Cambridgeshire & Peterborough Integrated Care System

Cambridgeshire County Council

PETERBOROUGH CITY COUNCIL

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

Date: Friday 21st July 2023

Time: 10.30 am

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

Agenda

Open to Public and Press

Constitutional Matters

			Times
1.	**Apologies for absence and declarations of interest** ***Guidance on declaring interests is available at:*** Declaration of Interest		10:30
2.	**Minutes of the Cambridgeshire and Peterborough Health and Wellbeing Board / Integrated Care Partnership 24th March 2023**	Chair	10:35
	Business Delivery		
3.	**HWB ICP Annual Report for Council**	Jyoti Atri	10:40
	Strategy Development		
4.	**HWB ICS Strategy Priority 2 – Update on Obesity Action Plan**	Jyoti Atri / Val Thomas	10:50
5.	**Joint Forward Plan / Executive Summary**	Jan Thomas	11:30
6.	**Better Care Fund Year End Report 2022/23**	Caroline Townsend	11:50

Governance

7.	**HWB ICP Forward Agenda Plan**	Martin Whelan	12:20
8.	**AOB**		

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 24 March 2023
Time: 13:30 pm
Venue: Red Kite Room, New Shire Hall, Alconbury Weald, Huntingdon PE28 4YE

MINUTES

Present:

Members:

Cllr Susan van de Ven	Vice-Chair of Adults and Health Committee (lead member for HWB) – Cambridgeshire County Council (Chair)
Jyoti Atri	Director of Public Health, Cambridgeshire County Council and Peterborough City Council
Cllr Lynne Ayres	Cabinet Member for Children's Services, Education, Skills and the University, Peterborough City Council
Professor Steve Barnett	Chair of North West Anglia NHS Foundation Trust (NWAFT)
Ged Curran	ICB Non-Executive Member
Kit Connick	ICB Chief Officer, Partnerships & Strategy
Julie Farrow	Voluntary and Community Sector Representative
Stewart Francis	Cambridgeshire and Peterborough Healthwatch Chair
Jim Haylett	Representative of the Cambridgeshire Police and Crime Commissioner
Cllr John Howard	Cabinet Member for Adult Social Care, Health and Public Health, Peterborough City Council
Cllr Richard Howitt	Chair of Adults and Health Committee - Cambridgeshire County Council
Dr Nik Johnson	Mayor, Cambridgeshire, and Peterborough Combined Authority
Louis Kamfer	ICB Deputy Chief Executive/ MD of Strategic Commissioning ABU
Dr Neil Modha	Primary Care Representative (North)
Dr Mike More	Chair Cambridge University Hospitals NHS Foundation Trust
John O'Brien	ICB Chair
Liz Watts	Chief Executive of South Cambridgeshire District Council and District Council representative (South)

Present (Virtually):

Mary Elford	Chair of Cambridgeshire Community Services NHS Trust (CCS)
Kathy Hartley	Consultant in Public Health

Officers:

Bob Bragger	Health Champion
Richard Kenny	Executive Director for Economy & Growth, Cambridgeshire, and Peterborough Combined Authority
Jonathan Lewis	Director of Education Cambridgeshire County Council and Peterborough City Council
Erin Lilley	Director, ICP Development & Transformation, Cambridgeshire (South)
Kate Parker	Head of Public Health Business Programme
Michelle Rowe	Democratic Services Manager, Cambridgeshire County Council
Val Thomas	Deputy Director of Public Health, Cambridgeshire County Council
Nicky Ward	Director of Strategy and Development, ICB
Emmeline Watkins	Deputy Director of Public Health, Peterborough City Council
Martin Whelan	Head of Governance and Data Protection Officer, ICB
Mathew Winn	Chief Executive Officer, Cambridgeshire Community Services NHS Trust
Uwem Okure	Corporate Services Support Manager, ICB

1. Apologies for Absence and Declarations of Interest

Apologies for absence were received from Dr James Morrow, Primary Care Representative (South); Vicki Evans, Cambridgeshire Constabulary; Jan Thomas, ICB Chief Executive; Debbie McQuade, Service Director: Adults and Safeguarding, Cambridgeshire County Council and Peterborough Council; Paul Medd, Chief Executive of Fenland District Council and District Council representative (North); Darryl Preston, Police and Crime Commissioner for Cambridgeshire and Peterborough; Ricky Cooper, Representative of the Executive Director of Children's Services, Peterborough City Council and Cambridgeshire County Council; Julie Spence, Chair of Cambridgeshire and Peterborough NHS Foundation Trust (CPFT); Professor John Wallwork, Chair of Royal Papworth Hospital NHS Foundation Trust.

No declarations of interest were received.

2. Minutes of the Cambridgeshire and Peterborough Joint Health and Wellbeing Board and Integrated Care Partnership 20 December 2022

The minutes of the meeting on 20 December 2022 were agreed as an accurate record.

Business Delivery

3. Community Story - Place Level

The Joint Health and Wellbeing Board / Integrated Care Partnership received a community story presented by the Director, ICP Development & Transformation, Cambridgeshire South and the Health Champion Lead regarding their engagement with the community and service users.

It was reported that Healthwatch had recruited twelve Health Champions in the south, who had been supported to develop basic research techniques and engaged with the community through two projects which investigated:

- People's experiences of Accident and Emergency department at Cambridge University Hospital.

- Gathered information to understand health inequalities and barriers for people accessing services.

The Health Champion reported that focus group meetings had been held with the community. Key themes from the focus groups had included:

- Poor access to dentistry services.
- Poor access to mental health services.
- Pressure on staff which reduced the ability to engage with patients.
- A lack of service co-ordination.
- There was a suggestion about volunteer groups working more closely with the NHS.

It was noted that the full report on these projects was available on the Healthwatch website and members were encouraged to read it.

The following points were raised in discussion.

- Engagement with under 18s and hard-to-reach groups (e.g., refugees) was encouraged. It was clarified that there had been and would continue to be engagement with people who previously didn't have their voice heard.
- The transfer of dentistry to the ICBs from April 2023 was highlighted and clarification was sought on how to improve dentistry within the patch. It was noted that there were significant challenges around access to dentistry and issues around national contracts. It was noted that the ICB were embarking on discussions on how service improvement could be delivered over time.
- It was highlighted that challenges are being reported to the Children in Care Council in Peterborough around getting their children to see an NHS dentist. There was a suggestion that the Children in Care Council might be a good place to hