vision. We want to demonstrate that Continuous Improvement is the way we do things here, where all organisations and their staff feel confident and empowered to challenge, problem solve and innovate to improve the care we deliver, eliminate waste, reduce variation and develop solutions and processes that are sustainable, which will improve people's experiences of our services, and the experience of our staff as they deliver those services. We also want to implement a culture of learning from failure to drive future success.

The role of the ICB is to champion adoption of that CQI culture across our partners and to co-ordinate the programmes of CQI innovation and transformation that are best delivered through a collaborative approach for a wider system benefit.

Measures of success

Success factors include:

- Staff who are passionate about the delivery of improving high-quality care for our patients.
- Staff and leaders at all levels across all organisations that are engaged, confident and committed to making improvements.
- Collaborative ways of working with patients, communities and key stakeholders in driving and co-producing system improvements.
- Clear links from local improvements to our vision, ambitions, and priorities.
- Integrated improvement planning with our strategic, business and performance management planning.
- Sharing opportunities with peers and internal networks to build skills and knowledge transfer.
- Demonstrable improvements in patient and clinician experience of service delivery.
- Demonstrable productivity efficiency gains.

Six elements of our CQI strategy

Our CQI Strategy has six elements, which are the building blocks to achieve improvement maturity.

1. Strategic intent for CQI: Support leaders to explore and identify CQI opportunities linked to strategic and annual planning.
2. Patients and staff at the heart of delivering our CQI Plan: Sharpen the focus on delivering high-quality patient care and aligning improvement activity to outcomes and patient and staff experience.
3. Leadership for CQI: Provide clear leadership for delivering quality improvements. Senior leaders, who model appropriate improvement focussed leadership behaviours and visible hands-on-approach.
4. Building CQI skills at all levels: Demonstrate an accessible approach to providing CQI to every level of the system.
5. Building CQI engagement all levels: Be more inclusive in our approaches, ensuring everyone has a voice in making improvements.
6. System view for CQI: Work as one team to deliver improvements that we can share and celebrate.

There will be an Annual CQI delivery plan produced as part of our business planning process and linked (for NHS partners) to the NHS operational and planning guidance. Through the planning processes, we will be able to identify existing, new, and emerging themes for improvement aligned to our vision, ambitions, improvement programmes, strategic and tactical priorities.

Measuring our outcomes in CQI

Our success will be measured by all the improvements we make, and learning lessons from the changes we make to improve the things that don't have the desired outcome (our 'failures'). We will ensure we can collate the benefits from everyone who undertakes an improvement activity, include it in our CQI Knowledge Hub and monitor all the improvements we have made. This will also provide a wealth of learning to be shared.

We will provide regular updates on the progress of delivery of this strategy and the supporting actions to demonstrate that we are achieving improved patient care through our Governance mechanisms.

We will adapt the CQC Quality Improvement maturity model and will conduct a continuous self-assessment as part of our maturity monitoring. This forms part of the Well-led criteria for CQC assessments:

- We will ensure that we can demonstrate our evidence of maturity against these criteria.
- We will be able to demonstrate improving maturity through our CQI Ambassadors and delivery of our programmes and monitoring of benefits, but more importantly, the biggest test of maturity will be through our staff and patient feedback.
- We will be able to demonstrate that we are a system participating in the NHS IMPACT College programme, which uses an organisational/system approach to building improvement capacity and capability.
- We will present our delivery plans and evidence of delivery to the Improvement and Reform Committee.
- We will align the work of this strategy with the other relevant ICB strategies.

Case Study

National Improvement Framework IMPACT

NWAFT has adopted the National Improvement Framework IMPACT to evolve a cultural change across the organisation through visible leadership and empowering staff to make changes through improvement techniques. The Back on Track programme focuses on three priorities: Cancer Care, Emergency Care & Patient Flow and Elective Care. It has executive and clinical leaderships and is supported by stakeholder groups which include system partners and patients.

Case Study

Special care dentistry

To address the backlog of people waiting for special care dentistry, Cambridgeshire Community Services NHS Trust undertook a review of the booking process, involving patients and carers through a "Working Together" group. As a result, some administrative processes have been simplified and automated, freeing up time to respond to calls. Patients are kept up-to-date and receive clearer information on discharge. A new operational dashboard is now used to monitor performance and ensure improvements are sustained.

Research

Cambridgeshire & Peterborough ICS is home to many world-leading organisations undertaking or supporting high-quality health and care research. Our five-year ICB Research and Innovation Strategy (2022/27) sets out our plans for making the most of opportunities to improve care, services, experiences and outcomes for our population by working with local partners to expand research activity and opportunities, and the use of research evidence, with a focus on local priority areas and needs. It also seeks to improve research participation among local people, especially from communities experiencing the worst outcomes.

Facilitating and promoting research

Research is represented at Board and executive level via the Medical Director. Our Research and Development Office supports the delivery of high-quality, local health and care research in primary, community and social care and non-NHS settings, and with a range of partner organisations. This includes:

- Supporting National Institute for Health and Care Research (NIHR) research recruitment and delivery through expert R&D governance and advice.

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- Hosting and sponsorship of NIHR research grants and contracts.
- Promoting research findings and evidence, especially in support of ICS' priorities.
- Developing and championing opportunities for patient, public and health professional involvement in research.
- Deploying Research Capability Funding (RCF) and supporting health and care research.
- Working collaboratively with system and research partners, including the NIHR East of England Clinical Research Network including the regional NIHR East of England Clinical Research Network (from October 2024, Regional Research Delivery Network) and the Office for Health Improvement and Disparities.

Over the past year, we have participated in national and regional strategic work to support community-based research, including local guidance for commercial research in primary care, forthcoming NHS England national guidance on research finance for ICBs, and establishment of regional Vaccine Innovation Hubs to support commercial vaccine trials. Via competitive award schemes we supported research activity in primary care practices, and the development of new academic grant applications in primary care, population health and social care.

Increasing diversity in research and tackling health inequalities

In 2023/24, we secured a total of £247,000 funding for NHS England Research Engagement Network (REN) development funding across two projects with a wide range of system partners. These focused on understanding and mitigating the impact of barriers to research engagement among underserved communities, especially ethnically diverse inner-city communities in areas of high deprivation, and refugees and asylum seekers. For the coming year, we will build on the learning and relationships from this work to embed research alongside wider public and patient involvement and engagement efforts, making research more visible, inclusive and accessible.

For 2024/25, we will trial a new approach to funding awards to develop new NIHR research applications that will address local population health needs and to support research activity in primary care, with an ongoing focus on underserved populations. We will also support more primary care practices to undertake commercial research activity, in line with NIHR priorities and with an ongoing focus on underserved populations.

Regular contact between the research function and other relevant areas of the ICB (notably innovation, partnerships and communities, health inequalities and sustainability, as well as primary care and specific clinical areas) will seek to identify opportunities to embed research in larger initiatives where it can add value. The R&D office is also supporting national and regional initiatives to maximise the value of research through collaboration between integrated care systems and partners. Within the East of England this includes maintaining awareness of developments in the Secure Data Environment for the region and dialogue in relation to potential research applications, and work to shape the relationship between ICB research leads and the new Regional Research Delivery Network.

Measures of success

The measures of success for these plans will include:

- Evidence of increased research activity across our ICS, particularly in primary care and wider community settings, including the number of research active sites, governance activity and hosted NIHR grants.
- Evidence of increased engagement with local people and communities about research.
- Alignment of research activity with our strategic priorities, including health inequalities.
- Evidence of external collaboration for strategic purposes.

Innovation Adoption Plan

Our ICS is the location of a globally leading healthcare and life sciences research and innovation ecosystem, which presents us with a huge and largely untapped opportunity. By being at the forefront of adopting innovation, the ICS will not only support its patients and population better but it will also support the ecosystem to continue to be a globally competitive destination for life science talent and investment, creating a virtuous circle of research, innovation, evaluation and better health and care. We want the ICS to become an investible proposition, where our local and national health and life sciences industries will come to give early access to the most relevant innovative treatments and care for our population, thus helping us to reduce the health inequalities that characterise our ICS and generating the evidence needed for wider adoption.

We are lucky in Cambridgeshire & Peterborough to benefit from the expertise of the institutions on the Cambridge Biomedical Campus in particular, but we have not traditionally made use of this expertise through the deployment of innovations into patient care. The ICS has both the opportunity and the obligation to work with the innovation community to generate positive benefit for those parts of the ICS characterised by greater deprivation and lower life expectancy. Only by doing things differently are we likely to tackle the challenges in equality and sustainability that we face.

We have made good progress in 2023/24 in establishing the infrastructure needed to support our new approach to innovation, building on the learning from the Health Foundation Adopting Innovation Hub project. The following key challenges for the future were identified through the project and the Hub's Innovation Showcase event which was attended by over 150 stakeholders from across the system:

- Dedicated Infrastructure - developing dedicated teams with support from the Health Innovation East for innovation in Cambridgeshire & Peterborough.
- Reducing complexity and facilitating easier navigation of innovation processes through the development of landing zones and clearly defined innovation process.
- Reducing budget silos – stakeholders benefiting from an intervention are not always those that implement it. We are establishing a system innovation panel which will seek to improve the opportunity to adopt innovation which benefits the whole system before the budget silos impact decisions.
- Proof of concepts which are sustainability tested before commencing – explore how to streamline adoption of tested innovations into business as usual. We have an Innovation Framework workshop facilitated by the Innovation Unit which will seek to build this into the innovation process.

- Developing an approach to systematically select innovations for development and adoption in line with system priorities.

The new approach to innovation seeks to address the learning identified. The Innovation Hub has transitioned to the ICB and includes a Citizen Participation Group which supports the selection, design and implementation of innovation that best addresses local needs and inequalities.

We have established the ICS Innovation Working Group and System Innovation Panel, where colleagues from across the ICS, including innovation experts such as Health Innovation East as well as academia, research and patient representatives come together to form the innovation governance to facilitate our ICS' innovation mission to: (i) become a health system that adopts innovation much more readily in search of its core goals and (ii) become an investable proposition for industry and tech to try out their developing innovations.

We have developed our innovation selection criteria collaboratively with ICS partners and the Institute for Manufacturing. This will assist the ICS Innovation working Group and System Innovation Panel to identify impactful innovations for financial investment. We are also developing a digital platform to support the prioritisation of available innovations, targeting local needs and specific funding opportunities.

In addition, Cambridge University Health Partners are working with provider organisations and primary care to develop Innovation Landing Zones, which are a coordinated front door for innovators, investors, and providers to facilitate the uptake of early innovations in our system. Landing Zones will facilitate access to our populations and their data, with the appropriate controls and approvals, for academic and industrial researchers, and they will encourage our populations to participate in trials, research and innovation. CPFT has recently had their landing zone recognised by NHS England InSites programme, receiving funding to support their progression.

Case Study

Innovation Landing Zone

NWAFT is seeking to create an Innovation Landing Zones to support the development of a single organisational gateway for early-stage ideas, incubation, early-stage testing and prototyping, pitching and collaboration. Alongside system partners, NWAFT is also exploring collaboration opportunities with other providers on new projects and developing a pipeline of innovations for adoption based on system-agreed criteria.

In terms of deploying the expertise and the infrastructure described above, we are starting a major programme of work to coincide with the launch of the government's Life Sciences Missions, where we will seek to harness the expertise of our leading providers and clinical academics to address the Missions which most clearly drive our population's health and health inequality. Areas under consideration include the rapid and equal uptake of new medicines for cholesterol and obesity management; the introduction of innovations into the heart failure pathway; and areas of mental health, including better management of young people's psychosis and the detection of mental health conditions in schools.

Digital foundations and tools to support delivery of our priorities

Digital focus and vision

Our focus and vision will be to consistently get the digital basics and solutions right, and to be at the forefront of digital innovation/transformation that supports local people and staff.

To set us on the right path for achieving this we will be undertaking the following areas of work as a priority:

- Digital foundations and strategy
- Data and analytics strategy
- Digital Innovation
- Electronic Patient Record and Shared Care Record
- Digital Governance
- Digital programmes and prioritisation

Digital foundations and strategy

Our digital vision is to use technology to improve outcomes for local people by empowering them to manage their own health, providing them with efficient, joined up services and giving staff the technology to do their jobs to the best of their ability.

Our Digital Strategy has been widely consulted to ensure that it supports improved outcomes for our local people, enhances our staff's ability to give excellent care and supports improvements in our productivity. It has been developed collaboratively over a 12-month period with our partners across the area. It has had input from our public representatives and highlights our intention to collaboratively deploy digital technologies to improve services and health and care outcomes for our local people.

Our digital vision enables delivery of our ICS-wide vision and goals and allows us to achieve the digital aspirations of NHS England. The programmes set out in our Digital Strategy support us with achieving this vision and to develop a world-class digital infrastructure and information systems. Our strategy builds on what already is working well across our area. For some of our partners convergence of systems may be possible. For other partners and for our Places we will strive for integration or interoperability.

Our progress towards a Shared Care Record, Digitising Social Care Records and integrated diagnostics capabilities provides the best possible foundations for our system to deliver great care. Wherever possible we will seek to rationalise our infrastructure, reduce complexity and unwarranted duplication and variation and drive down the costs and waste. We are also promoting the increased uptake of the NHS App through promotion and links across services.

Our digital programmes are:

- Shared Care Record
- Electronic Patient Record
- Digital Social Care Records
- Secure Data Environment
- Transforming Primary Care (digital)
- Cyber Security
- Digital Innovation and Transformation
- Digital Equipment
- Robotic Process Automation
- Virtual Wards
- Diagnostics and Digital Image Sharing

To get the best value for our local people, the above programmes include nationally sponsored and funded digital products, innovations, and services. These products form part of our transformation and innovation programme and others are part of our digital business-as-usual programme, providing vital technological infrastructure to run our health and care services effectively.

Our digital delivery is a collaboration between health, local government, and social care and all these partners have contributed to its contents. We have agreed six enabling themes of work:

Infrastructure and levelling up

- Make optimal use of our existing digital infrastructure and update this when appropriate.
- Provide the best security for our IT systems and data.
- Optimise our Electronic Patient Record Systems, creating a safe, robust, and fast network.
- Enhance our Electronic Prescriptions and Medicines Administration systems (EPMA).
- Standardising the way in which orders are placed on our providers for diagnostics (OCS).
- Continue to improve our digital maturity as a system.

Improved models of care

- Co-design services and innovation with local people to provide the best possible health and care.
- Embed robotic processes where they bring benefits and exploiting the benefits of AI.

Bringing our people with us (digital upskilling)

- Provide the best possible digital training for our clinicians and staff. Using our network of Upskill our primary care workforce and their customers via Digital Champions.
- Digitally upskill our future workforce by building digital solutions into their training and pathways.
- Support people to use digital innovations that will enhance their care and roles.

Supporting our local people

- Personalisation of services so that local people are in control of their health and care.
- Implement our Shared Care Record, patient portal, Population Health Management system and digitising social care record programmes.

Population Health Management and research

- Provide digital services that support and improve our delivery of care and reduce health inequalities.
- Develop information sharing agreements to help data flows and ensure they are secure.

Developing and securing our digital infrastructure

We will exploit the potential of digital technologies to transform the delivery of care and outcomes for local people. To do this we will work within the national What Good Looks Like Framework and continue to deliver to the seven success measures:

- **Well led** – Continue to build digital and data expertise and accountability into our leadership and governance arrangements and ensure delivery of the system-wide digital and data strategy. We will identify and recruit to digital leadership roles within the ICS to deliver the best possible digital outcomes.
- **Ensure smart foundations** – Continue to work across the system to ensure all digital and data infrastructure deliver reliable, modern, secure, sustainable and resilient services. We will work to ensure all organisations have highly skilled and well-resourced teams, sharing expertise and capacity at system level where most appropriate.
- **Safe practice** – Continue to work with all organisations to ensure our digital services meet the standards required for high quality and safe care.
- **Support people** – Work across the system to develop a workforce that can make the very best of world class digital solutions. Our health and care professionals must have access to the most effective technology to enable them to provide the best care possible for their patients. Enabling health and care professionals to access and share information across care settings is recognised as a key enabler for truly transformational change.

- **Empower people** – Provide access to our digital services to allow communities to collaborate with health and care professionals. We will enable people access to their integrated care record and care plans to empower them to manage their own health and care needs and will provide digital services to support people to stay healthy or to manage monitoring and treatment at home. We want to enable our communities to fully participate in the management, monitoring and decision-making regarding their health and care needs, providing access to these services through national initiatives such as the NHS App but with consideration to those who do not have access to technology.
- **Improve care** – Develop new ways of working and models of care through the introduction of innovative digital tools and services and continually evaluate new advances in technologies and explore the opportunities for adoption. We will support and encourage collaboration between providers, academic networks and commercial partners.
- **Healthy populations** – Build on existing platforms to improve our ability to identify groups of patients and identify specific interventions to further improve health and wellbeing in our system. We will scale up of our operational analytics capability allowing us to improve system-wide resource utilisation, flow and the identification of system pressures.

Case Study

Levelling up our electronic patient record systems

NWAFT have begun the process of procuring an electronic patient record system which will enable clinicians to access a full care history of their patients under the care of the Trust and achieve full continuity of care through a single system. This will require resources and take several years to reach full maturity, but will bring multiple benefits for personalising care, monitoring care delivery in different settings and improving services and outcomes.

Section 9: Environmental and financial sustainability, with a resilient workforce

Net zero

The direct link between health and a low carbon sustainable planet is well established. Climate change poses a major threat to the health and wellbeing of our communities, with the most vulnerable groups often the most affected.

We are committed to the carbon reduction goals of the NHS which are to achieve a net zero NHS by 2040 for direct emissions and by 2045 for the total carbon footprint. To achieve this, we have built an integrated approach with our wider ICS partners to tackle the threats of climate change and to promote sustainability and resilience across all our activities. This system-wide approach, further strengthened through shared learning over the past year, works through established forums, including our Climate Programme Board, the Local Resilience Forum and our ICS Green Programme Board.

The commitment to sustainability is reflected in our governance arrangements, with executive leadership, strategic oversight and reporting at ICS level. We will continue to strengthen sustainability awareness across our leaders and to engage and train Board members and staff at all levels so that this work becomes a shared goal for our system. We will continue to use and refine our sustainability impact assessments and social value weightings in tenders to ensure that carbon impact and wider environmental factors are a key consideration in our decision-making and contract awards. We are developing and reviewing our strategies, policies and procedures with carbon impact in mind. Underpinning our actions with sustainability considerations will lead to improved health of our populations and more resilient healthcare service delivery.

Our Green Plan for 2022-25 sets out the approach and pathway for us to reduce our carbon impact and make a positive impact on health and local communities through more sustainable practices. It sets out our priorities and actions across six workstreams:

- **Workforce and leadership:** Raising awareness, building knowledge and supporting staff to feel empowered and enabled to adopt behaviours and make choices which minimise the impact of our activities on the environment and integrate environmental considerations into everyday work. Using our Leadership Compact and established leadership development programmes we continue to develop carbon literacy and sustainability skills among our leaders and staff at all levels. We will work to deliver a joined-up approach to adaptation across the system.
- **Estates and facilities:** Measures to reduce energy consumption and work towards decarbonising the NHS estate are in place via centralised reporting. We are working towards the decarbonisation of our existing estate and embedding circular economy and design principles into all new capital developments. We have aligned our Estates Strategy with the Estates Net Zero Carbon delivery plan, with a focus on productivity, efficiency and ensuring performance against targets is effectively tracked.

- **Research and innovation:** Supporting research and adopting innovations that improve sustainable healthcare, by developing collaborations with research and academic partners.
- **Active and sustainable travel:** Working with wider partners to promote active travel for health as well as environmental benefit, and enabling sustainable modes of travel for staff, patients and visitors. In line with the NHS Net Zero Travel and Transport Strategy we will move towards a non-fossil fuel fleet across all organisations, with the infrastructure to support. We will work with partners on reducing the impact of transport on local air quality.
- **Supply chain, procurement and waste:** We will seek to embed circular economy principles in the way that we procure, use and manage resources, considering the cost of carbon and waste as part of our decision-making. We will further develop the skills and knowledge of staff to evaluate sustainability and social value in procurement and contract management. We will build a joint approach with our partners to learn from best practice and align our messaging to suppliers. We will raise staff awareness of waste and incentivise sustainable practices in the use and disposal of resources. We will aim to reduce the use of single use items and promote a reuse, repair, recycle approach, through targeted campaigns and initiatives, for example effective waste separation, food waste and plastics.
- **Sustainable models of care: I**ntegrating sustainability principles in the way care is designed and delivered, to improve patient health, increase efficiency and contribute towards carbon reduction. Key elements are digital healthcare solutions, personalised care and social prescribing. We also have a strong focus on sustainability as part of our Medicines Optimisation Plan, including more effective use of medical gases, greener prescribing where clinically appropriate and tackling overprescribing and medicines waste. We will look to improve our performance in the use of high carbon inhalers, working with primary care and pharmacy partners. We will review and look to extend our social prescribing activity, working with place to maximise opportunities for integrated approaches.

Case Study

Examples of progress with delivery of our Green Plan

Our trusts were successful in securing over £3.860m for LED replacements at NWAFT and CPFT premises, with NWAFT's grant being the largest in the region. CUH continues to work with the local authority solar scheme at Babraham Park and Ride, which will bring renewable energy directly to the hospital site this autumn.

The ICB secured a Sustainability Clinical Fellow for a year who is working on sustainable surgery and medicines across our system.

We have scheduled Board training and have now signed up over 20 ICB staff for sustainability training courses, they will disseminate this knowledge to their colleagues in turn. All new staff also get sustainability training on induction.

Across our system we have significantly reduced our use of the anaesthetic gas desflurane, which has a global warming potential 2,500 times greater than carbon dioxide.

Financial context

Financial duties

There is a collective local accountability and responsibility for delivering system and ICB financial balance. The ICB and our partner Trusts must ensure that, in respect of each financial year the local capital and revenue resource use does not exceed a limit set by NHS England. Our ICS has a duty to prepare a plan before the start of each year setting out its planned revenue and capital resource use, publish a copy of the plan and provide a copy to the integrated care partnership, Health & Wellbeing Boards and NHS England.

Our system has, over the past three years, established and developed a system approach to the planned use of revenue and capital resources and the regular monitoring and managing of the financial position to support the achievement of that plan.

The planning process is led by the senior finance and operational leaders within the system, working together to develop the plans ensuring that finance, activity and workforce plans are triangulated, and the system strategy is reflected appropriately whilst remaining within the revenue and capital resource limits as directed by NHS England.

This approach is strengthened through the formal system and organisational governance process with plans reviewed and challenged by a System Executive Team and approved by a Quality, Performance and Finance Committee, ICB Board and Trusts Boards before final approval by NHS England England.

Monthly monitoring of the system financial position is well established and has supported the system achievement of financial breakeven each year. A monthly financial monitoring report is continually reviewed to ensure it provides relevant information to support the system in monitoring and managing the financial position in year. The report includes the overall system financial position, as well as the ICB and provider level performance, efficiency delivery, financial risks and mitigations and capital performance and is presented to the System Finance Directors Group, Quality, Performance and Finance Committee and ICB Board. The monthly report includes financial forecasts allowing the system chief finance officers to project forward and identify early mitigations or system support if required.

This plan is supported by the ICB and Trust Board and the Quality, Performance and Finance Committees. The monthly financial monitoring pack is reviewed throughout the financial year to ensure that the information is pertinent to the audience. During 2023/24 we have incorporated additional information to report our elective recovery position and reviewed the information presented regarding our substantive and interim workforce. This iterative process will continue and will focus on development of trend analysis, benchmarking and long-term forecasting to support improvement of efficiency, productivity and long-term financial planning.

The system continues to develop and embed a capital prioritisation process to support the allocation of capital resource across the system. To support this a system-wide review of our collective NHS estate is underway to ensure compliance with statutory requirements, that the estate is fit for purpose and we are using our estate in the most efficient way to provide services to our local people. This review incorporates and informs our Estates Strategy and capital allocation, providing resources at the right time, in the right place to provide improved, efficient services to our people.

Financial strategy

The ICB recognises that its current financial position is not sustainable, and to achieve the best outcomes for our population we need to use the wealth and diversity of data available to us to support and inform our long-term financial planning. Our 2023/24 system financial plan aims to deliver a breakeven position but includes an efficiency requirement to achieve this. As a system we need to think differently and drive out system-wide transformation and efficiency that will support our long-term financial sustainability.

The basis of our financial strategy is a flat cash approach and where possible utilise new funding to support the community and prevention regime. We will be looking to drive productivity, needs based allocations to reduce health inequalities and ensuring value for money that will enable us to drive towards continued financial sustainability.

We have already embarked on a review and revision of the funding model for primary care. The underpinning principle is to create a sustainable and patient needs-based resourcing, investing in primary and community care to address patient needs and narrow health inequalities. Using our population health data we want to create a model that can flex to existing and newly identified population needs and effectively use resource to support transformation to deliver better outcomes.

For the future, the ICB intends to transition towards a resource allocation process informed by a population health approach. This shift is driven by the need for a more effective, efficient and equitable distribution of resources, emphasising health economics insights in decision-making.

The ICB commissioned PA Consultancy in April 2023 to undertake exploratory work to inform the prioritisation of financial resources based on the outcomes and impacts that interventions are likely to yield. This work has shown the value of economic insights in decision-making and helped us to develop an initial Prioritisation Framework and identify high-impact interventions. Further work is needed to embed this health economic approach from a technical expertise, processes and governance perspective. The ICB will refine and complete the development of an evidence-driven prioritisation and resource allocation framework to prioritise and allocate resources strategically to enhance outcomes, proactively focus on prevention and reduce health inequalities.

The framework will utilise our population health data and consider efficient use of our system-wide estate, workforce requirements and joint working with all our system partners to drive our efficiency and productivity and create a sustainable financial model. Medicines optimisation will be positioned as a strategic enabler of improved patient outcomes, NHS productivity and efficiencies across the system.

Appropriate evaluations will be regularly undertaken to assess the impact of implemented interventions on health outcomes and financial sustainability, adjusting strategies as needed.

Better Care Fund

The Better Care Fund programme supports local systems to deliver the Integration of health and social care in way that supports person centred care, sustainability and better outcomes for people and carers. Over the next year the ICB, along with our social care partners, will be reviewing the Better Care Funding to support an improvement in the outcomes for our people and best value for money. The review will use all of our available data to inspire transformation of our integrated services to deliver innovative, integrated, community-based services to our population that will improve their outcomes and reduce a reliance on emergency secondary care services.

From 1 April 2023 the commissioning of pharmacy, optometry and dental services was delegated to ICBs from NHS England. This has provided us with the opportunity to directly impact and influence the commissioning of these service for our population. The challenges faced in dental services capacity are not unique to our area but the delegation to the ICB has allowed commissioning to be considered at a local level to reflect the needs of the local populations. Work is underway to explore funding mechanisms and incentives to encourage an increase in NHS dental provision. In addition, a number of initiatives are underway to support improving access to dental services in the short, medium and longer term. It will also allow flexibility in the services commissioned from pharmacies across our area to support the population to access advice and support more quickly and closer to home.

The commissioning of specialised services is moving to East of England ICBs from 1 April 2024. In the long term this will allow the ICB to focus on managing Cambridgeshire and Peterborough patients at hospitals within the county boundaries, utilising resources more effectively within our hospitals. This will mean patients do not have to travel further for their specialist treatment. The ICB has spent 2023/24, working with our regional ICB and NHS England colleagues to ensure a smooth transfer of services from 1 April 2024. Over the next year we will be working with our system partners to understand the patient flows across the East of England and with our neighbouring regions for specialist services.

Efficiency and productivity

Our system has a duty to provide services that are of good quality, value for money and make efficient use of our resources. To do this we use local and national data to inform our decision-making across the system. These include, but are not limited to, population health data, model system, outputs from the McKinsey work commissioned in 19/20 and national benchmarking data. As a result of the analysis of this data, we have identified opportunities to deliver efficiencies and increase productivity. For example, national benchmarking data has identified potential efficiencies which can be made in our corporate services functions and work commenced in 2022/23 to scope out the financial benefit and develop solutions to address the identified opportunities for more efficient ways of working.

Productivity and efficiency have not yet recovered to pre-pandemic levels and therefore remain a critical focus for us all. Recognising our performance is not where we would want it to be for our local people, we continue to focus on specific improvement activities and ICS wide recovery plans. During 2023/24 there has been increased recovery of activity, with most elective areas being above 2019/20 levels but there are further opportunities for improved productivity across several areas including outpatients, diagnostics, theatres and length of stay. During the year a capacity and demand external review has been undertaken across diagnostic areas which has identified opportunities for the system which will progress into priority areas of focus for service improvement, productivity gains and implementation plans during 2024/25.

A system-wide group has been established to provide assurance on productivity and efficiency delivery, linking these two key areas of transformation will support the delivery of recurrent efficiencies. Our capacity investment has been designed to support our system productivity ambitions to maximise our capacity in the right place and drive the efficiencies required. This is subject to ongoing review to model the affordability and impact of the financial limitation on performance.

We continue to collaborate on our Workforce Strategy to reduce the reliance on agency staff by providing clear career progression and opportunities for all levels of staff across our providers. Work will continue to refine our efficiency plans with the ambition to convert more planned efficiency to be delivered recurrently.

Our triangulation of the draft 2023/24 Operational Plan highlighted a reduction in productivity within the acute sector and 0% productivity loss within our community providers. This mirrors the evidence from the whole system productivity review underway, including workforce and activity. The review has highlighted the key areas of challenge for the system:

- **Workforce:** The workforce in our system has increased by 16.1% (acute only 16.3%) since 2018/19 however activity has decreased except for A&E and outpatient virtual follow ups. Even though the workforce has increased, we have also seen increases in staff sickness and a deterioration in staff stress levels and satisfaction; all these indicators will impact productivity.
- **Electives:** Total elective activity is 11% lower than pre pandemic levels. North West Anglia Foundation Trust has seen a significant drop from pre covid levels of 20% whereas CUH activity is only 0.6% below 2018/19 and 2.7% below 2019/20.

  The length of stay for elective inpatients has increased by over 20% since pre-COVID-19 levels. This can potentially be explained, in part, by an increase in the day case rate implying lower acuity spells have moved to day case. The average price has also increased above tariff inflation showing that the acuity has increased. There has also been an increase in excess bed days which indicates that there are also productivity reasons for the increased length of stay.
- **Non-Electives:** The length of stay for non-electives has increased by just under 20% since pre-COVID-19 levels. This can, in part, be explained by an increase in acuity but there has additionally been an increase in excess bed days.

A subset of the productivity review has analysed diagnostics, as a key part of the system recovery plan. The headline areas of this speciality review have identified:

- **Waiting times for diagnostics:** Loss of or changes to referring processes for certain diagnostics has in some instances resulted in the originating referrer making multiple referrals within the system to expedite a test. There is also evidence that inter-provider referrals may have also increased to navigate a speedier way around this issue during the pandemic. This has resulted in multiple entries/duplicates on Provider waiting lists for diagnostics, possibly leading to inflated waiting lists, compounded by the availability of clinical and non-clinical to review and triage these lists to confirm their validity.

- **Workforce:** Administrative support roles have experienced a high turnover rate, directly impacting upon availability of staff to work with patients to coordinate and rebook appointments. Cost of living continues to impact on registered staff joining the system (especially around Cambridge). Overseas recruitment has shown some benefit but lead in times (visas) continues to compound delays in reacting to staff departures.

Addressing the challenges in the workforce is key to supporting the transformational changes required in care models to increase productivity. We have a track record of developing innovative skill mix, particularly in areas specialisms where there are national deficits in suitably trained staff. For example, NorthWest Anglia Foundation Trust has been national and regional leaders in developing imaging practitioners with advanced practice, to reduce the reliance on consultant radiologists. We will draw on this experience and knowledge to support the workforce challenges and increase productivity.

Workforce

People are the heart of the NHS and strengthening the workforce supply is a critical challenge. Working to our shared vision of 'All together for Healthier Futures' and the four pillars of the NHS People Plan we aim to ensure our workforce have the right skills to provide the right solutions in the most appropriate setting to improve outcomes for our communities, using resources as effectively and efficiently as possible. We are committed to aligning people planning with the ever-changing needs of our community's health and wellbeing.

Workforce capacity and productivity (as detailed above) is highlighted as a key risk for delivery including the provision of high-quality care, with specific challenges for several specialist areas and pathways. The labour market remains constrained, with particular local challenges due to the cost of living and affordable accommodation within our system. National workforce challenges with regard to long term sickness, early retirement and ageing workforce demographic are reflected locally, with impacts upon a tightening labour supply and workforce wellbeing and retention.

Delivery of our five-year plan is reliant upon key areas of growth with workforce implications including inpatient capacity, opening community diagnostic centers, further expansion of virtual wards and planned new hospital developments including Cambridge Children's and the Cambridge Cancer Research hospital.

Our workforce plans align with our ICB aims and have dedicated priority areas.

Supply, attraction and retention

We will work together to ensure resilient and sustainable workforce supply to meet the care and health needs of our communities.

Our key priorities and deliverables are:

Priority 1: **We will optimise the Supply and Retention activity to reduce our health care support worker (HCSW) vacancy rate across our area.** Specifically, we will:

- Develop collaborative recruitment plans through passive recruitment and careers events.
- Develop co-produced HCSW retention plans.

We are exploring new ways to recruit through joint approaches where we have vulnerable areas of workforce, such as health care support workers. This will increase visibility of health and care careers available to our local people.

Priority 2: **We will build our domestic workforce supply by exploring all supply routes, to build a strong, resilient workforce plan.** We will:

- Refresh ICS attraction branding.
- Use the intelligence from the operational plans to inform workforce transformation.
- Deliver our ICS Apprenticeship Strategy.
- Design and implement an Education Strategy.

We will further develop our Health and Care Academy together with our Apprenticeship schemes, promoting social mobility, supporting clearer visibility of career pathways and future development opportunities in both care and health. Together with shared mobile recruitment facilities and a new microsite, we are promoting roles in areas where traditional recruitment methods do not effectively engage with local people.

Our digital Health Academy opportunities currently include our Junior Academy aimed at 13-15 year olds which aims to promote careers in health and care throughout our area. Our Senior (16-18 year olds) and Pre-employment Academy (18+) are under development. Combined, these will support our domestic supply pipelines with routes into a wide range of workforce roles throughout our area and support our attraction as Anchor Institutions.

We are working with our Higher Education Institutions (HEIs) to improve access to new academic pathways that allow candidates to move between health and care within our area, improving social mobility for our local people by making educational courses easier to access.

Clinical placement capacity for Nursing, Midwifery and Allied Health Professional students remains a risk for our area. We have a Clinical Learning Strategy embedded within our system and our Clinical Learning Environment Lead is now in post to disseminate a range of opportunities including digital innovation, to support student placements.

Priority 3: **Implement NHS England's Retention Five High Impact Retention Interventions to create a resilient workforce.** We will:

- Implement a Legacy Practitioner model across primary, secondary care and VCSE organisations.
- Embed Flexible Working policies across the ICS.
- Implementation of a Retire and Return policy across the ICS.
- Cambridgeshire & Peterborough and NHS providers will complete the NHS England Assessment tool.

We are implementing the NHS England Five High Impact Interventions which are designed to retain staff and develop inclusivity within our workforce. These include the development of Menopause Policies, pension seminars, preceptorship frameworks, legacy practitioners, and completion of self-assessment tools by individual providers to facilitate NHS trusts with the development of their individual Retention Workforce Plans. Together with Flexible Working Policies and the ongoing support of our Health and Wellbeing Services available to all to NHS staff across our system, we will increase the number of those who remain at work, reduce turnover and improve workforce satisfaction and productivity.

Priority 4: **Support supply, attraction and retention through affordable accommodation in our system and to improve the availability of affordable accommodation for international and domestic recruits in 2023/24 and beyond.** We will:

- Following the completion of the housing needs survey in 2023, deliver an ICS Workforce Housing Needs Strategy in collaboration with the System Estates Group.
- Explore adoption of the Homeshare Model.
- Produce local area housing guides.
- Identify further opportunities to work with voluntary sector partners to strengthen the pastoral support for internationally recruited staff.

A strong international recruitment pipeline has reduced our vacancy factor within our systems, supporting growth in our Nursing and Midwifery workforce within the past 12 months. International recruitment continues at pace supported by further investment which has now expanded to include Allied Health Professionals (AHPs).

Regionally, through an Integrated Care & Health Workforce Delivery Group, we aim to develop a Centre of Excellence, to support recruitment of our International Workforce. This will be positioned within the care sector and its key aims are to have an ethical recruitment process, adhering to best practice with regards sponsorship opportunities, and linking with our VCSE sector to provide the best pastoral care and access to grants. This Centre of Excellence will safeguard in line with modern slavery guidance and provide support for existing international workers, particularly with regards to support for identifying safe, affordable accommodation in our area.

We have run successful Key Worker and Housing Accommodation engagement sessions, sharing experiences, challenges, and collaboration with all partners. Together with an ICS-wide accommodation survey we will identify the scale and profile of the housing needs amongst key workers, providing evidence of where the pressures are greatest. Homeshare, an intergenerational accommodation programme, is also being planned to help support adult social care.

Leadership and culture:

We need to build on the partnership working that we have started and create a shared culture that:

- Enables us to trust, connect and work differently.
- Is collaborative and inclusive – whole system and not just NHS focused.
- Is focused on strengthening integration and working effectively across professional, service and organisational boundaries.
- Is just and learning and focused on continuous improvement.
- Enables and encourages people/colleagues to be allowed to do the right thing for local people, say yes, be included in decisions and thrive.
- Enables and encourages people to contribute to and co-produce service developments.
- Enables and encourages everyone to understand the new world we are operating in and their role in making it a success.

We will develop compassionate and high performing leadership committed to driving a just and learning culture. Our leadership and culture priorities are: compassionate culture, talent management and succession planning, system leadership.

Our Leadership and Culture groups work to implement the learning through our staff survey results. Our programmes have a broad membership across the ICS and work to develop our leaders in systems thinking and system behaviours, teaching them how to work beyond their own organisational boundaries to support the needs of the local people. By creating collaborative and inclusive cultures across our ICS, we engender joint working and a common shared purpose, especially around the inclusion agenda and embedding sustainable solutions in all our processes and programmes.

The 'Above Difference Programme' will support the development of a cultural intelligence framework to support our leaders and staff to become more culturally aware using personal analysis and economic modelling. This will operate alongside the Cultural Ambassadors, an evidence-based programme based on national data of ethnic minority staff with experiences of being referred to respective governing bodies, and higher levels of disciplinary and grievances with an overall focus on improving patient safety.

- Implementation of our anti-racism strategy, including embedding "no more tick boxes" in recruitment; rollout of anti-racism training programme; and implementation of the anti-violence and aggression workstream.
- Develop and roll out "Above Difference" workshops as part of a system-wide programme.
- Co-produce an anti-racism toolkit.

Equality, diversity and inclusion:

As explained in section 6, we are committed to promoting Equality, Diversity and Inclusion (EDI) outcomes, with a focus on ensuring that all staff, patients and carers and stakeholders are treated fairly and with dignity and respect, regardless of their background or identity. We aim to drive out inequality in our workforce, recognising we are stronger as a system that values difference and inclusion. We are committed to working with our partners on a plan of action that delivers sustainable and measurable change, and to ensuring that everyone sees equality and inclusion as their responsibility.

To take this forward we will engage with a wide variety of stakeholders in developing and implementing a programme of targeted interventions, building on the existing areas of good practice and the outcomes from our collaboration event which identified key priorities for action around leadership and management; talent and career progression; and racial harassment. We will work collaboratively to implement innovative EDI initiatives and strengthen our policies and practices to build a truly inclusive and diverse culture.

Priority 1: Implementation of our anti-racism strategy; rollout of anti-racism training programme; and implementation of the anti-violence and aggression workstream.

Priority 2: Develop and roll out "Above Difference" workshops as part of a system wide programme.

Priority 3: Co-produce an anti-racism toolkit.

Delivery and governance

We have strong partnerships to support our workforce aspirations. This became more evident during the pandemic, where greater cross-sector collaboration working took place with effective and efficient communication between care, health, VCSE and wider community sector partners. We quickly learnt the power of working with local communities, successfully recruiting at scale and pace from health including primary care, social care, education, VCSE and faith-based groups to deliver the vaccination programme for the system.

To deliver on our ambitions and plans we have established robust and inclusive governance through the ICB People Board, the newly formed ICB People Team and sub-groups, with clear accountabilities and performance management at organisational and system level, ultimately reporting to the People Board and the Integrated Care Board.

There are eight workforce enabling groups: Health and Wellbeing; Education, Learning and Development; Equality Diversity & Inclusion; Leadership & Culture; Recruitment; Retention; Workforce Planning; and Futures.

Primary care sustainability

It is important to ensure that when discussing 'primary care' we are mindful that these services include more than just General Practitioners (GPs) and General Medical Services. Community Pharmacy, Optometry and Dental professionals are key members of the primary care service offering across our system.

Creating a resilient infrastructure to wrap around our primary care providers is vitally important for improving access to primary care and determining its future sustainability, and it is a key component of our aspiration to build thriving Integrated Neighbourhoods. This is a top priority for local people, as demonstrated by "Let's Talk: Your Health & Care", feedback from our ongoing engagement with VCSE, local Healthwatch priorities and other local involvement initiatives. An integrated and prevention-focused primary care system, as described in the NHS England Fuller Stocktake report, is a core foundation for achieving our ICS goals and improving access, experience, quality of care and outcomes, by:

- Streamlining access to care and advice so it is available in the community when needed.
- Delivering personalised proactive care to people with complex needs.
- Helping everyone to stay well for longer through joined up prevention pathways.

To deliver this vision we have identified three underpinning principles:

Population health and prevention	Sustainable and needs based resourcing	Patient centred transformation
• Build population health data to gain insights into our population and gather data to better serve them. • Neighbourhood teams to take more active role in improving health outcomes. • Data can empower neighbourhood teams to increase uptake of preventative interventions whilst also tackling health inequalities. • Use the Core20PLUS5 approach for reducing health inequalities. • Fully involve the wider primary care workforce - community pharmacists, optometrists and dentists/dental care professionals in delivery of preventative care. E.g. to screen for atrial fibrillation when patients attend for routine appointments, thus supporting the CVD strategy and reducing the risk of debilitating strokes.	• Investing in primary and community care to address patient needs and narrow health inequalities. • Use local patient data to create funding model that can flex to existing and newly identified population needs. • Simplified approach based on high trust low bureaucracy and moving to measuring outcomes. • Effectively use resource to support transformation to deliver better outcomes. • Ensure equitable allocations to encourage equality of outcomes.	• Build Integrated Neighbourhood teams rooted in sense of shared ownership for improving health & wellbeing of the population. • Foster improvement culture and safe environment for people to learn and experiment. • Deliver the change our patients and staff want and need through improving same-day access for urgent care and continuity of care for those with complex needs. • Develop current tools of healthcare into tools for self-care, empowering people to maintain and monitor their own health.

General practice

Recently there has been a major focus on supporting general practice resilience to meet both urgent care needs and maintenance of long-term conditions care, through an integrated community-based response, with clear accountabilities and responsibilities and reduced bureaucracy. This has included targeted investment to increase capacity; increase flexibility in using existing funding streams to support general practice sustainability; digital solutions and specific agreements with Trusts about referral; and discharge practices to help free up clinical time with more streamlined processes.

Our plans for the medium to longer term focus on the following:

- Developing a new framework for locally commissioned services that reflects an investment in all our local primary care providers providing financial security and supporting resilience as the ICS moves more towards a needs-based model of funding for general practice.
- Utilising local discretionary investment to meet identified population needs at place and neighbourhood level through local transformation initiatives and targeted services
- Using population health data to set outcome measures as part of a new primary care investment approach, underpinned by a culture of accountability, responsibility and reduced transaction.

How we will be taking this forward:

We have now assumed the commissioning responsibilities for wider primary care services and with that the associated challenges and opportunities that brings. We are working with local clinical leaders and representatives, and our local communities, to ensure the same robust support for service investment, integration, and improvement that we have previously directed to general practice services.

Working with local primary care providers alongside the Local Medical Committee (LMC), Local Dental Committee (LDC), Local Community Pharmacy Committee (LPC) and Local Ophthalmology Committee (LOC) the ICB is in the process of developing a Primary Care Local Commissioning and Investment Plan for 2024/25, (in line with the commitments we set out in the Primary Care Roadmap) to continue to invest in primary care to support the sustainability and integration of primary care serves within the ICS. The ICB has embarked on a series of stakeholder events to build relationships with the pharmacy, optometry and dental provider community to help understand the challenges that they are facing from the demands on their services, and to further explore opportunities for collaborative working.

Primary care leadership is already represented on the Professional and Clinical Leadership Assembly, the Joint Clinical & Professionals Executive Group and the Primary Care Commissioning Sub-Committee as well as local PCN Clinical Directors and Managers group. As we strive to integrate primary care service further within our neighbourhoods the breadth of that representation will increase.

The ICB will provide an environment to ignite local ambition, and the tools, training and time needed for staff to transform this sector of our system. Key elements of the current system, like the partnership model of General Practice, which where it is thriving, allows agility and early adoption of innovation, will be supported. Where current challenges mean future sustainability necessitates new clinical and business models, these will be explored and co-designed with our clinical and user groups.

We must embrace the opportunities of new technology, but not lose the human element to caring, affording our professionals the time they need to spend in ensuring holistic care of their patients.

The four Cs that have underpinned primary care services – first contact care, comprehensiveness, continuity, and coordination, are and will remain important to clinicians and patients, as we strive to design and sustain services for the future.

The Primary Care Strategy must be thought of as a hypothesis, that we can test through action, rather than a fixed plan. We will use data to empower our ability to adapt our hypothesis if the strategy is not leading to the results we want. Permission to fail fast and change direction will be as important as celebrating those positive changes made. Our local people and communities must be close to the change, not only to guide it, but also to help us reset expectations of what the primary care service of the future can realistically deliver and the importance of each individual's role in maintaining (and restoring where necessary) their own health through the lifestyle choices they make, the actions they take, and the interactions they have with health and care services.

Community pharmacies

Community pharmacies have a key role to play as part of a sustainable, prevention-focused primary care infrastructure. They are embedded in the heart of our communities and represent the healthcare services that people choose to use more frequently than any other. As such, they play a key part in our Anchor work and community resilience. We will work with community pharmacies to enhance opportunities for early intervention and detection of long-term conditions to help support improved outcomes.

Recognising that prescribing is the most common intervention made in healthcare and yet can also cause significant harm, we will prioritise medicines safety through utilising the community pharmacy workforce expertise in medicines optimisation, helping to reduce waste whilst maximising the benefits for patient care.

We will ensure that the full range of care professional and clinical leaders from diverse backgrounds are integrated into system decision-making at all levels. As such community pharmacy leaders will be involved and invested in planning and delivery at system, place and neighbourhood level.

Our plans for community pharmacy:

- Increase the use of the Discharge Medicines Service: Build and expand on the current service over the next one to two years by broadening the cohort of patients referred into the service and improving digital mechanisms for referral.
- Increase referrals via the Pharmacy First Service:
  - Inclusion of new providers to refer into the service including urgent care over the next year, collaboratively working with GP practices to align healthcare professionals ensuring increased accessibility and improving patient outcomes, including changing patient behaviours.
  - Developing clinical services provided by community pharmacies, including services which address inequalities and population need.
- Increase the number of prescriptions ordered via the electronic repeat dispensing service: Improve the ordering process, ensuring it is efficient and safe, to help patients have access to their medication when needed while reducing workload for various providers.
- Improve digital connectivity between providers through the NHS England SystmOne pilot: Digital connectivity enabling access to patient records is fundamental in ensuring safe and appropriate prescribing and medication supply. The development of future clinical services provided by community pharmacies over the next one to five years will be largely dependent on this.
- Support pharmacies to deliver self-care and self-management for both minor ailments and long-term conditions.
- Expand clinical services provided by community pharmacies:
  - Enhance opportunities for early intervention and detection of long-term conditions to help support improved outcomes, as an example the Community Pharmacist Independent Prescriber Pathfinder for the management of hypertension which will be piloted for a minimum of 12 months.
  - Increase provision of clinical services provided by community pharmacies, which will include development of new services; commissioning of new services; upskilling the pharmacy workforce, e.g. Pharmacist Independent Prescriber qualification.
- Maximise the use of community pharmacy Patient Group Directions (PGDs) enabling community pharmacies to provide certain over-the-counter and prescription-only medicines for specified conditions without the need for a doctor prescription.
- Make best use of prevention services - vaccination services, hypertension case finding, smoking cessation, weight management, supporting community pharmacies to further develop these services to improve prevention outcomes.
- Support workforce to minimise unexpected closures through workforce and development initiatives.

Dentistry

Dental practice, including the whole range of dentists and dental care practitioners, also have an important role in our sustainable, prevention-focussed primary care infrastructure. The recent oral health survey of 5-year old children in 2022 (National Dental Epidemiology Programme (NDEP) for England: oral health survey of 5 year old children 2022 - GOV.UK (www.gov.uk)) indicated that 63.3% of five year olds in Cambridge, 56.4% in Peterborough and 52.6% in East Cambridgeshire have enamel/dental decay with local intelligence indicating significant requirements for tooth extraction. The East of England Dental Transformation Strategy indicated that following the 'Steele Review', a clinically led Dental Contract Reform (2011-) programme led by Professor Jimmy Steele focused on:

- Prevention focused care pathways and self-care plans.
- Increasing access to NHS dental services and reducing health inequalities.
- New remuneration models based on the local populations and quality of care - access, prevention, oral health and quality of life and health inequalities.

The Dental Strategy through a new model of care aims to:

- Address regional inequalities in oral health and inequity of access across the life course including the impact of rurality on workforce and patient access.
- To flex as COVID-19 continues to challenge delivery and access to care & address the reduction in throughput of patients due to COVID-19.
- Align to the NHS LTP, whereby local clusters of dental providers working in a hub and spoke system and broadly aligned to PCN areas, will work collaboratively to meet the needs of local communities.

The application of the above in our area will be carefully considered as we continue the development of our primary care sustainability plans including how we improve access to dentistry, a key theme in the feedback we have received from our people and communities, and how we take further opportunities for prevention and tackling health inequalities in this area.

Optometry

Eye care is crucial to people's health and quality of life. Access to disease prevention, earlier identification and patient self-care improves patient outcomes. Following diagnosis, many people have chronic long-term ophthalmic conditions requiring lifelong regular, timely eye care to prevent permanent visual loss.

Opportunities for improving access and outcomes through primary eye care services:

- Utilising primary eye care optometrists as first contact practitioners and as part of referral pathways for eye care, reducing demand for GP attendances.

- Developing assessment and co-management pathways, including using core competencies and the skills of higher qualified optometrists.
- Maximise on the ability of optometrists to support the delivery of eye care for minor and low risk patient cohorts within primary and community settings utilising the Optometry First model.
- Improving digital connectivity for referrals, communication and image sharing with secondary care.
- Making best use of workforce for non-optometry prevention services such as hypertension case finding, atrial fibrilation case finding.

Estates and infrastructure

An efficient and effective estate is a key foundation for the delivery of excellent care, for meeting the needs of our current and future workforce and for supporting the delivery of our system's strategic objectives.

Our goal is to provide a fit for purpose, accessible, financially viable and environmentally sustainable estate at system, place and Integrated Neighbourhood level, that allows the right care in the right place and enables better patient outcomes.

We have worked closely with partners and NHS Property Services on a strategic review of estates as a basis for future strategic planning. The review covered approximately 240 properties with a total gross internal floor area of 650,000 sqm, including 125primary care properties (87 GP practices), four main acute hospitals and eight main community and mental health hospitals/main sites. We are working with partners through the System Estates Group and One Public Estate to maximise the opportunities for efficiencies and integration through joined up working and a shared approach to decision-making that is based on data about our current estate, strategic intent, demographic growth and population health. This is important because the 240 healthcare facilities represent only 10% of the total footprint of our ICS estate portfolio.

Key challenges and opportunities identified include:

- Ageing and undersized primary care estate, with additional pressures from a growing and ageing population.
- Third party owned property that may not be maintained to modern standards and that may be sold and therefore lost to the system, without succession plans in place.
- Reinforced Autoclaved Aerated Concrete (RAAC) in trust and general practice buildings, with ongoing monitoring, reporting and risk management.
- The opportunity to rebuild Hinchingbrooke Hospital, following funding from the New Hospital Programme, which requires reprovision of services based on long term population health needs.
- Strategic developments at the Cambridge Biomedical Campus (Cancer and Children's Hospitals and the wider masterplan).
- Underutilised back-office accommodation.
- A significant amount of work has been undertaken to gather comprehensive and consolidated data to support strategic planning for primary care and trust assets. Further work is ongoing for local authority and one public estate.

- Affordable staff accommodation is a barrier to recruitment and retention for key workers across health and care, and needs to be addressed in collaboration with workforce colleagues.

Our infrastructure must meet the needs of our communities, be fit for purpose, provide a good environment for delivery of care and provide a safe and effective working environment for staff. Much of our estate is aging, requires investment and, due to population growth over the past 20 years, is not always located in the right geography to meet the growing needs of our population. As we develop our vision for our estates, it needs to be aligned with our strategic aims, as well as meet the needs of our communities, and respond positively to the challenges put forward in national guidance, such as the Fuller Stocktake Report.

Case Study

Town Planning Support

Our population is growing at a significant rate across the county, with 77,860 new homes planned, plus 150,000 new homes proposed in the Cambridge 2040 plan. Current health infrastructure (based on the current model of care) cannot maintain this rate of growth at the current investment level.

We are therefore looking to deliver new models of care to support this growth as well as investing in Town Planning Support to maximising the opportunities for the NHS from the town planning system.

The Town Planning Support has resulted in 1000 planning policy consultations reviews and over £12m funding requests for healthcare services from emerging site allocations. Over the next 12 months we will continue to focus on maximising the contributions towards primary healthcare-led developments and broaden the definition of these requests to ensure that the spaces and funding can incorporate other NHS services such as community services and dental to reflect modern health hub provision.

We will continue to use our Estates Strategy to inform key decisions about how best to use our existing and future infrastructure to deliver on our strategic aims and do so within our system capital envelope. There is much to tackle, and finite financial and capacity to do so. We therefore need to continue to focus our efforts for most impact and be clear and consistent about and the rationale for this focus.

The Estates Strategy has been informed by research about what matters most for communities in creating spaces for wellbeing. This highlighted access issues, welcoming environments, inclusive culture, multi-purpose and community spaces as key themes. In addition, the 1:1 engagement sessions with stakeholders, carried out as part of the strategic estates review, identified several recurring themes around culture, integration, flexibility and efficiency, focus on population health, prevention and social value. These have informed our strategy which is centred around the following priority objectives:

Transform spaces and places

- Develop a hub strategy integrating primary, community and specialised services. Our focus will be to identify neighbourhood hubs that improve local access to a wider range of services more locally, incorporating the social and voluntary sectors. Potential sites are emerging, which we need to verify with data and partner feedback.
- Those areas of highest population growth have been identified and we are working with the local population and stakeholders, including local authorities and developers, to progress programmes across the county to ensure we develop the right building, in the right place, delivering the right service to meet local population needs. These new localities present opportunities for us to design new facilities that embrace our principles of integrated care closer to home.
- Increase access to diagnostics in the community and widen the reach of testing by bringing these services closer to people's homes - system-side sites have been identified and are under development.
- We will continue to work with partners to optimise public sector estate options. We need to share estate thinking, planning and facilities to realise financial efficiencies as well as encourage better integration with social care and VCSE sector to realise our collective objectives.

A smarter and greener NHS estate

- Develop policies to improve estate flexibility and utilisation. We need to move away from a 'name on the door' model of estate use. We need to understand utilisation better and develop a robust digital platform whereby all our estate partners can make better use of our estate, siting/grouping services with good public and active transport access.
- Rationalise the back-office estate and create multi-agency hubs. We need to assess our needs, locations and work with our colleagues within the One Public Estate to create collaborative environments.
- We are developing a productivity programme to review under-performing assets to identify what estate is coming to the end of its useful life - the state of repair, cost to bring up to the required specification/ standard (where necessary), and its current utilisation. This will help to inform our future estate needs. In particular, we will work to reduce energy usage and move away from fossil fuels, utilising the best technology and design to deliver effective daylight, shade and ventilation.

We will work towards reduced use of high carbon footprint medical gasses and effective management of waste, bearing in mind guidance such as the NHS Clinical Waste Strategy 2023. We will work to ensure use of low carbon material in new build and refurbishments and utilise our green estate to the best advantage for biodiversity, delivering against the new 10% biodiversity net gain requirements in all developments, sustainable urban drainage, active travel and shade potential. All new builds and reconfiguration are now mandated to deliver in a sustainable manner, however there is a large retrofit challenge across all our older estate.

Excellence in delivery and insights

- Improved estate data and insights to provide us with the clarity on vacancy, utilisation, condition, lease dates, age, size and to aid project tracking - this is in place for primary care and ongoing for trust-owned estate.
- We are developing an ICS capital planning strategy, with a clear definition around the prioritisation of projects set against the availability of capital.
- We have developed a PMO to effectively deliver workstreams and projects, focused resource and governance to manage and track our workstreams.

Major estates projects

We have a number of proposed hospital developments in our area, which present an opportunity to improve patient experience and utilisation of resources. These include: Cambridge Children's Hospital and the Cambridge Cancer Research Hospital at the Cambridge Biomedical Campus, as well as proposed redevelopments at Hinchingbrooke Hospital and the Princess of Wales Hospital, along with other acute, community and primary care sites across the system. Further detail is set out in our Estates Strategy.

Our proposed focus for 2024/25:

We will need to be brave and incisive in our decisions, using data to inform our planning, whilst recognising that these estates are often regarded as anchor institutions within local communities and as such will have community and political attention.

We need to learn from innovation in other areas, deliver community hubs and services that don't take years to plan and set the bar for future facilities. We need buildings that can grow over time to support the needs of a growing population and to enable the co-location of wider health, care and community services.

We need to harness the power of modern methods of construction, minimise disruption for staff and the local community. We need to deliver the space needed to provide good patient care, that can grow with the local population and act as a pilot for a new way of tackling the estates challenges identified in the Fuller Stocktake Report.

Finally, we need to live within our financial means, so will need to make some difficult decisions about where we invest as well as being innovative about how we attract additional income to support our aspirations. In Let's Talk our people and communities, when asked if they are supportive of releasing or selling buildings that are under-performing or no longer fit for purpose, to reduce maintenance costs and release funds for investment, 61% of respondents said they were supportive of this approach.

Based on our strategic aims, the population health needs, and the data set out in the System Insights Pack we have identified our acute/community and primary care sites (not in order of priority) where we need to consider our capital investment and recycling opportunities:

Acute/community sites:

- Hinchingbrooke Hospital, Huntingdon
- CUH Cancer and Children's Hospitals
- Princess of Wales Hospital, Ely
- Royston Hospital and Royston Health Centre
- Doddington Hospital
- North Cambs Hospital, Wisbech
- Peterborough City Hospital.
- Brookfields Hospital, Cambridge.

Sustainability and reform of primary care, focusing on urgency of need:

- Alconbury Weald Development (Interim and Health Hub)
- Park Medical Centre, Peterborough
- Royston Health Centre (Granta expansion)
- Great Haddon
- North East Cambridge and Marleigh
- Northstowe.

Case Study

The replacement of the existing Hinchingbrooke Hospital remains one of the highest priorities within the ICS estates strategy. As part of the national New Hospital Programme, the new Hospital will offer an opportunity to re-provide services within a modern hospital setting retaining local A&E facilities, alongside the development of an elective hub located within the existing Treatment Centre and new theatre block on the Hinchingbrooke site.

Case Study

Following approval of the Outline Business Case (OBC) for the Cambridge Cancer Research Hospital (CCRH) in summer 2023, enabling works commenced in February 2024. CCRH will bring together clinical and research expertise in a new, world-class hospital, designed in partnership with our patients and uniquely poised to radically transform patient care through, for example, early detection and personalised precision medicine.

Case Study

The OBC for the Cambridge Children's Hospital (CCH) was also approved in principle in October 2023, with the fundraising campaign already past the halfway mark of its £100m target. CCH will be unique in its vision to treat mental health and physical health together, under one roof, alongside world-leading research.

Section 10: Implementation

Our Culture and Values

To deliver the health and wellbeing ambitions and priorities of the Health & Wellbeing Integrated Care Strategy, we cannot do this as a group of individual organisations.

We need to make a transformative cultural shift from individual organisational and silo working to a systems and partnership approach where we are collectively responsible, and we help each other to improve the health and wellbeing of our local people and communities.

In section nine (leadership and culture) we set out our vision and principles for the cultural shift we aim to achieve in our system.

This cultural shift will develop as our system matures and relationships strengthen, and this in turn will be enabled by:

- A strong focus on our culture and organisational development at a system, place and team level.
- Supporting our leaders from all organisations to compassionately lead and drive the culture change we need.
- Living and embedding our values and Leadership Compact in all that we do:

Put people and quality first

Have honest relationships and act with integrity

Be transparent and inclusive when making decisions

Do what we say, celebrating success and learning from failure

Hold each other to account

Organisational Development

Organisational Development (OD) will be an important enabler to achieve this cultural shift. As our system matures, different parts of the ICS architecture will be developing at different rates and so their OD focus will be dependent on where they are in their development cycle. For this reason, it is anticipated that all parts of the ICS (ICB, ABUs, Provider and stakeholder organisations) will have their own OD plan, tailored to meet their specific needs; this will mean that OD interventions identified in individual plans may be similar, but the timing of when these are implemented will be different.

To oversee the delivery of OD across the ICS, we have established a System Development Forum that reports to the ICB Management Executive and as with the OD framework that we have produced, this board will:

- Identify areas where OD support is required.
- Highlight areas where we can work together as a system to design and deliver OD interventions that can be applied to the whole system.
- Ensure that there is a level of consistency in approach, where it is applicable.
- Share learning and good practice.

Our OD interventions will be prioritised, to focus on the areas of integrated team working culture, leadership development and system relationships/collaborative working.

Tailored support to enable teams to deliver care differently:

- Agreed shared outcomes
- Understanding what we each do
- Using skills and strenths of different partners including VCSE etc
- Co-design with communities

Building effective working relationships, where there is clarity about roles, responsibilities, decision-making and accountability

- Partnership development
- Relationship between the four Partnerships
- Relationship between the Partnerships abd ICB teams/functions
- ICB Management Executive
- Relationship between ICP and ICB
- Professional and Clinical Leadership Assembly

Embedding:

- Leadership Compact
- System Leadership Behaviours Framework
- Multi-organisational Leadership Programmes
- Leadership development for leaders of integrated teams
- Care Professional and Clinical Leadership development
- Understanding different organisational/ professional cultures - “Stepping into my Shoes”

Governance, accountability and performance

Our ICS brings together the full spectrum of local partners responsible for planning and delivering health and care to the population of Cambridgeshire, Peterborough and Royston, including:

- NHS Commissioners – ICBs and specialised commissioning
- NHS Providers – acute, mental health, ambulance and community
- Local government – county councils, district and borough councils, town councils, parish councils
- NHS regulators and other bodies – NHS England, CQC, HEE
- GP practices, Local Medical Committees, GP Federations, Local Professional Networks, community pharmacists, optometrists and dentists
- Independent sector providers – private sector and Community Interest Companies
- Voluntary, community and social enterprise (VCSE) sector – Community Foundations and other funders, infrastructure organisations, faith organisations, hospices and other community or sector specific organisations
- Public representatives – Healthwatch, community, patient and carer groups
- Education and research – schools, universities and academic health sciences networks
- Other sectors – industry, police and crime, environment

Together we have developed an integrated governance framework that describes how we work together for outcomes that are collectively achieved. It works alongside existing accountabilities and structures and aligns with the roles and accountabilities of the NHS and local government. The ICB Functions and Decisions map sets out the governance for our new integrated landscape. It is a high-level structural chart that details the health commissioning duties of NHS Cambridgeshire & Peterborough ICB. It also sets out which key decisions are delegated and taken by which part or parts of the system and includes decision-making responsibilities that are delegated to the ICB (for example, from NHS England).

The ICB meets as a unitary board and is collectively accountable for the performance of the ICB's functions, and accountable to NHS England.

The ICB has agreed a Scheme of Reservation and Delegation (SoRD) which is published in full in the ICB Governance Handbook. The SoRD sets out: those functions that are reserved to the board, those functions that have been delegated to an individual or to committees and sub-committees, those functions delegated to another body or to be exercised jointly.

The ICB Board has established several committees to assist it with the discharge of its functions:

- Audit and Risk Committee.
- Commissioning, Investment, Improvement and Reform Committee.
- Quality, Performance and Finance Committee.
- Remuneration Committee.
- People Board.

Each of the Board Committees has a documented structure of informal and formal feeder groups, through which there is appropriate involvement of local stakeholders and professional expertise.

The ICB Board remains accountable for all the ICB's functions, including those that it has delegated and therefore appropriate reporting and assurance mechanisms are in place as part of agreeing terms of a delegation.

Our ICB Programme Executive is responsible for collaboration and alignment of activities across the NHS partners. The Programme Executive is responsible for monitoring system-wide programmes and where appropriate making recommendations. Routine reporting is via the report of the ICB Chief Executive to the ICB Board. The Programme Executive maintains oversight and assurance on delivery of the ICS' Operational Plan and Joint Forward Plan. The Programme Executive gains assurance and maintain oversight on delivery via a robust Business Cycle provided via regular reports and deep dives from the JFP delivery groups. The Programme Executive reports to the ICB Board via the Chief Executive's Report.

The ICB Governance Handbook features the SoRD, the Functions and Decisions Map and the Terms of Reference for all ICB Committees and can be found on the ICB website.

The ICB has a clear performance and assurance governance structure in place through the following boards that report into the Quality, Performance and Finance Committee and the Improvement and Reform Committee:

- Unscheduled Care Board.
- Planned Care Board.
- Diagnostic Board.
- Cancer Board.
- Mental Health, Learning Disabilities & Autism Partnership Board.
- Community Board.

Each of these groups have system-wide representation and review performance across the system including traction and risks on the relevant system recovery plans.

In addition, the Performance Assurance Framework provides a clear process to review and manage performance and assurance across providers, with clear escalation based on performance trigger points.

Quality and safety

Overview

We have co-produced a Quality and Patient Safety Strategy, within which the overriding principle is to foster a culture of safety, learning and support with standards and structures that underpin safer care.The strategy has been developed collaboratively by patients, partners, including health/social care, public health and the Local Authority.

The strategy has been developed following the COVID-19 pandemic and unexpected disruption on people's lives, their health and wellbeing. The NHS has also seen unprecedented levels of demand, both during the peaks of infection with high hospital admissions and demand on critical care services but also the highest level of demand for all other emergency, elective inpatient, residential and nursing care homes. The pandemic, conditions and workload have had a significant impact on the health and wellbeing of all health and care staff, and this will be a major consideration as we start to develop and implement the strategy.

During 2024 we will revise our Strategy to embed the NHS England Patients Safety Incident Response Framework (PSIRF). This new framework aims to provide guidance to enable local healthcare systems on how to conduct "strategic, preventative, collaborative, fair and just, credible and people focused" investigations into any safety breaches by:

- Advocating for a co-ordinated and data-driven response to incidents, prioritising compassionate engagement with those affected.
- Embedding patient safety incident response within a wider system of improvement and prompting a cultural shift towards systematic patient safety management.

System Quality Oversight

Our System Quality Group (SQG) is the key forum within our ICS to share and triangulate intelligence, early warning signs and quality risks/ concerns; partners will develop and implement actions and responses to mitigate and address the risk raised. As per National Quality Board guidance, the System Quality Group alternates its focus on surveillance and assurance and is accountable for the effective management of local healthcare patient safety and quality risks.

We have had an established System Quality Group meeting since 2022. The meeting is Executive-led and enables the system to identify risk and take actions as appropriate. The System Quality Group reports to the Integrated Care Board's Quality and Performance Committee who seeks assurance on progress against milestones for delivery as well as providing challenge in relation to quality standards.

Throughout 2024 we will work collaboratively as a System to agree a minimum of two system-wide patient safety and quality priorities and develop a System Quality Account by June 2025.

Deliverable	Timeline	Owner(s)	Oversight Groups
Agree System Patient Safety and Quality Priority x 2	June 2024 to March 2025	Chief Medical Officer/Chief Nursing Officer/Chief Clinical Improvement Officer	System Quality Group, Quality, Performance and Finance Committee & ICB Board
Develop metrics to enable assessment of improvement	June 2024 to March 2025	Chief Medical Officer/Chief Nursing Officer/Chief Clinical Improvement Officer	System Quality Group
Develop and publish System Quality Account	March 2025 – June 2025	Chief Medical Officer/Chief Nursing Officer/Chief Clinical Improvement Officer	Quality, Performance and Finance Committee

Measurable and evidenced safe quality care across the system

The standards measured at the System Quality Group (SQG) and the ICB Quality, Performance and Finance Committee are drawn from a plethora of clinical evidence, national requirements and locally agreed standards. Whilst individual organisations have agreed several focussed priorities within respective organisations, the Chief Nurses have worked collaboratively to agree a small number of metrics that provide an overview of quality and health inequality locally:

- Summary Hospital Level Mortality (SHMI).
- Falls.
- Pressure ulcers.
- Learning disability health checks.
- Perinatal mortality.
- Reduce the incidence of Restrictive Practice.

Our ICB has committed to maximise a safety culture by working collaboratively and alongside partners within their quality and safety meeting.

Key targets:

Deliverable	Timeline	SRO	Oversight groups
Maintain SHMI within accepted levels of tolerance	Quarterly from April 2023	Medical Director	• Individual Trust Quality Committee • System Quality Group • Quality, Performance and Finance Committee • ICB Board
Ensure all people at risk of falling in hospital and care home environments are risk assessed and personalised mitigations are in place	April 2023 to March 2025	Chief Nurses	• Individual Trust Quality Committee • System Quality Group • Quality, Performance and Finance Committee • ICB Board • Care Home Operational Meeting
Reduce the number of acquired pressure ulcers by 10% on baseline of March 2023	April 2023 to March 2025	Chief Nurses	• Individual Trust Quality Committee • System Quality Group • Quality, Performance and Finance Committee • ICB Board
Zero tolerance to missed learning disability health checks	March 2025	PCN Medical Directors	• Primary Care Quality Group • System Quality Group • Quality, Performance and Finance Committee • ICB Board
Reduce still-births by 50% (based on 2020 data)	2025	Chief Nurse	• Individual Trust Quality Committee • Local Maternity and Neonatal System Board • System Quality Group • Quality, Performance and Finance Committee • ICB Board

Medication incidents

Medication-related incidents remain one of the most frequently reported categories of patient safety incidents, accounting for 10% of reported incidents. This is understood through CQC inspections, high risk drug monitoring, reported incidents including serious incidents (SIs) and patient feedback. We know that unsafe medication practices and medication errors are a leading cause of injury and harm in healthcare.

The World Health Organisation aimed to reduce avoidable medication-related harm by 50% over the five years to 2024. Our plan is to embed medicines safety within the System Quality Group and will include promoting reporting, quantify a baseline and develop improvement plans.

Safeguarding

Safeguarding children, young people and adults is a collective responsibility. NHS Cambridgeshire & Peterborough ICB, as a statutory safeguarding partner, is committed to working in collaboration with Police and the Local Authority to ensure the people across our area are safeguarded. Safeguarding means protecting people's health, wellbeing and human rights; enabling them to live free from harm, abuse and neglect. It is an integral part of providing high-quality health care.

Our Health & Wellbeing Integrated Care Strategy identifies the responsibility of all agencies to promote the wellbeing of all children and adults and to ensure that vulnerable people are safeguarded from harm.

- This is achieved through partnership working with all statutory and VCSE agencies across our area via the Safeguarding Partnership Boards, Domestic Abuse and Sexual Violence Boards, Community Safety Partnerships and the Health & Wellbeing Boards. Effective safeguarding arrangements seek to prevent and protect individuals from harm or abuse, regardless of their circumstances. The ICB Chief Nurse will chair the Children's Safeguarding Partnership Board.

We are achieving this through:

- Working as a partnership to build strong families and communities, building capacity and taking a whole family approach, with early intervention to address specific needs.
- Identification and support children and adults who experience neglect. The ICB is an active member of the Cambridgeshire and Peterborough neglect sub-group which is reviewing the multi-agency neglect strategy, policies and assessment tools.
- Understanding and robust multi-agency response to children who are victims of sexual abuse. A sexual abuse sub-group has been facilitated by the Designated Doctor and this has resulted in a review and relaunch of the Sexual Abuse strategy in the Children's Safeguarding Partnership Board. This will support the early identification and signposting of children and young people to the right support when they have been victims of child sexual abuse.
- Ensuring children and young people have timely access to appropriate crisis and mental health services.

- Ensuring that children in care receive regular health assessments and dental support. Working alongside the local authorities via corporate parenting panels. We are monitoring and supporting provider agencies to meet the statutory timeframes for initial and review health assessments of children in care. Annual dental checkups have improved, with 94% of children in care in Peterborough receiving a dental check in the past 12 months and we similarly hope to improve access throughout the rest of the ICB geographical area.
- Embedding the Mental Capacity Act (MCA) to ensure that individuals who lack capacity have their human rights met and receive appropriate care and support. A health MCA steering group has been established to share learning across the health providers in Cambridgeshire & Peterborough. MCA training has been facilitated within the ICB.
- Working with statutory and VCSE agencies to identify and capture the patient experience.
- Learning from safeguarding incidents through multi-agency working, shared investigations and reviews and development of training materials to support practitioners. Throughout the course of the last year any learning identified in rapid reviews, and other statutory safeguarding learning reviews has been shared across the health community for example in GP forums and the ICB safeguarding newsletter. An audit was completed across primary care to review compliance with S.11 Children Act and Adult Safeguarding arrangements which had a positive response and has enabled us to focus on areas for development across primary care which align to the targets identified in the JFP.
- Reviewing how safeguarding support is delivered within each locality or neighbourhood to address inequalities.

Serious violence duty

As part of the ICB duty to safeguard, a key area of focus is the protection of the victims of abuse and to prevent and reduce serious violence within our local communities. This is in line with the Serious Violence Duty which was published in December 2022 and launched in January 2023.

Case Study

Anglia Ruskin Trusted Adult Programme

In collaboration with education, we are developing a new pathway which aims to reduce the number of A&E attendances for youth violence related injuries, facilitating a 'teachable moment' approach which offers timely and tailored support for young people under the age of 18 years old. The new referral pathway from A&E to Anglia Ruskin University Trusted Adult Scheme will provide young people who have been involved in criminality a safe space to engage in diversion therapies such as music, street art and trauma informed yoga.

Funded by the Home Office, the Duty brings specified authorities across health, police, justice, fire and rescue and the local authorities together to form specialist teams, which will scope what is occurring locally, share information and co-design and implement strategies to protect our local communities across the life course.

The ICB is working as part of the local area specialist team to support strategic planning in the prevention and reduction of violence in our local communities. This includes collating and analysing health data from NHS Accident and Emergencies, strengthening links with primary care networks and sharing of intelligence. We will also ensure links with safeguarding professionals specialising in contextual and transitional safeguarding, and Modern Slavery to share insight and gain a fuller picture of what is happening locally.

A Serious Violence Health Coordinator is the single point of contact, representing NHS Cambridgeshire & Peterborough as one voice and supporting NHS organisations to understand and embed the Duty as everyday business. The creation of 60 NHS Serious Violence Champions will support this work, creating sustainable change in practice.

The local definition of serious violence has been co-designed based on the World Health Organisation definition:

'Serious violence is the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group, or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, adverse childhood experiences/early life experiences and adversity'.

To gain an insight into the causes of violence and the devastating consequences for members of our communities, we are connecting with local agencies such as education, probation, charity organisations and faith leaders. A primary focus is engaging with our communities and where consent is gained conducting interviews to hear the lived experience from victims of violence and/or their families. Their lived experiences will be reflected in our Strategic Needs Assessment and local strategy. Individual's journeys and lessons gained from Safeguarding Practice Reviews have also been embedded into mandatory level 3 safeguarding children and adults staff training and bespoke presentations on the Serious Violence Duty.

To assess readiness to tackle and prevent serious violence a training skills analysis and staff survey has been completed and a training plan implemented across primary and secondary care. NHS Cambridgeshire & Peterborough ICB are proactive in ensuring healthcare staff are confident and competent in knowing how to safely identify, refer and respond to victims of serious violence. Training commences in January 2024 and consists of evidence based expert trainers in exploitation, serious violence, domestic abuse and gangs. To ensure sustainability of training, three identified professionals will complete a train the trainer approach course and be committed to the continuation of healthcare staff training in serious violence locally.

We are working as part of the specialist team to embed lessons learned from Child Safeguarding Practice Reviews, Safeguarding Adult Reviews and Domestic Homicides Reviews. We attend the local authority community safety partnerships to collate recommendations and disseminate these to healthcare staff in a variety of platforms such as staff training, safeguarding supervision and newsletters. Action plans and task and finish groups will drive any required changes to clinical practice. NHS Cambridgeshire & Peterborough ICB is committed to avoid preventable deaths wherever possible.

In the implementation stage, serious violence pathways will be collaboratively designed with partner agencies so frontline staff know who to inform and where to refer to ensure the safety of victims. Relevant training will be disseminated as part of an additional mandatory module. We will work collaboratively with partner agencies to form an Early Help response to identifying and preventing where possible violent crime.

Objectives:

- Implement training to all necessary staff to meet the health requirements of the Serious Violence Duty 2022.
- Embed learning and improvements to practice following children Safeguarding Practice Reviews, Safeguarding Adult Review and Domestic Homicide Reviews.
- Working in collaboration with partner agencies, establish pathway for victims of serious violence.
- Ensure health elements of the pathway are linked to the broader ICB health inequalities agenda.

Deliverable	Timeline	SRO	Oversight groups
Undertake an audit of Serious Violence Duty training compliance of healthcare staff	March 2025	Chief Nurses	• Individual Provider Quality Committees • ICB System Quality Group • ICB Performance Quality and Finance Committee • ICB Board • Cambridgeshire & Peterborough Safeguarding Board
Safeguarding audit to demonstrate learning from case reviews (as part of Section 11 Audit) to be repeated to evidence learning from Case Reviews following the implementation of Patient Safety Incident Response Framework (PSIIRF) across the system	March 2025	Chief Nurse	• Individual Provider Quality Committees • ICB System Quality Group • ICB Performance Quality and Finance Committee • ICB Board
Health element of pathway to support victims of serious violence implemented	March 2025	Chief Nurse	• Individual Provider Quality Committees • ICB System Quality Group • ICB Quality, Performance and Finance Committee • ICB Board
Establish links between victims of serious crime and broader health inequalities work	March 2025	Medical Director	• Individual Provider Quality Committees • ICB System Quality Group • ICB Quality, Performance and Finance Committee • ICB Board

Clinical and care professional leadership

Our ICS Care Professional and Clinical Leadership Framework supports the development of distributed care professional and clinical leadership across the ICS. It covers the broad range of professions working together through the ICB, the ICP, our ABUs, and sets out the core principles and approach for involvement, leadership and development.

The Professional and Clinical Leadership Assembly (PCLA) is the main forum for overseeing the framework and ensuring that care professional and clinical representation and leadership are embedded within our system. The group has a wide representation from ICB and ICP partner organisations; from professional groups such as general practice, primary care, AHPs, community and social care; and knowledge experts from clinical communities, public health, academia and specialist areas. The Assembly provides a focus for shared learning, collaboration and innovation, linking across all levels of the ICS.

Case Study

Cambridge Movement Surgical Hub

Throughout 2023, workshops dedicated to developing Clinical and Care Professional Leadership were conducted, laying the groundwork for strategic initiatives to enhance leadership capabilities within the ICS. These workshops facilitated discussions among professionals on optimising Clinical and Care Professional Leadership to support integrated decision-making with a shared learning and sustainability culture. They provided a unique platform for face-to-face interactions, allowing participants to explore diverse systemic working methods.

The insights gained from these workshops helped us develop a draft comprehensive leadership development framework centred on four critical pillars: Collaborative Efficiency and Patient-Centricity; Inclusive Engagement and Shared Success; Empowered Leadership and Workforce Development; and Strategic Integration and Quality Improvement.

This framework is designed to steer future leadership practices in alignment with the overarching goals of collaboration, inclusivity, empowerment, and strategic foresight.

The ICB Clinical Communities Lead was officially launched in October 2023, marking the beginning of efforts to establish a robust network of clinical communities. This network aims to reinforce Clinical and Care Professional Leadership across the ICS. Engagements have been key with prominent North and South healthcare leaders. These interactions have been fundamental in understanding the current landscape and support a collaborative approach to shaping the clinical community's network.

As part of this initiative, preliminary documents have been developed, including a draft vision for our efforts and foundational pillars for the roles of system clinical leads. These efforts mark a significant stride towards enhancing leadership and collaboration within the ICS, underpinned by the shared insights and commitments from the 2023 workshops and ongoing stakeholder engagements.

The main functions of the Assembly are to:

- Provide a forum for clinical decision-making, recommendations of priorities and actions on new clinical strategies and implementation plans.
- Enable partners to bring new clinical issues for discussion and action and feedback into the ICB.
- Promote information sharing concerning ICP and ICB decisions and plans.

The Assembly has an executive group which reports to the ICB Board through the Quality, Performance and Finance Committee.

Place and Collaborative Partnerships (Accountable Business Units)

Under the ICS structure, we have four Accountable Business Units (ABUs) which will, over time, take on delegated responsibility for a broad range of ICB functions.

Our ABUs work across health, local authority, and voluntary, community and social enterprise (VCSE) organisations to provide care and support to our people and communities. They are:

- North Cambridgeshire & Peterborough Care Partnership (focusing on care for people living in Peterborough, Fenland and Huntingdonshire).
- Cambridgeshire South Care Partnership (focusing on care for people living in East and South Cambridgeshire and Cambridge City).
- Mental Health, Learning Disability & Autism Partnership (focusing on care for people experiencing those conditions).
- Children's & Maternity Partnership (focusing on care related to pregnancy and for children and young people).
- Strategic Commissioning Unit, hosted by the ICB (focusing on providing strategic understanding of healthcare needs, insights to make informed decisions on ICS investment priorities, and offering evidence to enhance health outcomes for the local population).

The Accountable Business Units continue to develop their approach to partnership working, co-production and integrated delivery for services, with the aim of:

- Assurance and delegation of delivery of services to ABUs.
- Ongoing development of ABUs and their readiness to take on these responsibilities.
- Facilitating integrated leadership and governance across ICS providers and partners.
- Driving a strong culture of integrated delivery and transformation that improves health outcomes for all our local communities.
- Accelerating service improvement and align workforce and finances to where it is needed.

The role of the ABUs is to understand local patient needs, drive service improvement, high-quality care, and deliver ICS and locally agreed priorities within the funding available. They are working collaboratively to ensure alignment and avoid duplication of effort to ensure joined up services and support for all our local people.

Delegated commissioning

We have worked to ensure the safe delegation of Pharmaceutical Services, General Ophthalmic Services and Dental (Primary, Secondary and Community) Services (POD) on 1 April 2023, in line with the requirements set by NHS England. For Pharmacy and Ophthalmic Services, the staffing, budgets and governance will be hosted by Herts and West Essex ICB, on behalf of all six ICBs in the East of England. A Memorandum of Understanding has been developed which sets out how the responsibilities will be split between the host ICB, the other ICBs and the interdependent functions that will be retained by NHS England and how they will work together to provide an effective hosted contract management function. We have prepared a Safe Delegation Checklist as part of the due diligence process to take on the new POD functions.

We are working in partnership with NHS England and other ICBs in the East of England to prepare for the future delegation of Specialist Services, through the Specialised Services Joint Commissioning Committee (SSJCC). A formal Joint Working Agreement between ICBs and NHS England has been established to support the SSJCC. Subject to due diligence, Bedfordshire, Luton & Milton Keynes (BLMK) will host the regional Specialised Commissioning team.

Both programmes of work are managed internally by Task and Finish Groups, led by the Director of Commissioning and overseen by the Commissioning and Investment Committee (CIC) of our ICB Board.

Summary

Our revised Joint Forward Plan continues to demonstrate how we will work together to sustainably tackle the strategic aims for our system and deliver the key duties required by an ICB for our people and communities.

We know that a clear roadmap and a focus on the areas of most importance will help us to define where and how we direct our resources for maximum impact. We have clarity on how we will deliver our joint Health & Wellbeing Integrated Care Strategy, alongside this plan that articulates how we will continue to improve performance of our NHS commitments. We have created detailed delivery plans for the next five years that describe how we will deliver transformation across key areas such as cancer, estates, planned care and CVD, as well as many others that underpin our strategy and plan.

We have engaged with our people and communities in the development of this plan. We have asked key questions about their priorities for health and wellbeing and prevention to ensure we are listening and responding to their needs and have a continued focus on addressing the inequalities that exist across our communities.

Our Health & Wellbeing Integrated Care Strategy demonstrated how every part of our system has come together to prevent ill health and support the sustained improvement in the overall health and wellbeing of the people and communities of Cambridgeshire, Peterborough and Royston.

This Joint Forward Plan describes how we will translate our Health & Wellbeing Integrated Care Strategy into delivery and the outcomes we expect to achieve as a result of our collective endeavours, monitored through our new Outcomes Framework.

We will continue to maximise the opportunities that true integration brings, working with key partners in all tiers of Local Authority and the VCSE sector as well as across the NHS. Together we will solve challenges, grasp opportunities and in doing so transform and improve the way we provide health and care so local people and communities can lead happier and healthier lives.

Partner statements

Statement of support from NHS Trusts and Accountable Business Units (ABUs)

"We collectively confirm our support for the Cambridgeshire & Peterborough Joint Forward Plan that gives assurance on how we will deliver our duties and core requirements as an Integrated Care Board and System. This is underpinned by detailed delivery plans for each area that collectively support our strategic priorities and NHS commitments. We will work together, alongside our wider partnership which includes voluntary, community and social enterprise and local authority colleagues, to deliver this plan."

Agreed by:

- Cambridge University Hospitals NHS Foundation Trust
- Cambridgeshire & Peterborough NHS Foundation Trust
- Cambridgeshire Community Services NHS Trust
- North West Anglia NHS Foundation Trust
- Royal Papworth NHS Foundation Trust
- North Cambridgeshire & Peterborough Care Partnership (ABU)
- Cambridgeshire South Care Partnership (ABU)
- Children's and Maternity Partnership (ABU)
- Mental Health, Learning Disabilities and Autism Partnership (ABU)
- Strategic Commissioning Unit (ABU)

Statement of support from the Cambridgeshire & Peterborough Health and Wellbeing Board

"The Cambridgeshire & Peterborough Health and Wellbeing Board confirms its support for the Cambridgeshire & Peterborough Joint Forward Plan.

"The Plan sets out how it will support delivery of our Joint Health & Wellbeing Integrated Care Strategy, whilst acknowledging the scale and complexity of the challenges faced by the ICB and its NHS partners, alongside their statutory duties.

"The Cambridgeshire & Peterborough Health and Wellbeing Board fully supports the commitments and core requirements set out in this Plan and commits to working together to support delivery and ensure accountability, so that together we maximise the opportunities for integration of our health and care services."

Statement of support from the Hertfordshire Wellbeing Board

"The Hertfordshire Wellbeing Board: confirms its support for the Cambridgeshire & Peterborough Joint Forward Plan."

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Agenda Item No: 6

Update on action plan in response the Health of adults with a learning disability Joint Strategic Needs Assessment for Cambridgeshire and Peterborough

To:	Cambridgeshire and Peterborough Health & Wellbeing Board
Meeting Date:	March 2024
From:	Emily Smith Consultant in Public Health, Cambridgeshire County Council and Peterborough City Council
Outcome:	Reduction in health inequalities for adults with a learning disability

Recommendation:

a) Note the system-wide action plan that has been developed in response to the recommendations of the Joint Strategic Needs Assessment on the health of adults with a learning disability in Cambridgeshire and Peterborough

b) Agree a timeline for an update on the action plan to be brought back to the Health and Wellbeing Board

1. Background

1.1 Adults with a learning disability suffer from worse health and wellbeing outcomes in many areas, compared to adults without a learning disability. There is currently significant system work in Cambridgeshire and Peterborough happening to support the improvement of outcomes across health and care organisations.

1.2 To support this work, a joint strategic needs assessment (JSNA) on the health of adults with a learning disability was undertaken for Cambridgeshire and Peterborough. Cambridgeshire and Peterborough Health and Wellbeing Board endorsed the recommendations of the Learning Disability JSNA (adults) on 20th October 2023. The board requested that they receive an update on how the recommendations would be taken forward within the system.

1.3 Oversight of the implementation of the recommendations is through the Learning disability health inequalities working group, which reports into the Mental Health, Learning Disability and Autism Strategic Partnership. This group has representatives from Cambridgeshire County Council, Peterborough City Council, Cambridgeshire and Peterborough Integrated Care Board, Cambridgeshire and Peterborough NHS Foundation Trust, Cambridge University Hospitals NHS Foundation Trust, North West Anglia NHS Foundation Trust and the Cambridgeshire and Peterborough voluntary sector Health Alliance.

2. Main Issues

2.1 The JSNA made recommendations to a very wide range of organisations. Appendix 2 sets out the actions that organisations across Cambridgeshire and Peterborough have committed to in response to the recommendations. These actions have been endorsed by individual organisational governance processes.

2.2 Key themes within the recommendations are:

- Review of gaps within specialist LD services across Cambridgeshire and Peterborough;
- Training for mainstream health providers, particularly around reasonable adjustments;
- Training for specialist LD care providers, particularly around supporting the health needs of adults with a learning disability;
- Support for mainstream health and care services to make reasonable adjustments and provide accessible information;
- Support for delivery of annual health checks.

2.3 There is also some system-wide work in progress relating to supporting respiratory care for adults with a learning disability.

2.4 The original needs assessment made 194 recommendations to a range of organisations. Over 80% of these recommendations have a committed action against them in appendix 2, with an expectation of delivery of the next 3 years. There are some recommendations which were made to primary care providers that are not within this action plan, as it is not practical to ask individual GP practices for a response. The majority of these primary care actions relate to the quality of Annual Health Checks, where there is a longstanding system programme of quality improvement work already in place, as noted in the ICB's

response in appendix 1.

2.5 This leaves a very small number of recommendations with no current action that are still being worked through. The recommendations where there are currently no clear actions against are still being worked through, and predominately relate to reasonable adjustments to mainstream mental health services and some care processes that are delivered in primary care.

2.6 Progress against actions will be monitored through the Learning disability health inequalities working group.

3. Alignment with the Cambridgeshire & Peterborough Health and Wellbeing Strategy

3.1 These recommendations and the corresponding action plans are relevant to priorities 2 and 4 of the Cambridgeshire and Peterborough Health and Wellbeing Strategy.

- Priority 2: Create an environment to give people the opportunities to be as healthy as they can be.
- Priority 4: Promote early intervention and prevention measures to improve mental health and wellbeing.

3.2 This work also supports the overarching Health and Wellbeing Strategy outcome, “We will reduce inequalities in preventable deaths before age 75 years”.

4. Significant Implications

4.1 Resources
There is no direct request for resources within the action plan in response to the needs assessment, although implementation of some actions may require additional resource in terms of staff time or funding. Where this is identified, individual organisations remain responsible for requesting resources through their usual business planning processes.

4.2 Statutory, Legal and Risk Implications
The action plan supports a range of statutory responsibilities for partner organisations within the Health and Wellbeing Board, including the Integrated Care Board’s responsibilities under the Health and Care Act 2022 around provision of health services, both local authorities’ responsibilities under the Care Act around prevention and promotion of wellbeing for people with care and support needs, and both local authorities’ responsibilities to improve the health of their populations.

4.3 Equality and Diversity Implications
The action plan supports reducing inequalities for adults with a learning disability in Cambridgeshire and Peterborough.

This report has been signed off by the Executive Director for Public Health, Jyoti Atri.

5. Appendices

5.1 Appendix 1 – commentary provided by Cambridgeshire and Peterborough Integrated Care Board, outlining their response to the recommendations in the needs assessment; this is supplied as an additional document

5.2 Appendix 2 – system-wide action plan; this is supplied as an additional document

6. Source documents

6.1 The Learning Disability Health Needs Assessment is available here: Cambridgeshire Insight – Joint Strategic Needs Assessment (JSNA) – Published Joint Strategic Needs Assessments

7. Conflict of Interest

7.1 Conflict of Interest have been reviewed and addressed in line with the ICB Conflicts of Interest and standards of Business Conduct Policy

Appendix 1 - commentary provided by Cambridgeshire and Peterborough Integrated Care Board, outlining their response to the recommendations in the needs assessment and LeDeR report

1. Introduction

Cambridgeshire and Peterborough have seen the recent publication of the Joint Strategic Needs Assessment (JSNA) on the Health of Adults with a Learning Disability, and the annual LeDeR (the Learning Disability Mortality Review programme) report. These two reports provide further evidence to the Integrated Care Board (ICB) and system partners that adults with a learning disability in Cambridge and Peterborough experience poor health outcomes and face health inequalities.

These two reports have highlighted areas where changes in service commissioning and provision should have the greatest impact on user outcomes and experience. On the basis of these recommendations in the Health Needs Assessment (HNA) section of the JSNA report and the LeDeR report, the leads of the two reports have compiled a combined list of actions for each system partner in Cambridgeshire and Peterborough to provide a response to. The paper, the “ICB Action Plan”, provides a summary of the ICB’s response to the recommendations identified for the ICB to take forward. The relevant table in Appendix 2 details the line-by-line recommendation.

This paper is presented to the Cambridgeshire and Peterborough Health and Wellbeing Board, along with the supplemental table in Appendix 2 which outlines the line-by-line response to the Action Plan, to be shared as part of a system-wide response to the HNA and LeDeR reports.

2. Background

As defined by the JSNA the term ‘learning disability’ is used to describe a range of conditions that cause a reduced intellectual ability and difficulties with everyday living, affecting an individual throughout their life. Learning disabilities are characterised by onset during the developmental period, significantly below average intellectual function and significantly below average adaptive behaviours[1].

The 2023 JSNA report estimates that there are around 17,000 people with a learning disability living in Cambridgeshire and Peterborough. Most of these adults are not known to services: according to the LeDeR report the primary care learning disability register in Cambridgeshire and Peterborough contains 4,888 adults.

The HNA, as part of the JSNA report of 2023 describes the health needs of adults with a learning disability living in Cambridgeshire and Peterborough. The report finds that adults with a learning disability are much more likely to have a range of significant long-term physical health conditions that the general population: most commonly epilepsy, constipation and hypothyroidism. The report makes a number of recommendations which are addressed in this Action Plan.

[1] JSNA report 2023

The LeDeR report (April 2022-March 2023) examines the deaths of adults with a learning disability or autism, reported to the LeDeR programme during the period. The report shows that during this period the median age of death for someone with learning disability or autism in Cambridge in Peterborough was 60, compared to 62 nationally across the learning disability and autistic population and 81.77 in the general population. The leading cause of death was diseases of the respiratory system impacting 37% of patients, and when including COVID-19, 42% overall, and 54% of deaths were coded to be treatable or preventable and are therefore classified as avoidable deaths.

To address the findings set out in the HNA and the LeDeR report, a number of recommendations were made in the paper and associated actions allocated to each system partner, including the ICB, to demonstrate how they are planning to address these.

3. The Action Plan

The ICB recognises the need to do more, both as a system and as a commissioner, to proactively address the gaps and recommendations identified in the JSNA and LeDeR reports, and to meet national guidance from NICE, NHS England and other national bodies.

In the Joint Forward Plan, the ICB has already committed to taking action to reduce the inequalities faced by people with a learning disability through improved quality and delivery of health interventions such as vaccination programmes, and completion of annual physical health checks, and now seeks to build on good progress already made in this area, including meeting high standards for attendance at Annual Health Checks (73%)[2].

The Action Plan outlined here builds on good progress to date and draws together ongoing work to set out the actions the ICB is undertaking to address the recommendations set out in the HNA and LeDeR report.

Commitment to Action

The ICB is committed to ensuring that commissioning arrangements address the health inequalities that the LeDeR report and HNA have made so apparent for the population of adults living with a learning disability in Cambridgeshire and Peterborough. In particular, commissioning must address:

- Geographical inequity: people with a learning disability should have the same access to services of the same quality irrespective of whether they live in Cambridgeshire or Peterborough
- Inequity in access to services: people with a learning disability should be able to access the same services that those without a learning disability can access and have an equivalent experience in interacting with these services.

To address the health inequalities currently seen within the population, the ICB is taking several actions to improve the quality of services in the short-term, and to

[2] LeDeR report April 2022- March 2023

ensure that service models are high quality and sustainable over the long-term, to best respond to the needs of current and future populations. The relevant table in Appendix 2 sets out a line-by-line response to the ICB's response to each allocated action: key areas of action are summarised here.

The NHS Standard Contract is explicit in its expectation of application of The Equality Act 2010. Given the importance of improving access, the ICB is additionally incorporating commitments in relation to the population with a learning disability into new Quality Schedules which will guide future service specifications. To address inequity in access to services for people with a learning disability. The ICB 2024/25 Quality Schedules will incorporate a need for all services to make reasonable adjustments for the population with a learning disability, and for all providers to implement the required policies and procedures to meet the Accessible Information Standard. The ICB will also use the Quality Schedule to address key areas identified through the JSNA, also incorporating into the Quality Schedules a requirement for providers that all staff working with people with a learning disability are encouraged to take up flu and Covid vaccines and making sure that multi-disciplinary team (MDT) processes are in place to support people and their carers to manage distressed or challenging behaviours.

Alongside the new Quality Schedules, the ICB is working with system partners to improve pathways and to improve the experience of people with a learning disability as they access commissioned services. The ICB is committing to continuing to deliver existing Quality Improvement programmes which address the issues raised in the LeDeR report and JSNAs:

- **Sharing learnings from the national and local LeDeR reviews** across all health and care partners to ensure that everyone providing care to a person with a learning disability understands the key causes of mortality for adults with a learning disability, and assigning Health Inequality Champions in all system partners to ensure recommendations are carried out and to embed the learnings within all organisations.
- **Retaining a commitment to coproduction** through the Coproduction Collaborative, embedding co-production throughout service model design work, and ensuring that co-production continues to be embedded throughout governance including at the highest levels through the Accountable Business Unit Partnerships.
- **Focused effort on accessibility of high-priority mainstream services:** working with local respiratory consultants at Cambridge University Hospitals (CUH) to review the local pathway for the medical assessment of individuals at risk of community acquired pneumonia, and coordinating system immunisation campaigns to ensure that information is accessible for people a learning disability and that providers are able to make the reasonable adjustments as needed.
- **Delivering training on care for people with a learning disability**: Rolling out Oliver McGowan training across the system, to 50,000 staff across 9 large providers, 2 local authorities and VCSEs

- **Increasing uptake of Annual Health Checks:** continuing to improve the uptake of Annual Health Checks through targeted communication and support with GP practices, paediatric services, specialist schools, and SENDCOs with the ambition of achieving 85% take up in 24/25.
- **Better linking of data:** working to support local data linkage between primary care and hospital episode statistics datasets, to enable monitoring of hospital admissions for pneumonia. An application to enable the ICB to have access to the primary care data to enable this to happen is underway.

Alongside the short-term actions listed, the Action Plan also contains a commitment to review the service model for the delivery of care for people with a learning disability across Cambridgeshire and Peterborough to ensure it is fit for purpose over the long-term. The ICB has commenced a piece of work to review and redesign the model of services and support, working closely with local authority partners. This work is carried out with the ambition to consider how commissioning may need to change to deliver sustainable services which best meet the needs of people with a learning disability now and in the future, working with providers to deliver services differently. Through the service model redesign, the ICB aims to improve access, experience, and outcomes for people with a learning disability, eliminate geographic variation, and embed the voices of service users, carers and families into how services are designed, developed and delivered. As part of the service model redesign, the ICB will be considering:

- Provision of equitable and sustainable services across Cambridgeshire and Peterborough, including LD psychiatry, psychology, arts and music therapy, care coordination, speech and language therapy, LD physiotherapy, dietetic support, intensive support for people heading into crisis service
- The model of services and support for older adults with a learning disability, including access to diagnosis and support for dementia

<u>Plan for Delivery</u>
The ICB must start making progress immediately on the highest priority actions which have a significant impact on the safety of people with learning disabilities. Immediate work has commenced to review the respiratory pathway for people with a learning disability, and progress is being made on the Quality Improvement actions. Outputs from many of these workstreams are expected over the coming 3-6 months. The new Quality Schedules will also go live and start to inform service specifications and contracts for delivery within Provider organisations over the next 3-6 months.

Over the long-term, the ICB has commenced the service model redesign work. The ICB expects to have completed the redesign over the upcoming 12 months, and after to implement the changes to service models across the system after that point, dependent on the outcomes of the service model redesign work.

Each action will be taken forwards by a nominated lead within the ICB, and reporting on progress against these actions will take place at the Strategic Transformation Partnership for Learning Disability and Autism, and the Mental Health, Learning

Disability, and Autism Accountable Business Unit.

Risks

The ICB acknowledges that addressing every health recommendation emerging from the JSNA and LeDeR report is challenging and requires close working with existing system partners to coordinate on areas of highest priority and direct resources collaboratively, given existing funding pressures on health and care services nationally and locally.

To deliver on every recommendation set out in the JSNA and LeDeR report allocated to the ICB, the ICB would require additional funding to enable service changes where needed and cover costs of the programme, workforce availability to fulfil new roles or new posts, and capacity across the leads for learning disability within the ICB to support and lead on key initiatives. Given the limitations of funding and resources, phasing and prioritising this work is key, starting with highest priority actions and working with system partners to deliver changes over a realistic time period.

Next steps

The ICB commits to a number of next steps to ensure that commissioning arrangements can play a role in addressing the health inequalities highlighted in the LeDeR report and JSNA, through response to the allocated actions. The ICB will:

- Continue with the ongoing development of Quality Schedules including incorporating of commitments to reasonable adjustments for people with a learning disability. These will act to inform future service specifications and contracts, ensuring that they meet the needs of the population with LD.
- Continue to deliver on the quality improvement actions set out above
- Continue on the programme of work to review the service models providing care and support for people with a learning disability

The ICB knows that there is further to go to develop a response in some areas of this Action Plan and is committed to coordinating and engaging with system partners to develop achievable next steps for:

- Re-establishing postural care pathways in Cambridge and Peterborough, ensuring that the best pathway for managing postural care is considered when individuals are admitted to hospital.
- Exploring the best ways to support informal carers to recognise signs and symptoms of clinical deterioration, enabling earlier recognition and treatment.
- Working with specialist epilepsy pathways to ensure diagnosis and treatment for people with LD is in line with NICE guidelines, and that reasonable adjustments are made. A clinical lead for paediatric epilepsy is being appointed and will support work to improve the transition pathway.
- Considering whether there is a need for regular audiology screening in residential settings.

Appendix 2: system wide action plan

1. Cambridgeshire County Council and Peterborough City Council Public Health directorate

Action plan in response to needs assessment recommendations

Theme: Self-management and structured education providers and commissioners	Recommendations: • All pathways for prevention and management of cardiovascular disease should ensure that they are making appropriate reasonable adjustments for people with an LD. This includes any commissioned self-management or structured education programmes for people with long-term conditions, which should include carers where appropriate.	Action: To be further explored
Theme: Health promotion	Recommendations: • People with an LD should be actively targeted in health promotion campaigns to increase screening uptake, including with accessible information. • Develop a regular health promotion education offer incorporating physical activity for people with a learning disability and their carers • Continue to promote AHCs to people with an LD and their carers. • Health promotion work around healthy eating should be targeted at people with an LD and their carers. • People with an LD should be supported to be physically active and to eat a balanced diet.	Action: scoping work is planned to understand opportunities to ensure all health promotion communications are accessible to adults with a learning disability
Theme: Health promotion	Recommendations: • Given the lack of good quality data and the current issues with accessing NHS dentistry, commissioning an oral health survey for the most vulnerable cohorts (adults in nursing and residential care) of adults with LD would enable an understanding of unmet need. • Incorporate messaging around toothbrushing and oral health into regular wider health promotion work with adults with learning disabilities.	Action: an action plan has been developed to undertake a survey to understand oral health needs of adults with an LD in residential accommodation in Cambridgeshire and Peterborough over the next 12 months, to inform further oral health quality improvement work
Theme: Health promotion	Recommendations: • Consider initiating discussions around introducing water fluoridation.	Action: the recent Health and Care bill on water fluoridation has transferred this responsibility to central government, meaning

		there is no local action that can currently be taken
Theme: Screening providers and commissioners	Recommendations: • Screening providers and commissioners should be confident that they have a process in place to identify when reasonable adjustments are needed, and to make them. Currently only the diabetic eye screening programme has access to the primary care LD flag. Providers and screening commissioners should work to understand how to support other screening programmes to access the digital LD flag. Once the NHS England reasonable adjustments flag is rolled out (see chapter 15), commissioners and providers should work together to ensure that this information can be accessed by all screening providers. • Screening providers and commissioners should be confident that they can make appropriate reasonable adjustments where need has been identified. • Findings from the diabetic eye screening and planned AAA screening Health Equity Audits should be disseminated to other screening programmes, as there is likely to be common learning. Cervical, bowel and breast screening programmes should consider if they would benefit from undertaking a Health Equity Audit. • Providers and commissioners should be confident that there are clear processes and training for staff in how to apply the Mental Capacity Act with regards to consent for screening.	Action: scoping work is being undertaken between regional and local public health teams to understand how improvements to screening pathways can be operationalised
Theme: Provider of specialist alcohol and drugs services	Recommendations: • CGL should continue to ensure that they are complying with national legislation around training for staff relating to learning disability.	Action: CGL are aware of the Oliver McGowan training requirements and staff are compliant with the online learning. The face-to-face learning has not yet been launched in Cambridgeshire and Peterborough. CGL will continue to work to source face-to-face Oliver McGowan training provision as it becomes available and will maintain compliance with the online training amongst its staff.

Theme: Provider of specialist alcohol and drugs services	Recommendations: • CGL should consider monitoring treatment outcomes for patients with an LD, to see how they compare to their broader population of service users. If service users with an LD have poorer treatment outcomes, further work will be needed to understand why.	Action: CGL will explore the existing outcomes data available for its clients via the TOPs system to understand if it offers any insight into outcomes for this cohort, recognising that not all of its clients with a learning disability will have had a formal diagnosis and so the data may not be completely representative.
Theme: Provider of specialist alcohol and drugs services	Recommendation: • As CGL are not an NHS provider, it is not clear whether they will be able to access NHS reasonable adjustment flags when this programme goes live (see section 15). Commissioners should explore whether the current process of relying on patient self-report at the initial appointment is sufficient, and whether there is value in supporting CGL to have access to SystmOne.	Action: Commissioners are working with CGL to understand the implications of the rollout of the NHS digital reasonable adjustments flag for their systems
Theme: Provider of specialist alcohol and drugs services	Recommendations: • CGL should continue to develop links with specialist LD services to ensure that they can access specialist guidance where needed around the needs of service users with an LD.	Current work: CGL have links with specialist LD health and social care services. They will continue to maintain these links as appropriate to maintain links with clients
Theme: Commissioners of specialist alcohol and drugs services	Recommendations: • Commissioners should understand what options there are for patients with an LD who need inpatient detox, and how this can be supported where it is indicated.	Action: To undertake an evidence, review of residential rehab to determine future investment (23/24) Special consideration should be given to ensure the needs are met for those with Learning Disabilities looking to access inpatient detoxification and residential rehabilitation.

Theme: Smoking cessation services	Recommendations: • Commissioners and providers should ensure that smoking cessation practitioners have training appropriate to their role around making reasonable adjustments for adults with an LD.	Action: review service specifications and contracts and adjust specification to be more explicit around reasonable adjustments for LD. Identify suitable training for practitioners and develop communication plan to include all services delivered by provider. Add to Audit plans to ensure training is checked by providers
Theme: Smoking cessation services	Recommendations: • Services should ensure that they have appropriate Easy Read materials.	Action: review with provider what materials they have in place.
Theme: Smoking cessation services	Recommendations: • Commissioners and providers should ensure that flexibilities around making reasonable adjustments to length and number of appointments are clear to practitioners.	Action: review service specifications and contracts and adjust specification to be more explicit around reasonable adjustments for LD.
Theme: Sexual health services commissioners and providers	Recommendations: • Commissioned sexual health promotion work should include adults with an LD as routine.	Action: Recommissioning of Sexual Ill health Prevention services will take place in 24/25. Service specifications will include Adults with a Learning Disability as a specific cohort for delivery.
Theme: Sexual health services commissioners and providers	Recommendations: • Sexual health services should ensure that they are able to make appropriate reasonable adjustments for adults with an LD.	Action: Providers to review processes and ensure reasonable adjustments are in place.
Theme: Sexual health services commissioners and providers	Recommendations: • CQC-registered services should ensure they are compliant with legislation around staff training relating to the needs of adults with an LD.	Action: Providers to review training requirements for staff and training is compliant.

Theme: Sexual health services commissioners and providers	Recommendations: • Commissioned clinical sexual health services should consider how they will incorporate the NHS reasonable adjustments flag into their services once this national programme is live.	Action: Providers to review systems and processes in line with the introduction of the NHS reasonable adjustments and make necessary amendments to incorporate this into service delivery.
Theme: Sexual health services commissioners and providers	Recommendations: • Specialist LD services and commissioned sexual health services should consider how they can collaborate to ensure that there is a route for adults with an LD to access appropriate sex and relationship education.	Action: Commissioners to set up task and finish group to bring together providers and Specialist LD Providers to agree cohorts and routes for access to appropriate SRE content.
Theme: Sexual health services commissioners and providers	Recommendations: • There is an upcoming sexual health needs assessment about to be undertaken to inform services in Cambridgeshire and Peterborough. The needs of adults with an LD should be considered in detail as part of this, particularly with regards to ensuring that commissioned services are able to make reasonable adjustments, and that sexual health outreach and promotion work actively includes adults with an LD.	Action: Learning Disability practitioners will be consulted with as part of the development of the Sexual Health Needs Assessment. Recommendations will include people with a Learning Disability and their needs to inform future commissioning of services.
Theme Physical activity providers	Recommendations: • Consider how additional opportunities can be supported in geographical areas where currently there is a limited offer targeted at people with disabilities	Action: To link with the Tier 1 Healthy, You coordinators to ensure that all districts have knowledge of the physical activity opportunities available for those with an LD and actively signpost to these.
Theme Physical activity providers	Recommendations: • Work with public health commissioned health trainer and physical activity provision to ensure appropriate pathways are in place	Action: Health Trainers currently refer all service users to Tier 1, where they will have

		communication with the Healthy Lifestyle Advisor for physical activity advice/support and to find an appropriate local service/group for them.
Theme Physical activity providers	Recommendations: • Ensure staff within public health-commissioned healthy lifestyles service receive regular training around reasonable adjustments • Ensure exercise professionals have appropriate level of training (skills and knowledge) to adapt and tailor delivery of activity for successful inclusion	Action: To ensure that all providers/subcontractors include mandatory training on how to make reasonable adjustments for people with a learning disability and on mental capacity. Action: To obtain a list of appropriate courses/training to pass on to providers. Action: for procurement 2025 - add this mandatory training in to the quality indicators to formalise the process.
Theme: Weight management commissioners and providers	Recommendations: • Staff in all weight management services should have training on how to make reasonable adjustments for people with a learning disability and on mental capacity.	Action: To ensure that all weight management providers/subcontractors (Everyone Health, MoreLife, CUH, WW, Slimming World) include mandatory training on how to make reasonable adjustments for people with a learning disability and on mental capacity. Action: To obtain a list of appropriate courses/training to pass

		on to providers. Action for procurement 2025 - add this mandatory training in to the training section of the quality indicators to formalise the process.
Theme: Weight management commissioners and providers	Recommendations: • Commissioners should consider whether there is a need to add in additional eligibility criteria for tier 3 services that are related to complexity of need, rather than BMI.	Action: Current local Tier 3 criteria (Healthy You) states that the individual can have: -a BMI 30 Kg/m2 with complex needs and has not responded to previous tier interventions or -Or have a BMI 35 Kg/m2 with co-morbidities (e.g. type 2 diabetes) - Or have a BMI 40 Kg/m2 Individuals with an LD would therefore be able to access the Tier 3 service at the lowest BMI threshold of 30 due to their complex needs. There does not appear to be any specific evidence/national guidance to support reducing this BMI threshold any lower than 30 (e.g. as there is for certain ethnicities). Additionally, for the new Tier 3 service (MoreLife)

		which started in September 23, an additional reporting KPI was added which would include those with an LD - '% of total referrals received from deprived areas and/or vulnerable/high risk groups' Action: for procurement in 2025 - to ensure that reporting for vulnerable/high risk groups is included in all weight management KPI's
Theme: Weight management commissioners and providers	Recommendations: • There should be a clear pathway to access dietetic support for individuals whose weight gain is linked to medical reasons rather than behavioural factors.	Action - to clarify any relevant pathways and referral processes and share with weight management providers.
Theme: Weight management commissioners and providers	Recommendations: • Commissioners and providers should be assured that appropriate reasonable adjustments can be made within weight management services	Action: To ask all providers for their processes around: 1. How they identify service users as having an LD 2. How they make reasonable adjustments for those identified as having an LD, as well as supporting their carers Action for procurement 2025: - To consider ways to better ensure that those with LD's are sufficiently

		accommodated within weight management services, including appropriate reasonable adjustments (e.g. case studies for service users with an LD, or from staff who have supported those with an LD). - Add into the audit section of the quality indicators around assurance of reasonable adjustments.

2. Cambridgeshire County Council Adults, Health and Commissioning directorate

Response to needs assessment recommendations from the Learning Disability Partnership

Theme	Recommendations	Actions
Theme: Health promotion	Recommendations: • Specialist LD services should screen for substance misuse at initial referral and offer referral into substance misuse services where appropriate. • Specialist LD health services should ask service users their smoking status on initial screening and offer support individuals to access smoking cessation services as appropriate. • Ensure staff in specialist LD services have knowledge of physical activity recommendations and local opportunities. • Ensure that specialist LD services are aware of referral routes into specialist weight management services.	Current work: At present referrals are made to health promotion services such as smoking cessation or substance misuse as required. LDP will provide bespoke training if required Action: LDP to continue to support health promotion agencies to enable adults with a learning disability access to these services.

Theme: Unpaid carers	Recommendations: • Unpaid carers should be supported to access information and education relating to supporting the person they care for with long term clinical risk factors such as diabetes, hypertension, hypercholesterolaemia and atrial fibrillation. • Unpaid carers of people with an LD should be included in health promotion campaigns to increase screening uptake. • Unpaid carers of people with an LD should be supported to access flu and covid vaccinations. • Given the mortality due to pneumonia in adults with an LD (see section 6), unpaid carers of adults with an LD should be offered support to quit, to reduce exposure to second-hand smoke. • Unpaid carers should be offered access to health promotion and education around healthy diet, alongside the people they care for. • Unpaid carers of adults with an LD should be able to access support to claim any benefits that they are entitled to. • Consideration is needed of what support and advice might be needed for unpaid carers of adults with an LD who have a mental illness or challenging behaviour. • Consider offering education and support for unpaid carers who care for adults with an LD around healthy ageing, including dementia awareness. • Ensure accessible information is available for individuals with an LD and their carers about dementia. • Consider if there is a need for a specific training offer for unpaid carers of people with epilepsy. • Unpaid carers of people with an LD should be supported to be aware of the symptoms and signs of constipation. • There should be consideration of how to offer unpaid carers of people with a learning disability training around eating and drinking/dysphagia. • Where individuals have postural care systems, carers must be adequately trained so that they understand the importance of adhering to them 24 hours/day.	Current work: LDP nurses work alongside primary health services to ensure information is accessible. During people annual statutory review people are signposted to benefit advice. Support and advice are provided to unpaid carers regarding Positive Behavioural Support for adults with a LD and behaviours that challenge. Liaison occurs with primary health as required. Specific training is completed on dysphagia and constipation Action: Considerations needs to be given on how the LDP can align the above with the implementation of the carer's strategy

Theme: LeDeR	• All providers and commissioners of care to adults with an LD should ensure their staff have an understanding of the key causes of mortality in adults with an LD. • All providers and commissioners of care to adults with an LD should ensure they consider what systemic actions they need to take to address actions identified by local and national LeDeR work. • Commissioners and providers should consider how to support STOMP in Cambridgeshire and Peterborough, in line with the NHS Long Term Plan.	Current work: LDP provides staff training in constipation around a specific person's needs which is a key cause of mortality. Psychiatrists support the STOMP agenda Action: When the local Leder report is shared the LDP will formulate actions and consider alongside the national Leder report produced by the Kings Fund
Theme: Reasonable adjustments, training, AIS	Recommendations: • All health services should be confident in the ability of their services to make reasonable adjustments for people with an LD. Audit tools such as those provided by the NHS England Quality Checkers programme may help give assurance to commissioners. • All health staff in CQC registered organisations need to undertake training appropriate to their role in line with new legislation. Cambridgeshire and Peterborough ICB should liaise with Health Education England and Skills for Care to ensure that the rollout reaches all providers. Commissioners should ensure that they gain assurance from services that the rollout has taken place. • All health and social care organisations providing publicly funded care should ensure they have the appropriate policies, processes and staff training in place for the AIS to be implemented fully.	Current work: All staff working within the LDP (CPFT and LA employees) receive EDI / Treating people with respect training. The LDP has capacity to record an individual's communication needs on our electronic record. LDP use some accessible information but there are areas for improvement. There is some access to photo library. All community LDP staff have completed Oliver Mc Gowan training. The LA has a Accessible Information and Communication Policy. Action: To review the LA accessible information and communication policy and formulate further actions

Theme: In house services - staff training	Recommendations • Providers of residential and domiciliary social care should ensure their staff have appropriate training to support adults with an LD in the management of long-term conditions linked to cardiovascular disease where they care for individuals with one of these conditions. • Care providers should ensure that their staff have an awareness of screening programmes that they may need to support their clients to attend. • Ensure that social care staff have adequate awareness of the importance of attending AHCs. • Staff in residential care and domiciliary care providers should have training on healthy eating and mental capacity relating to food choices. • Care providers should ensure that their staff have the knowledge and understanding to support adults with an LD who are eligible to claim benefits to access income maximisation support if needed. • Care providers should ensure that their staff have the knowledge and skills to help individuals they support to access training, education, and employment opportunities. • Commissioners and social care providers should ensure that social care staff who care for individuals with an LD who have a mental illness have the necessary knowledge and skills to meet their needs. • Commissioners and social care providers who provide care to adults with an LD who have behaviour that challenge in the community should ensure that staff who have appropriate skills and knowledge to support effectively. • All care staff in residential services should undertake training about sexual health and relationships, as well as around capacity and consent, that is appropriate to their role. • Providers of residential care for adults with an LD should ensure their staff are familiar with how to access smoking cessation services and can support their service users to access them as appropriate. • There is a need to ensure that adults with an LD have opportunities to socialise and develop social networks, including both friendships and personal relationships. This should be recognised as an outcome of day services. • Section 11 considers residential care commissioning for adults with an LD. Some of these adults will have challenging behaviour. In light of the NHS Long Term Plan ambition to reduce the number of inpatient stays, consideration is needed of whether there is sufficient, appropriate community capacity for individuals being discharged. • Commissioners and providers should ensure that care staff who care for adults with an LD have the skills and knowledge to support people with dementia. • Ensure that care providers of people with a learning disability offer their staff training on epilepsy as standard, reflecting the likely high prevalence of epilepsy	Current work: all service users living within in house services have a health file which records each person's dietary needs, recent hearing / sight tests / health check etc, these are monitored by seniors. Staff complete CCC training through the LA. Support workers work alongside primary care specialists to adapt information into easy read format. Public Health piloting training in 'supporting good health and well-being in care and support plans. Staff enable and promote access to mainstream mental health services. Support workers are trained in Proact SKIP to support people with behaviours that challenge. Advice is sought from the LDP community teams as required **Action:** To review training options for staff support across all in house services on cardiovascular disease and signs of clinical deterioration such as NEWS 2. To consider the impact on the day-to-day support for people. To work with the LDP community teams and other stakeholders around

	amongst their residents. • Social care providers should ensure that their staff are aware of the symptoms and signs of constipation. • Social care providers should ensure that their staff are supporting the people they care for to be physically active and eat healthily. • All social care staff working with people with an LD should be required to have up-to-date Basic Life Support training as a minimum contractual requirement in service specifications. • Commissioners and providers should ensure that all care staff working with people with a learning disability receive regular training around eating and drinking/dysphagia that is appropriate to their role. • Where individuals have postural care systems, carers must be adequately trained so that they understand the importance of adhering to them 24 hours/day. • Ensure staff who are required to support with toothbrushing are trained on how to do so appropriately. • Ensure that staff training around health promotion includes elements of oral health promotion. • Social care providers should ensure that staff have appropriate training around falls prevention, both in terms of individual and environmental risk factors. • Ensure that social care staff have an awareness of signs of hearing loss amongst adults with an LD. • Providers of residential social care should ensure that they support the people they care for to access routine sight tests. • Social care staff should receive training on diet and nutrition appropriate for the needs of the residents they are caring for. • Residential care providers should ensure that staff have training on recognition of signs and symptoms of clinical deterioration that is appropriate to their role. • Residential care providers should ensure they have access to scales, including wheelchair-accessible scales, for individuals where weight monitoring is indicated. • System work will be needed to implement the national framework for delegations once it is released.	improving oral care for all people with learning disabilities

Theme: Vaccinations	Recommendations: • Frontline health and social care workers should be supported to access flu and covid vaccinations. • Care providers should ensure that their staff have an awareness of routine immunisations that they may need to support their clients to attend.	Current work: information is circulated to all staff every year through employing organisations on immunisations which are available free of charge for frontline health and care practitioners at high street chemists. Annual health checks include immunisations and LDP teams work alongside GP's if necessary
Theme: Care planning	Recommendations • If individuals have a need for a paid carer to accompany them to a screening appointment, this should be included within their care plan. • If individuals have a need for a paid carer to accompany them to an immunisation appointment, this should be included within their care plan. • Care plans should include supporting an individual's needs around domestic, family and personal relationships • If support is necessary to support an individual with care needs to access physical activity, this should be included within their care plans. • Support social workers, alternatively qualified practitioners and commissioned social care provider staff to undertake training around physical activity, to cover how to embed into care plans (including different components of physical activity), behaviour change and motivational approaches, and supporting service users to access opportunities. • Ensure that supporting attendance at AHCs is included in care plans if necessary. • If an individual with care needs requires support around making food choices, this should be incorporated into their care plan. • Many of the wider determinants of health intersect with eligible care needs under the Care Act, particularly: (e) being able to make use of the adult's home safely; (f) maintaining a habitable home environment; (g) developing and maintaining family or other personal relationships; (h) accessing and engaging in work, training, education or volunteering; (i) making use of necessary facilities or services in the local community including public transport, and recreational facilities or services Care planning should consider all of these areas.	Action: work is taking place to develop and pilot care planning training to consider how these elements can be fully considered in care planning, particularly around attendance at routine health appointments, physical activity, nutrition, sensory needs and oral health.

	• Planning for later life should be part of care planning for adults with an LD and their carers. • Care plans should consider eating and drinking needs as standard. • Care plans should include regular dental check-ups; attendance should be monitored as part of the annual review. • Ensure that mouth care is explicitly incorporated into care plans. • Attendance at routine dental appointments should be incorporated into care plans, including any necessary support for attendance. • Attendance at routine sight tests should be incorporated into an individual's care plan, with support identified if required.	

Theme: Training	Recommendations: • All providers and commissioners of care to adults with an LD should ensure their staff have an understanding of the key causes of mortality in adults with an LD • Commissioners of residential and domiciliary social care for adults with an LD should ensure that appropriate training is in place for staff to support adults with an LD in the management of long-term conditions linked to cardiovascular disease where they care for individuals with one of these conditions. • Care providers should ensure that their staff have an awareness of routine immunisations that they may need to support their clients to attend • All care staff in residential services should undertake training about sexual health and relationships, as well as around capacity and consent, that is appropriate to their role • Ensure that social care staff have adequate awareness of the importance of attending AHCs • Support social workers, alternatively qualified practitioners and commissioned social care provider staff to undertake training around physical activity, to cover how to embed into care plans (including different components of physical activity), behaviour change and motivational approaches, and supporting service users to access opportunities. • Providers of residential care for adults with an LD should ensure their staff are familiar with how to access smoking cessation services, and can support their service users to access them as appropriate. • Care providers should ensure that their staff have the knowledge and understanding to support adults with an LD who are eligible to claim benefits to access income maximisation support if needed • Care providers should ensure that their staff have the knowledge and skills to help individuals they support to access training, education and employment opportunities. • Commissioners and social care providers should ensure that social care staff who care for individuals with an LD who have a mental illness have the necessary knowledge and skills to meet their needs. • Commissioners and social care providers who provide care to adults with an LD who have behaviour that challenge in the community should ensure that staff who have appropriate skills and knowledge to support effectively.	Action: Commissioners will review the identified training needs for providers of LD services against the Skills for Care curriculum and identify funding to support the plan to improve, develop and professionalise the social care workforce in Cambridgeshire. It is anticipated that there will be a clearer offer available through the Care Academy later in 2024/25.

	• All social care staff working with people with an LD should be required to have up to date Basic Life Support training as a minimum contractual requirement in service specifications • Commissioners and providers should ensure that all care staff working with people with a learning disability receive regular training around eating and drinking/dysphagia that is appropriate to their role. • Where individuals have postural care systems, carers must be adequately trained so that they understand the importance of adhering to them 24 hours/day. • Ensure staff who are required to support with toothbrushing are trained on how to do so appropriately • Ensure that staff training around health promotion includes elements of oral health promotion. • Social care providers should ensure that staff have appropriate training around falls prevention, both in terms of individual and environmental risk factors • Ensure that social care staff have an awareness of signs of hearing loss amongst adults with an LD. • Residential care providers should ensure that staff have training on recognition of signs and symptoms of clinical deterioration that is appropriate to their role • Social care providers should ensure that their staff are aware of the symptoms and signs of constipation. • Ensure that care providers of people with a learning disability offer their staff training on epilepsy as standard, reflecting the likely high prevalence of epilepsy amongst their residents.	

Theme: Attendance at health appointments	Recommendations: • Commissioners of social care should ensure there is sufficient flexibility and funding within service provision to enable paid carers to accompany individuals to a screening appointment where there is an identified need • Commissioners of social care should ensure there is sufficient flexibility and funding within service provision to enable paid carers to accompany individuals to an immunisation appointment where there is an identified need • Commissioners of social care should review flexibilities within funding arrangements for enabling paid carers to attend hospital whilst their service user is an inpatient, to facilitate the process of reasonable adjustments. • Ensure that where a staff member is needed to attend with the person to support, this is someone who knows the individual well.	Action: Commissioners will proactively ensure that any opportunities to promote the identified needs of people with LD will be incorporated into service specifications and are addressed with providers in all future recommissioning opportunities.

Theme: Service specification development	Recommendations: • Commissioners should ensure that they have a varied day opportunities offer, that supports with developing employment skills and with developing friendships and social networks • There is a need to ensure that adults with an LD have opportunities to socialise and develop social networks, including both friendships and personal relationships. This should be recognised as an outcome of day services. • Consider embedding requirements around supporting service users to access physical activity into care home, supported living and domiciliary care service specifications • Consider embedding requirements to offer physical activity to service users attending day opportunities. • Residential care providers should ensure they have access to scales, including wheelchair-accessible scales, for individuals where weight monitoring is indicated. • System work will be needed to implement the national framework for delegations once it is released. • Commissioners should ensure that the AIS is included within contracts and that there is sufficient funding to enable organisations to meet their legal requirements. • All health and social care organisations providing publicly funded care should ensure they have the appropriate policies, processes and staff training in place for the AIS to be implemented fully • All social care staff in CQC registered organisations need to undertake training appropriate to their role in line with new legislation. Cambridgeshire and Peterborough ICB should liaise with Health Education England and Skills for Care to ensure that the rollout reaches all providers. Commissioners should ensure that they gain assurance from services that the rollout has taken place • Section 11 considers residential care commissioning for adults with an LD. Some of these adults will have challenging behaviour. In light of the NHS Long Term Plan ambition to reduce the number of inpatient stays, consideration is needed of whether there is sufficient, appropriate community capacity for individuals being discharged.	Action: Commissioners will proactively ensure that any opportunities to promote the identified needs of people with LD will be incorporated into service specifications and are addressed with providers in all future recommissioning opportunities.

Theme: Care planning	Recommendations: • If individuals have a need for a paid carer to accompany them to a screening appointment, this should be included within their care plan. • If individuals have a need for a paid carer to accompany them to an immunisation appointment, this should be included within their care plan. • Care plans should include supporting an individual's needs around domestic, family and personal relationships • If support is necessary to support an individual with care needs to access physical activity, this should be included within their care plans. • Support social workers, alternatively qualified practitioners and commissioned social care provider staff to undertake training around physical activity, to cover how to embed into care plans (including different components of physical activity), behaviour change and motivational approaches, and supporting service users to access opportunities. • Ensure that supporting attendance at AHCs is included in care plans if necessary. • If an individual with care needs requires support around making food choices, this should be incorporated into their care plan. • Many of the wider determinants of health intersect with eligible care needs under the Care Act, particularly: (e) being able to make use of the adult's home safely; (f) maintaining a habitable home environment; (g) developing and maintaining family or other personal relationships; (h) accessing and engaging in work, training, education or volunteering; (i) making use of necessary facilities or services in the local community including public transport, and recreational facilities or services Care planning should consider all of these areas. • Planning for later life should be part of care planning for adults with an LD and their carers. • Care plans should consider eating and drinking needs as standard. • Care plans should include regular dental check-ups; attendance should be monitored as part of the annual review. • Ensure that mouth care is explicitly incorporated into care plans. • Attendance at routine dental appointments should be incorporated into care plans, including any necessary support for attendance. • Attendance at routine sight tests should be incorporated into an individual's care plan, with support identified if required.	Actions: Commissioners will review the identified training needs for providers of LD services against the Skills for Care curriculum and identify funding to support the plan to improve, develop and professionalise the social care workforce in Cambridgeshire. It is anticipated that there will be a clearer offer available through the Care Academy later in 2024/25.

Theme: Data	Recommendations: • Commissioners need to ensure they have an understanding of the future housing needs of adults with an LD who live with their parents • CCC and PCC commissioners should work with Cambridgeshire and Peterborough ICB to understand the future demand for single service user provision that will derive from individuals who are currently in long stay inpatient units. • CCC and PCC commissioners should work with Cambridgeshire and Peterborough ICB to make use of the new DSCRO data warehouse once appropriate data-sharing agreements are in place, in order to understand the physical and mental health comorbidities of individuals that are in long-term care.	Actions: Commissioners are currently developing an accommodation needs assessment for people with a learning disability, and will consider these recommendations through this work. System work is ongoing relating to rollout of the DSCRO system, opportunities to make use of this intelligence will be considered once local authority analysts have access to the system

Theme: Unpaid carers	Recommendations: • Unpaid carers should be supported to access information and education relating to supporting the person they care for with long term clinical risk factors such as diabetes, hypertension, hypercholesterolaemia and atrial fibrillation. • Unpaid carers of people with an LD should be included in health promotion campaigns to increase screening uptake. • Unpaid carers of people with an LD should be supported to access flu and covid vaccinations. • Given the mortality due to pneumonia in adults with an LD (see section 6), unpaid carers of adults with an LD should be offered support to quit, to reduce exposure to second-hand smoke. • Unpaid carers should be offered access to health promotion and education around healthy diet, alongside the people they care for. • Unpaid carers of adults with an LD should be able to access support to claim any benefits that they are entitled to. • Consideration is needed of what support and advice might be needed for unpaid carers of adults with an LD who have a mental illness or challenging behaviour. • Consider offering education and support for unpaid carers who care for adults with an LD around healthy ageing, including dementia awareness. • Ensure accessible information is available for individuals with an LD and their carers about dementia. • Consider if there is a need for a specific training offer for unpaid carers of people with epilepsy. • Unpaid carers of people with an LD should be supported to be aware of the symptoms and signs of constipation. • There should be consideration of how to offer unpaid carers of people with a learning disability training around eating and drinking/dysphagia. • Where individuals have postural care systems, carers must be adequately trained so that they understand the importance of adhering to them 24 hours/day.	Action: CCC are embarking on recommissioning their carers support services in line with the new All Age Carers strategy. The needs of Carers of people with Learning Disabilities (of all ages) will be considered and incorporated into service specifications and a programme of work agreed with providers in Q3/Q4 of 2024/25.

3. Cambridgeshire and Peterborough Integrated Care Board action plan

Action plan in response to needs assessment recommendations, to be read in conjunction with commentary provided in appendix 1

Theme	Recommendations	Actions	Timeline
Theme: LeDeR	C&P ICB and LeDeR representatives should ensure learning from local and national LeDeR reviews is shared widely amongst health and care partners, with identified actions addressed.	Learning has been shared through a system wide meeting in October 2023. LAC is arranging further system-wide learning events, and will continue to review and take learnings from all deaths and roll out learnings to partners. AHC teaching modules have been designed with LeDeR LAC to teach care partners to focus on common causes of death.	Ongoing, preliminary phase
Theme: LeDeR	All healthcare providers and commissioners should ensure they consider what systemic actions they need to take to address actions identified by local and national LeDeR work	The work is being done by the Action Plan.	Ongoing, established programme of work
Theme: LeDeR	LeDeR representative from all collaborative system partners to be assigned as a Health Inequality Champion	This action is being investigated through a system-wide forum, through their health inequalities subgroup.	Roll out in 24/25
Theme: Coproduction	The current programme of coproduction work should continue, to ensure people with an LD have their views and experiences heard.	Existing coproduction collaborative supporting the system, and service model redesign will identify how coproduction can continue to be used to support LD service design This will be built into key roles within the ABU	Ongoing, established programme of work
Theme: Physical health pathways	Postural care: urgently re-establish postural care pathways for both Cambridgeshire and Peterborough. Consideration is needed as to the best pathway for managing postural care need when an individual is admitted to hospital.	This does not currently fall under an existing programme of work, and the ICB is committed to coordinating and engaging with system partners to develop achievable next steps for this action. An initial system workshop led by CPFT as part of the Health Inequalities Working Group is being mobilised to explore this question.	Initial meetings to be set up Q1 24/25
Theme: Physical health pathways	Consider whether there is a need for regular audiology screening in residential settings.	This does not currently fall under an existing programme of work, and the ICB is committed to coordinating and engaging with system partners to develop achievable next steps for this action	Initial meetings to be set up Q1 24/25
Theme: Physical health pathways	Further work is needed to clarify the local pathway for medical assessment for individuals at risk of community	There is a nationally funded programme of work ongoing in this space at CUH with respiratory consultant - taking place through Health Inequalities Group	Ongoing, established programme of work

	acquired pneumonia for Cambridgeshire and Peterborough, in line with BTS guidance.		
Theme: Physical health pathways	Informal carers need support in recognising signs and symptoms of clinical deterioration, to enable early recognition and treatment.	This does not currently fall under an existing programme of work, and the ICB is committed to coordinating and engaging with system partners to develop achievable next steps for this action. This will tie into work on virtual wards, winter planning, and learning from the MediApp for health monitoring for young people (14-18) with a learning disability, planned for a roll-out in sites across the country by this summer.	Initial meetings to be set up Q2 24/25
Theme: Physical health pathways	Commissioners and providers should consider how to support STOMP in Cambridgeshire and Peterborough, in line with the NHS Long Term Plan.	A pharmacist within the STOMP programme is currently scoping what has happened in the past within the system, and what training has been offered. Following this the ICB will need to consider next steps.	Ongoing, preliminary phase
Theme: Physical health pathways	Commissioners should ensure there is a clear pathway for diagnosis of adults with an LD who need assessment for dementia.	To be taken forward as part of service model redesign for “Ageing Well”	Redesign over the next 12 months
Theme: Physical health pathways	Commissioners should assure themselves that the NICE recommendations relevant to the needs of people with an LD who have dementia are being met in Cambridgeshire and Peterborough.	To be taken forward as part of service model redesign for “Ageing Well”	Redesign over the next 12 months
Theme: Physical health pathways	Ensure that people with an LD in Cambridgeshire and Peterborough are offered diagnostic and treatment pathways for epilepsy that are in line with NICE guidance for the diagnosis and management of epilepsy regardless of whether they are managed in specialist epilepsy services or learning disability psychiatry.	This does not currently fall under an existing programme of work, and the ICB is committed to coordinating and engaging with system partners to develop achievable next steps for this action	TBC
Theme: Physical health pathways	Ensure that specialist epilepsy services in neurology are able to make reasonable adjustments for people with a learning disability.	Reasonable adjustments will be considered as part of service model redesign. Provision of reasonable adjustments is contractually mandated.	Ongoing, established programme of work
Theme: Physical health pathways	All health staff working with people with an LD should be required to have up-to-date Basic Life Support training as a minimum contractual requirement in	BLS is a mandatory requirement for all clinical staff and is part of mandatory training. This requirement forms part of the quality schedule.	Ongoing, established programme of work

	service specifications.		
Theme: Physical health pathways	Liaison with service providers around health inequalities	This is included within the Health Inequalities Working Group within ABU	Ongoing, established programme of work
Theme: Physical health pathways	Identify strategies for early identification of deterioration and ill health in individuals with a learning disability and autistic people	This forms part of the Oliver McGowan training: everyone receiving this training will understand importance of annual health checks for early diagnosis. The training addresses issues relating to diagnostic overshadowing which can lead to late presentation and avoidable deaths.	Workforce roll commencing April 24.
Theme: Reasonable adjustments	Improved reasonable adjustments and face to face access to health, ensuring health providers have sufficient flexibility in care pathways & sufficient funding to enable reasonable adjustments to be made, including the provision of AHCs and follow up health action plans	Ongoing annual health check work involves targeted letters to GP practices and paeds/special schools/SEND signposting and offering support Service model redesign to cover flexibility and funding in pathways to make reasonable adjustments	Ongoing, established programme of work
Theme: Reasonable adjustments	All health services should be confident in the ability of their services to make reasonable adjustments for people with an LD. Audit tools such as those provided by the NHS England Quality Checkers programme may help give assurance to commissioners.	Audit tools are built into quality schedules to give assurance around this.	Ongoing, established programme of work
Theme: Reasonable adjustments	System partners to delivering reasonable adjustments training with support from LeDeR	There is a national roll out of training from NHSE. LeDeR LAC has designed and is delivering an additional hour of training around what is specific requirements in Cambridgeshire and Peterborough - covering health inequalities and LeDeR. For primary care this forms part of LD training modules and sits on the learning hub. Training covers AHC and common conditions for people with LD. The training has been co-written with LD nurses	Ongoing, established programme of work
Theme: Data	Further work is needed to support local data linkage between primary care and hospital episode statistics datasets, via DSCRO, to enable monitoring of hospital admissions for pneumonia.	Work is underway to link primary care and hospital episodes statistics datasets, with requests imminently submitted to national bodies for approval. Hospital admissions for pneumonia for people with an LD may be monitored in the future using the population management tool Eclipse- this is being investigated.	Over the next 12 months

Theme: Immunisations	Frontline health and social care workers should be supported to access flu and covid vaccinations.	This is a longstanding CQUIN - and all organisations should be encouraging their staff to take up vaccinations.	Ongoing, established programme of work
Theme: Immunisations	Improved screening and vaccination uptake	Engagement from the ICB to ensure LD is part of November immunisation comms campaigns, reasonable adjustment are made, and vaccine centres have appropriate facilities e.g. quiet spaces. The AHC looks at whether the person is up to date with screening and vaccinations, and increased uptake of AHCs will improve screening and vaccine uptake.	Ongoing, established programme of work
Theme: Training	RESTORE2 training should be offered to learning disability residential settings as well as older people's settings.	This has been rolled out to LD partnership and previously delivered by a third party provider. Currently the contract has finished and the ICB will consider the need to continue this.	TBC
Theme: Training	All healthcare providers and commissioners should ensure their staff have an understanding of the key causes of mortality in adults with an LD	This forms part of roll out of LeDeR learning and training	Ongoing, established programme of work
Theme: Training	Commissioners and providers should ensure that all health staff working with people with a learning disability receive regular training physical health for individuals with a LD and autistic people, and around eating and drinking/dysphagia that is appropriate to their role.	Health staff working with people with an LD receive reasonable adjustments training. Oliver McGowan training is being rolled out. There is a contract for a dedicated LD speech and language therapist and in Cambridge University Hospital SLT provides extra support and training to ward staff, some of whom are able to carry out ward based swallow assessments. Learning disability nurses at each acute hospital lead training: in Peterborough City Hospital LD champions receive 1-2 full days of training per year, which includes physical health and has previously involved SLT to provide education. Bespoke training is provided when learning has been identified following a LeDeR review, structured judgment review or a complaint	Ongoing, established programme of work
Theme: Training	All health staff in CQC registered organisations need to undertake training (on LD and autism) appropriate to their role in line with new legislation. Cambridgeshire and Peterborough ICB should liaise with Health Education England and Skills for Care to ensure that the rollout reaches all providers. Commissioners should ensure that they	The Oliver McGowan training is being rolled out all CQC registered organisations. It will train 50,000 system partners across health and social care (including 9 major providers, 2 local authorities and CQC registered VCSEs). Assurance will be ensured as part of standard contract monitoring, as with other mandatory training requirements.	Workforce roll out predicted to commence April 24.

	gain assurance from services that the rollout has taken place.		
Theme: Accessible information standard	All health and social care organisations providing publicly funded care should ensure they have the appropriate policies, processes and staff training in place for the AIS to be implemented fully.	There is a contractual requirement to meet AIS. Providers are required to implement this contractual requirement.	Ongoing, established programme of work
Theme: Accessible information standard	Commissioners should ensure that the AIS is included within contracts and that there is sufficient funding to enable organisations to meet their legal requirements.	The Accessible Information Standard is included within the NHS standard contract.	Ongoing, established programme of work
Theme: LD workforce	Commissioners should consider how to strengthen LD psychiatry and psychology capacity in Peterborough, as the service is not currently resilient.	Being covered through service model redesign	Redesign over the next 12 months
Theme: LD workforce	Commissioners should consider how to provide art and/or music therapy in Peterborough, as there is currently an inequity in provision for non-verbal adults with an LD who would benefit from therapy.	Being covered through service model redesign	Redesign over the next 12 months
Theme: LD workforce	Commissioners should consider how capacity for care coordination can be provided more consistently in Peterborough.	Being covered through service model redesign	Redesign over the next 12 months
Theme: LD workforce	Currently there is only one qualified specialist LD speech and language therapist in post covering Peterborough. Consideration is needed from commissioners of how to improve the resilience of this service.	Being covered through service model redesign	Redesign over the next 12 months
Theme: LD workforce	Commissioners should consider if there is a need for an IST in Cambridgeshire	Being covered through service model redesign	Redesign over the next 12 months
Theme: LD workforce	Health commissioners should consider whether there is sufficient breadth of dietetic support to meet the needs of adults with an LD, as per Royal College	Being covered through service model redesign	Redesign over the next 12 months

	of Psychiatrist recommendations in section 17 of this needs assessment.		
Theme: LD workforce	The vacancies in LD physiotherapy in Cambridgeshire and lack of commissioned service in Peterborough represent significant risks, although significant work has been undertaken in Cambridgeshire to try to fill the current vacancies. Further support is needed to address the service gaps across both areas.	Currently there is a trial of LD physio in children's services - learning can be applied to adult services. This will be tied to community acquired pneumonia and postural pathway work. As part of offering reasonable adjustments training: PTs should receive this to help look after people with LD	TBC
Theme: LD workforce	Commissioners should look to at minimum achieve parity of services between Cambridgeshire and Peterborough. This would mean increasing WTE to achieve similar caseload/WTE staff across current Peterborough services. This would also mean looking to commission specialist LD physiotherapy, art and music therapy, and to create a service lead and a care coordination function.	Being covered through service model redesign	Redesign over the next 12 months
Theme: LD workforce	Once national LD workforce data is available, benchmarking should be attempted.	Once data is available this will be done.	Pending workforce data availability
Theme: Specialist LD services	Commissioners should assure themselves that the NICE Quality Standards on behaviour that challenges are being met in Cambridgeshire and Peterborough, regardless of which service supports the individual. This includes the provision of MDT support	MDT support for distressed or behaviour that challenges has been added to the quality schedule, therefore will enter into contracts	Ongoing, established programme of work
Theme: Specialist LD services	Commissioners should ensure that they have embedded lessons from national reviews of inpatient, such as those generated from Winterbourne View and Cawston Park.	As a result of the Department of Health review of Winterbourne View Hospital the ICB now performs Care and Treatment Reviews and Commissioner Oversight Visits for The Hollies (6-8 weekly) and Kneesworth House Hospital. There are regular ICS Oversight Panels for Care and Treatment Reviews and Care, Education and Treatment Reviews and the NHSE requirement for Safe and Wellbeing Reviews for all patients covered by CTR are met.	Ongoing, established programme of work

Theme: Specialist LD services	Inconsistencies in the section 75 agreement for Peterborough should be reviewed, with clinical input from provider services as appropriate.	Being covered through service model redesign	Redesign over the next 12 months
Theme: Specialist LD services	Issues identified with Peterborough services should be reviewed by both commissioners and service providers.	Being covered through service model redesign	Redesign over the next 12 months

4. Peterborough City Council Adult Social Care directorate

Action plan in response to needs assessment from operational team within adult social care

Theme	Recommendations	Actions
Theme: Health Promotion	Recommendation: Specialist LD services should screen for substance misuse at initial referral, and offer referral into substance misuse services where appropriate.	Action: To be discussed at practice governance board for additional scoping regarding any updates needed in practitioner guidance. To check if CGL worker has been to all team meetings.
Theme: Health Promotion	Recommendation: Specialist LD health services should ask service users their smoking status on initial screening and offer support individuals to access smoking cessation services as appropriate.	Action: As above - smoking team to be invited to attend team meetings.
Theme: Health Promotion	Recommendation: Ensure staff in specialist LD services have knowledge of physical activity recommendations and local opportunities.	Action: To check information on the PIN re current offer. To ask LD OT for information on resources to them discuss at a team meeting.
Theme: Health Promotion	Recommendation: Ensure that specialist LD services are aware of referral routes into specialist weight management services.	Action: As above - to check the informaiton / resource available and shared with staff in team meeting.
Theme: Unpaid carers	Recommendation: Unpaid carers should be supported to access information and education relating to supporting the person they care for with long term clinical risk factors such as diabetes, hypertension, hypercholesterolaemia and atrial fibrillation.	Action: This will align with our Carers Strategy
Theme: Unpaid carers	Recommendation: Unpaid carers of people with an LD should be included in health promotion campaigns to increase screening uptake.	Action: This will align with our Carers Strategy
Theme: Unpaid carers	Recommendation: Unpaid carers of people with an LD should be supported to access flu and covid vaccinations.	Action: This will align with our Carers Strategy
Theme: Unpaid carers	Recommendation: Given the mortality due to pneumonia in adults with an LD (see section 6), unpaid carers of adults with an LD should be offered support to quit, to reduce exposure to second-hand smoke.	Action: This will align with our Carers Strategy
Theme: Unpaid carers	Recommendation: Unpaid carers should be offered access to health promotion and education around healthy diet, alongside the people they care for.	Action: This will align with our Carers Strategy
Theme: Unpaid carers	Recommendation: Unpaid carers of adults with an LD should be able to access support to claim any benefits that they are entitled to.	Action: This will align with our Carers Strategy

Theme: Unpaid carers	Recommendation: Consideration is needed of what support and advice might be needed for unpaid carers of adults with an LD who have a mental illness or challenging behaviour.	Action: This will align with our Carers Strategy
Theme: Unpaid carers	Recommendation: Consider offering education and support for unpaid carers who care for adults with an LD around healthy ageing, including dementia awareness.	Action: This will align with our Carers Strategy
Theme: Unpaid carers	Recommendation: Ensure accessible information is available for individuals with an LD and their carers about dementia.	Action: This will align with our Carers Strategy
Theme: Unpaid carers	Recommendation: Consider if there is a need for a specific training offer for unpaid carers of people with epilepsy.	Action: This will align with our Carers Strategy. CLDN to consider.
Theme: Unpaid carers	Recommendation: Unpaid carers of people with an LD should be supported to be aware of the symptoms and signs of constipation.	Action: This will align with our Carers Strategy. CLDN to consider.
Theme: Unpaid carers	Recommendation: There should be consideration of how to offer unpaid carers of people with a learning disability training around eating and drinking/dysphagia.	Action: This will align with our Carers Strategy. SLT to consider
Theme: Unpaid carers	Recommendation: Where individuals have postural care systems, carers must be adequately trained so that they understand the importance of adhering to them 24 hours/day.	Action: This will align with our Carers Strategy
Theme: LeDeR	Recommendation: All providers and commissioners of care to adults with an LD should ensure their staff understand the key causes of mortality in adults with an LD.	Actions: 1. Recommissioning of the Care at Home Framework, including homecare and supported living services (by March 2025) 2. Ensure monitoring of services includes relevant questions on training.
Theme: LeDeR	Recommendation: All providers and commissioners of care to adults with an LD should ensure they consider what systemic actions they need to take to address actions identified by local and national LeDeR work.	Actions: 1. Recommissioning of the Care at Home Framework, including homecare and supported living services (by March 2025) 2. Ensure monitoring of services includes relevant questions on training.
Theme: LeDeR	Recommendation: Commissioners and providers should consider how to support STOMP in Cambridgeshire and Peterborough, in line with the NHS Long Term Plan.	Actions: 1. Recommissioning of the Care at Home Framework, including homecare and supported living services (by March 2025)

		2. Ensure monitoring of services includes relevant questions on training.
Theme: Reasonable adjustments, training, AIS	Recommendation: All health staff in CQC registered organisations need to undertake training appropriate to their role in line with new legislation. Cambridgeshire and Peterborough ICB should liaise with Health Education England and Skills for Care to ensure that the rollout reaches all providers. Commissioners should ensure that they gain assurance from services that the rollout has taken place.	Action: PCC ASC will ensure that in house training is provided in line with new legislation
Theme: Reasonable adjustments, training, AIS	Recommendation: All health and social care organisations providing publicly funded care should ensure they have the appropriate policies, processes and staff training in place for the AIS to be implemented fully.	Action: PCC ASC has a clear process in place for producing Easy Read information, with trained staff in place to ensure that public-facing documents are in the appropriate format. There is ongoing work to ensure that external webpages are fully compliant with accessibility requirements.
Theme: In house services - staff training	Recommendation: Ensure that social care staff have adequate awareness of the importance of attending AHCs.	Action: To be review via practice governance board regarding any updates needed in practitioner guidance to encourage staff to check and ask view if social care should ask this as well as health staff.
Theme: Immunisations	Recommendation: Frontline health and social care workers should be supported to access flu and covid vaccinations.	Action: This work is already in place.
Theme: Care Planning	Recommendation: If individuals have a need for a paid carer to accompany them to a screening appointment, this should be included within their care plan.	Action: We are scoping this through our Practice Governance Board
Theme: Care Planning	Recommendation: If individuals have a need for a paid carer to accompany them to an immunisation appointment, this should be included within their care plan.	Action: We are scoping this through our Practice Governance Board
Theme: Care Planning	Recommendation: Care plans should include supporting an individual's needs around domestic, family and personal relationships	Action: We are scoping this through our Practice Governance Board
Theme: Care Planning	Recommendation: If support is necessary to support an individual with care needs to access physical activity, this should be included within their care plans.	Action: We are scoping this through our Practice Governance Board
Theme: Care Planning	Recommendation: Support social workers, alternatively qualified practitioners and commissioned social care provider staff to undertake training around physical activity, to cover how to embed into care plans (including different components of physical activity), behaviour change and motivational approaches, and	Action: We are scoping this through Practice Governance Board

	supporting service users to access opportunities.	
Theme: Care Planning	Recommendation: Ensure that supporting attendance at AHCs is included in care plans if necessary.	Action: We are scoping this through Practice Governance Board
Theme: Care Planning	Recommendation: If an individual with care needs requires support around making food choices, this should be incorporated into their care plan.	Action: We are scoping this through Practice Governance Board
Theme: Care Planning	Recommendation: Many of the wider determinants of health intersect with eligible care needs under the Care Act, particularly: (e) being able to make use of the adult's home safely; (f) maintaining a habitable home environment; (g) developing and maintaining family or other personal relationships;(h) accessing and engaging in work, training, education or volunteering; (i) making use of necessary facilities or services in the local community including public transport, and recreational facilities or services Care planning should consider all of these areas.	Action: We are scoping this through Practice Governance Board
Theme: Care Planning	Recommendation: Planning for later life should be part of care planning for adults with an LD and their carers.	Action: We are scoping this through Practice Governance Board
Theme: Care Planning	Recommendation: Care plans should consider eating and drinking needs as standard.	Action: We are scoping this through Practice Governance Board
Theme: Care Planning	Recommendation: Care plans should include regular dental check-ups; attendance should be monitored as part of the annual review.	Action: We are scoping this through Practice Governance Board
Theme: Care Planning	Recommendation: Ensure that mouth care is explicitly incorporated into care plans.	Action: We are scoping this through Practice Governance Board
Theme: Care Planning	Recommendation: Attendance at routine dental appointments should be incorporated into care plans, including any necessary support for attendance.	Action: We are scoping this through Practice Governance Board
Theme: Care Planning	Recommendation: Attendance at routine sight tests should be incorporated into an individual's care plan, with support identified if required.	Action: We are scoping this through Practice Governance Board
Theme: Care Planning	Recommendation: Include signposting to inclusive sports offer within the local authority's Directory of Services	Action: We are scoping this through Practice Governance Board

Theme: Training	Recommendations • All providers and commissioners of care to adults with an LD should ensure their staff have an understanding of the key causes of mortality in adults with an LD • Commissioners of residential and domiciliary social care for adults with an LD should ensure that appropriate training is in place for staff to support adults with an LD in the management of long-term conditions linked to cardiovascular disease where they care for individuals with one of these conditions. • Care providers should ensure that their staff have an awareness of routine immunisations that they may need to support their clients to attend • All care staff in residential services should undertake training about sexual health and relationships, as well as around capacity and consent, that is appropriate to their role • Ensure that social care staff have adequate awareness of the importance of attending AHCs • Support social workers, alternatively qualified practitioners and commissioned social care provider staff to undertake training around physical activity, to cover how to embed into care plans (including different components of physical activity), behaviour change and motivational approaches, and supporting service users to access opportunities. • Providers of residential care for adults with an LD should ensure their staff are familiar with how to access smoking cessation services, and can support their service users to access them as appropriate. • Care providers should ensure that their staff have the knowledge and understanding to support adults with an LD who are eligible to claim benefits to access income maximisation support if needed • Care providers should ensure that their staff have the knowledge and skills to help individuals they support to access training, education and employment opportunities.	Actions: This is a large piece of work, and will likely take 1 to 2 years to fully roll out, given the development required, and changes to contracts. Upcoming work includes: 1. Recommissioning of the Care at Home Framework, including homecare and supported living services (by March 2025) 2. Workforce Development - opportunities to link in with training development

	• Commissioners and social care providers should ensure that social care staff who care for individuals with an LD who have a mental illness have the necessary knowledge and skills to meet their needs. • Commissioners and social care providers who provide care to adults with an LD who have behaviour that challenge in the community should ensure that staff who have appropriate skills and knowledge to support effectively. • All social care staff working with people with an LD should be required to have up-to-date Basic Life Support training as a minimum contractual requirement in service specifications • Commissioners and providers should ensure that all care staff working with people with a learning disability receive regular training around eating and drinking/dysphagia that is appropriate to their role. • Where individuals have postural care systems, carers must be adequately trained so that they understand the importance of adhering to them 24 hours/day. • Ensure staff who are required to support with toothbrushing are trained on how to do so appropriately • Ensure that staff training around health promotion includes elements of oral health promotion. • Social care providers should ensure that staff have appropriate training around falls prevention, both in terms of individual and environmental risk factors • Ensure that social care staff have an awareness of signs of hearing loss amongst adults with an LD. • Residential care providers should ensure that staff have training on recognition of signs and symptoms of clinical deterioration that is appropriate to their role • Social care providers should ensure that their staff are aware of the symptoms and signs of constipation. • Ensure that care providers of people with a learning disability offer their staff training on epilepsy as	

	standard, reflecting the likely high prevalence of epilepsy amongst their residents.	

Theme: Health Appointments	Recommendations: • Commissioners of social care should ensure there is sufficient flexibility and funding within service provision to enable paid carers to accompany individuals to a screening appointment where there is an identified need • Commissioners of social care should ensure there is sufficient flexibility and funding within service provision to enable paid carers to accompany individuals to an immunisation appointment where there is an identified need • Commissioners of social care should review flexibilities within funding arrangements for enabling paid carers to attend hospital whilst their service user is an inpatient, to facilitate the process of reasonable adjustments. • Ensure that where a staff member is needed to attend with the person to support, this is someone who knows the individual well	Actions: 1. Recommissioning of the Care at Home Framework, including homecare and supported living services (by March 2025) 2. Ensure monitoring of services includes questions on medical appointments.
Theme: Contract Monitoring	Recommendations: • Care provider policies around relationships for individuals in residential care should be reviewed as part of the routine contract monitoring process • Commissioners should ensure commissioned housing is of a high quality, without environmental hazards	Action: PCC are currently preparing to roll out a new monitoring tool called PAMMS. In preparing for this, officers are reviewing the guidance and tools that policies will be evaluated against.
Theme: Service Specification Development	Recommendation: Commissioners should ensure that they have a varied day opportunities offer, that supports with developing employment skills and with developing friendships and social networks	Action: Will be considered in recommissioning of day services planned for 2024.
Theme: Service Specification Development	Recommendation: There is a need to ensure that adults with an LD have opportunities to socialise and develop social networks, including both friendships and personal relationships. This should be recognised as an outcome of day services.	Action: Will be considered in recommissioning of day services planned for 2024.
Theme: Service Specification Development	Recommendation: Consider embedding requirements around supporting service users to access physical activity into care home, supported living and domiciliary care service specifications	Actions: 1. Recommissioning of the Care at Home Framework, including homecare and supported living services (by March 2025) will allow for changes in the specifications. 2. Ensure monitoring of services includes questions on

		physical activity.
Theme: Service Specification Development	Recommendation: Consider embedding requirements to offer physical activity to service users attending day opportunities.	Action: Will be considered in recomissioning of day services planned for 2024.
Theme: Service Specification Development	Recommendation: Residential care providers should ensure they have access to scales, including wheelchair-accessible scales, for individuals where weight monitoring is indicated.	Action: Discussion required at LDHI Action Plan group, as this will need a multi-agency response.
Theme: Service Specification Development	Recommendation: System work will be needed to implement the national framework for delegations once it is released.	Action: 1. Commissioners will engage in system work once it commences
Theme: Service Specification Development	Recommendations: • Commissioners should ensure that the AIS is included within contracts and that there is sufficient funding to enable organisations to meet their legal requirements. • All health and social care organisations providing publicly funded care should ensure they have the appropriate policies, processes and staff training in place for the AIS to be implemented fully	Actions: 1. Recommissioning of the Care at Home Framework, including homecare and supported living services (by March 2025) will allow for changes in the specifications. 2. PCC are currently preparing to roll out a new monitoring tool called PAMMS. In preparing for this, officers are reviewing the guidance and tools that policies will be evaluated against.
Theme: Service Specification Development	All social care staff in CQC registered organisations need to undertake undertake training appropriate to their role in line with new legislation. Cambridgeshire and Peterborough ICB should liaise with Health Education England and Skills for Care to ensure that the rollout reaches all providers. Commissioners should ensure that they gain assurance from services that the rollout has taken place	Actions: 1. Recommissioning of the Care at Home Framework, including homecare and supported living services (by March 2025) will allow for changes in the specifications. 2. PCC are currently preparing to roll out a new monitoring tool called PAMMS. In preparing for this, officers are reviewing the guidance and tools that policies will be evaluated against. 3. Review of Council's Training Standards
Theme: Service Specification Development	Recommendation: Section 11 considers residential care commissioning for adults with an LD. Some of these adults will have challenging behaviour. In light of the NHS Long Term Plan ambition to reduce the number of inpatient stays, consideration is needed of	Actions: 1. As part of the Commissioning function, PCC will be looking to ensure there is enough capacity to meet demand for social-care funded clients.

	whether there is sufficient, appropriate community capacity for individuals being discharged.	

Theme: Care Planning	Recommendations: • If individuals have a need for a paid carer to accompany them to a screening appointment, this should be included within their care plan. • If individuals have a need for a paid carer to accompany them to an immunisation appointment, this should be included within their care plan. • Care plans should include supporting an individual's needs around domestic, family and personal relationships • If support is necessary to support an individual with care needs to access physical activity, this should be included within their care plans. • Support social workers, alternatively qualified practitioners and commissioned social care provider staff to undertake training around physical activity, to cover how to embed into care plans (including different components of physical activity), behaviour change and motivational approaches, and supporting service users to access opportunities. • Ensure that supporting attendance at Annual Health Checks (AHCs) is included in care plans if necessary. • If an individual with care needs requires support around making food choices, this should be incorporated into their care plan. • Many of the wider determinants of health intersect with eligible care needs under the Care Act, particularly: (e) being able to make use of the adult's home safely; (f) maintaining a habitable home environment; (g) developing and maintaining family or other personal relationships;(h) accessing and engaging in work, training, education or volunteering; (i) making use of necessary facilities or services in the local community including public transport, and recreational facilities or services Care planning should consider all of these areas. • Planning for later life should be part of care	Actions: 1. Recommissioning of the Care at Home Framework, including homecare and supported living services (by March 2025). Information around person-centred and strengths-based care plans will be included in the specification. 2. PCC are currently preparing to roll out a new monitoring tool called PAMMS. In preparing for this, officers are reviewing the guidance and tools that care plans (and other elements of care) are reviewed against.

	planning for adults with an LD and their carers. • Care plans should consider eating and drinking needs as standard. • Care plans should include regular dental check-ups; attendance should be monitored as part of the annual review. • Ensure that mouth care is explicitly incorporated into care plans. • Attendance at routine dental appointments should be incorporated into care plans, including any necessary support for attendance. • Attendance at routine sight tests should be incorporated into an individual's care plan, with support identified if required.	

Theme: Data	Recommendation: Commissioners need to ensure they have an understanding of the future housing needs of adults with an LD who live with their parents	Current actions include: 1. Continue to research and understand current demand, while mapping available capacity within the City. 2. Recommissioning of the Care at Home Framework, including homecare and supported living services (by March 2025) in order to access a wider range of care providers. 3. Workforce Development - opportunities to link in with training development
Theme: Data	Recommendation: CCC and PCC commissioners should work with Cambridgeshire and Peterborough ICB to understand the future demand for single service user provision that will derive from individuals who are currently in long stay inpatient units.	Action: 1. Commissioners will work collaboratively with the ICB to include these considerations in the current demand management and forecasting work
Theme: Data	Recommendation: CCC and PCC commissioners should work with Cambridgeshire and Peterborough ICB to make use of the new DSCRO data warehouse once appropriate data-sharing agreements are in place, in order to understand the physical and mental health comorbidities of individuals that are in long-term care.	Current actions include: 1. Ensuring data sharing agreement is in place, and agreeing process for sharing data and findings.

Theme: Unpaid Carers	Recommendations: • Unpaid carers should be supported to access information and education relating to supporting the person they care for with long term clinical risk factors such as diabetes, hypertension, hypercholesterolaemia and atrial fibrillation. • Unpaid carers of people with an LD should be included in health promotion campaigns to increase screening uptake. • Unpaid carers of people with an LD should be supported to access flu and covid vaccinations. • Given the mortality due to pneumonia in adults with an LD (see section 6), unpaid carers of adults with an LD should be offered support to quit, to reduce exposure to second-hand smoke. • Unpaid carers should be offered access to health promotion and education around healthy diet, alongside the people they care for. • Unpaid carers of adults with an LD should be able to access support to claim any benefits that they are entitled to. • Consideration is needed of what support and advice might be needed for unpaid carers of adults with an LD who have a mental illness or challenging behaviour. • Consider offering education and support for unpaid carers who care for adults with an LD around healthy ageing, including dementia awareness. • Ensure accessible information is available for individuals with an LD and their carers about dementia.	Actions: Ensure this forms a part of a quarterly review in contract management meetings. Each quarter 1 or 2 specific recommendations will be reviewed in order to highlight and understand how the current service perorms in regards the recommendation
Theme: Unpaid Carers	Consider if there is a need for a specific training offer for unpaid carers of people with epilepsy.	Action: Bring this into the recommissioning work for the unpaid carers contract to understand if there is a need
Theme: Unpaid Carers	Recommendation: Unpaid carers of people with an LD should be supported to be aware of the symptoms and signs of constipation.	Action: Bring this into the recommissioning work for the unpaid carers contract to understand how this could be implemented
Theme: Unpaid Carers	Recommendation: There should be consideration of how to offer unpaid carers of people with a learning disability training around eating and drinking/dysphagia.	Action: Bring this into the recommissioning work for the unpaid carers contract to understand if there is a need

Theme: Unpaid Carers	Recommendation: Where individuals have postural care systems, carers must be adequately trained so that they understand the importance of adhering to them 24 hours/day.	Actions: Ensure this forms a part of a quarterly review in contract management meetings. Each quarter 1 or 2 specific recommendations will be reviewed in order to highlight and understand how the current service performs in regards the recommendation

Agenda Item No: 7

Healthy Places Joint Strategic Needs Assessment – Community Engagement Briefing

To:	Cambridgeshire and Peterborough Health & Wellbeing Board / Integrated Care Partnership
Meeting Date:	22nd March 2024
From:	Director of Public Health, Cambridgeshire County Council and Peterborough City Council
Outcome:	For information only.
Recommendation:	For the board to consider and note the contents of this paper.

Officer contact:
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1. Background

1.1 Wider determinants of health are non-medical factors that influence health outcomes. These determinants include socio-economic (e.g., employment opportunities, food security) and environmental (e.g., access to green space, housing quality) factors external to the individual. The Faculty of Public Health recognises climate change as the greatest threat to public health in the 21st century.

1.2 The Healthy Places Joint Strategic Needs Assessment (HP JSNA) aims to evidence the role of the built environment and climate change on human health across Cambridgeshire and Peterborough. The HP JSNA was approved in the Health and Wellbeing Board work plan, agreed on 20th October 2023.

1.3 The HP JSNA is scheduled to be brought to the Health and Wellbeing Board on 19th July 2024. The final report will include system-wide recommendations to support the development of healthier, more accessible and inclusive communities. Specifically, the HP JSNA will support healthier local plan development, as well as housing and commissioning strategies across Cambridgeshire and Peterborough.

1.4 The HP JSNA held a stakeholder engagement event November 2023, gathering input from over 50 attendees from diverse organisations. Following on from feedback at this event, the structure for the HP JSNA has been refined, evidence reviews have been completed, and a community engagement strategy has been developed, as outlined below. HP JSNA development is currently underway, with over 30 multi-disciplinary contributors from across Cambridgeshire and Peterborough.

2. Main Issues

2.1 The target population for the HP JSNA is all residents across Cambridgeshire and Peterborough. Consideration will also be given to relevant cross-boundary issues. To collect representative and diverse community perspectives, the HP JSNA is engaging in 2 community engagement activities. (1) Community survey and (2) Healthwatch forums.

2.2 (1) The community survey seeks to understand residents' views on the built environment across Cambridgeshire and Peterborough. This includes the physical structures where people live, work, play, and socialise, as well as networks and connectivity between areas. The survey opened on 19th February and will close on 15th April. The survey is being promoted through local authority communication channels and Healthwatch's networks. A contract has been awarded to Healthwatch for targeted survey distribution, ensuring that underrepresented and hard-to-reach groups have the opportunity to represent their views. A link to the online version of this survey and a copy of the paper version can be found in Appendix 1.

2.3 (2) Engagement is planned with Healthwatch's Partnership Boards to explore built environment considerations specific to vulnerable populations (Learning Disability, Older People, Physical Disability, and Sensory Impairment). Engagement is also planned with Healthwatch's Health and Care Forums to explore geographic-specific findings from the community survey.

3. Alignment with the Cambridgeshire & Peterborough Health and Wellbeing Strategy

3.1 The HP JSNA is relevant to all 4 priorities of the Cambridgeshire and Peterborough Health and Wellbeing Strategy. The greatest relevance is to Priority 2.

- Priority 1: Ensure our children are ready to enter education and exit, prepared for the next phase of their lives
- Priority 2: Create an environment to give people the opportunities to be as healthy as they can be.
- Priority 3: Reduce poverty through better employment and better housing.
- Priority 4: Promote early intervention and prevention measures to improve mental health and wellbeing.

4. Significant Implications

4.1 Resources

This briefing document is for information only. There are no significant resource implications. A separate paper will be submitted to the Health and Wellbeing Board prior to the July meeting, which will include details any significant resource implications resulting from the HP JSNA recommendations.

4.2 Statutory, Legal and Risk Implications

This briefing document is for information only. There are no significant statutory, legal, or risk implications. A separate paper will be submitted to the Health and Wellbeing Board prior to the July meeting, which will include details any significant statutory, legal, or risk implications resulting from the HP JSNA recommendations.

4.3 Equality and Diversity Implications

To maximise the representativeness of the HP JSNA community survey, interim analyses are planned to identify underrepresented groups (geographic or demographic). Healthwatch have been awarded a contract to perform targeted survey distribution work, focussing on these underrepresented or hard-to-reach communities. The online version of the survey has been designed so that it may be completed on behalf of someone a resident is caring for, allowing representation of children and dependent adults. The paper version of the survey has been distributed across libraries and council buildings in Cambridgeshire and Peterborough, to mitigate digital exclusion. Healthwatch Partnership Board engagement is planned to specifically ensure the views of these groups are represented.

This report has been signed off by the Executive Director of Public Health, Jyoti Atri

5. Appendices

5.1 Appendix 1 includes a link to the online version of the HP JSNA community survey and a copy of the paper version.

6. Source documents

6.1 None

7. Conflict of Interest

7.1 Conflict of Interest have been reviewed and addressed in line with the ICB Conflicts of Interest and standards of Business Conduct Policy

Appendix 1

Healthy Places JSNA survey - online version

Healthy Places Joint Strategic Needs Assessment

1. Introduction

The Public Health team at Cambridgeshire County Council and Peterborough City Council is working towards making Cambridgeshire and Peterborough a healthier, more supportive, and inclusive environment for everyone.

This survey aims to understand residents' views on the built environment across Cambridgeshire and Peterborough. This includes the physical structures where people live, work, play, and socialise, as well as networks and connectivity between areas.

Your response will be used to inform the Healthy Places Joint Strategic Needs Assessment, a piece of work which will support the development of healthier, more accessible and inclusive communities.

This survey should take around 10-15 minutes and may be completed on behalf of yourself or someone you care for. Your answers will help us to understand the values and experiences of local residents. Thank you for your time and assistance.

The survey closes on Monday 15 April 2024.

You can give your views in a number of ways:

1. By filling in the questionnaire below and returning the completed form in the Freepost envelope provided.
2. By completing the questionnaire online at cambridgeshireinsight.org.uk/jsna/healthy-places-jsna/healthy-places-jsna-survey (or follow the QR code at the top of this document).
3. If you are unable to complete the questionnaire because you have special requirements (for example, problems with vision or language) and there is no one that can help you complete the questionnaire, please call 0345 650 0280 Monday-Friday between 9am-5pm and leave your contact details. We will then contact you within 7 working days and will work with you to help you respond to the consultation.
4. If you have other queries about this questionnaire, please email healthinallpolicies@cambridgeshire.gov.uk and we will respond to your email within 7 working days.

Data Protection

The survey asks for postcode (not full address) to allow us to place your views in the context of your local built environment. We may share your information with our consultants and with the council analysis team.

You do not have to give us any personal information. Data will be published such that individual responses will not be identifiable. Personal data will be held securely, in accordance with data protection legislation. We will only store it for 12 months after the survey results have been analysed and the Healthy Places Joint Strategic Needs Assessment has been published.

2. Demographics

Age

1. How old are you? (Please tick one)

☐ 0-4	☐ 20- 4	☐ 55 64
☐ 5-9	☐ 25-34	☐ 65-74
☐ 10-14	☐ 35-44	☐ 75+
☐ 15-19	☐ 45-54	

Sex and Gender

2. What is your sex? (Please tick one)

☐ Female	☐ Male	☐ Prefer not to say

3. What is your gender? (Please tick one)

☐ Woman	☐ Man	☐ Non-binary
☐ Prefer not to say	☐ Prefer to self-describe (please give details in the box below)	

4. Is the gender you identify with the same as your gender registered at birth? (Please tick one)

☐ Yes	☐ No	☐ Prefer not to say

Ethnicity

5. How would you best describe your ethnic background? (Please tick one)

Asian

- [ ] **Indian**
- [ ] **Pakistani**
- [ ] **Bangladeshi**
- [ ] **Chinese**
- [ ] **Any other Asian background**

Black, Black British, Caribbean or African

- [ ] **Caribbean**
- [ ] **African**
- [ ] **Any other Black, Black British, or Caribbean background**

Mixed or multiple ethnic groups

- [ ] **White and Black Caribbean**
- [ ] **White and Black African**
- [ ] **White and Asian**
- [ ] **Any other Mixed or multiple ethnic background**

White

- [ ] **English, Welsh, Scottish, Northern Irish, British Irish**
- [ ] **Irish**
- [ ] **Gypsy or Irish Traveller**
- [ ] **Roma**
- [ ] **Any other White background**

Other ethnic group

- [ ] **Arab**
- [ ] **Any other ethnic group**
- [ ] **Prefer not to say**

Disability

6. Do you consider yourself to have a disability? (Please tick one)

("A physical or mental impairment that has a substantial and long-term negative effect on your ability to do normal daily activities")

- ☐ **Yes**
- ☐ **No**
- ☐ **Prefer not to say**

Employment

7. What is your current working status if you work? (Please tick one)

- ☐ **Working Full time (30+ hours)**
- ☐ **Working Part time (29 hours or less)**
- ☐ **Self employed**
- ☐ **Unemployed**
- ☐ **Not working – retired**
- ☐ **Not working – looking after house/children**
- ☐ **Not working – disability or health condition**
- ☐ **Not working – carer**
- ☐ **Student or child**

Occupation

8. Which option most closely describes your current occupation? If you are retired, please choose the option that most closely aligns to your role before retirement. (Please tick one)

- ☐ **Professional / higher managerial (e.g. doctor, lawyer, chairperson or managing director of a medium or large firm)**
- ☐ **Manager / senior administrator (e.g. senior manager, owner of small business, head teacher)**
- ☐ **Supervisor / clerical/ skilled non manual role (e.g. teacher, secretary, junior manager, police officer)**
- ☐ **Skilled manual worker (e.g. plumber, electrician, hairdresser)**
- ☐ **Semi-skilled / unskilled manual worker (e.g. assembler, postal worker, shop assistant)**
- ☐ **Receiving state benefit, unemployment, old age or any other reason.**
- ☐ **Other**
- ☐ **Prefer not say**

3. The area you live

Location

9. Which council area do you currently live in? (Please tick one)

- [ ] **Cambridge City**
- [ ] **Fenland**
- [ ] **East Cambridgeshire**
- [ ] **Huntingdonshire**
- [ ] **South Cambridgeshire**
- [ ] **Peterborough**
- [ ] **Other (please give details in the box below)**

Postcode

10. What is your postcode? (Please do not include spaces e.g., CB28DD)

4. Your local area

Location

For the below questions, your 'local area' is taken to mean your village/town or nearby villages/towns that are easy for you to travel to.

11. Please rate the following: "Where I live…"

	Strongly disagree				Strongly agree
I can meet up with people I know	☐	☐	☐	☐	☐
I can meet new people	☐	☐	☐	☐	☐
I can have a say in how things are run around here	☐	☐	☐	☐	☐
I can run things around here	☐	☐	☐	☐	☐
I can easily get the information I need (e.g., for health, leisure, transport, housing)	☐	☐	☐	☐	☐
I know who to go to if I need help (e.g., for health, leisure, transport, housing)	☐	☐	☐	☐	☐

12. Please rate the below options on how important they are to you to have in your local area (even if you don't currently have them):

	Not important to me				Very important to me
Ability to have a say in local decisions (e.g., Parish council)	☐	☐	☐	☐	☐
Access to local health care (e.g., local health services)	☐	☐	☐	☐	☐
Sense of community (e.g. community groups or clubs, newsletter/magazine, know your neighbours)	☐	☐	☐	☐	☐
Inclusive and accessible green spaces (e.g., parks, fields, woodland, nature reserve)	☐	☐	☐	☐	☐
Options for active travel (e.g., footpaths for walking/running, cycle lanes)	☐	☐	☐	☐	☐

	Not important to me				Very important to me
Affordable options for healthy food (e.g., fresh fruit and vegetables, farmer's market, locally grown produce)	☐	☐	☐	☐	☐
Community buildings that support health and/or social connections (e.g., community centre, village hall)	☐	☐	☐	☐	☐
Options for healthy play and leisure (e.g., children's play parks, sports/leisure centre)	☐	☐	☐	☐	☐

13. Please rate the below options on how easy or difficult they are to access in your local area:

	Very hard to access		Neither easy nor hard to access / not sure		Very easy to access
Affordable options for healthy food (e.g., fresh fruit and vegetables, farmer's market, locally grown produce)	☐	☐	☐	☐	☐
Access to local health care (e.g., local health services)	☐	☐	☐	☐	☐
Sense of community (e.g. get involved in a local club, ask neighbours for help)	☐	☐	☐	☐	☐
Inclusive and accessible green spaces (e.g., parks, fields, woodland, nature reserve)	☐	☐	☐	☐	☐
Options for active travel (e.g., footpaths for walking/running, cycle lanes)	☐	☐	☐	☐	☐
Affordable options for healthy food (e.g., fresh fruit and vegetables, farmer's market, locally grown produce)	☐	☐	☐	☐	☐
Community buildings that support health and/or social connections (e.g., community centre, village hall)	☐	☐	☐	☐	☐
Options for healthy play and leisure (e.g., children's play parks, sports/leisure centre)	☐	☐	☐	☐	☐

5. Your comments

14. Is there anything specific you would like us to know about your local built environment? For example, does a feature of your local park make it more or less appealing to use?

Please note, this survey should not be used to report active problems to the council. We are unable to address these through survey responses.

Please address any such issues through existing reporting routes:

- Cambridgeshire: go to cambridgeshire.gov.uk/top-tasks/report or call 0345 045 5200
- Peterborough: go to peterborough.gov.uk/report-it-online or call 01733 747474

Thank you for your participation.

Your response will help to inform our ongoing work on the Healthy Places Joint Strategic Needs Assessment, which will become publicly available in Autumn 2024 via Cambridgeshire and Peterborough Insight:

cambridgeshireinsight.org.uk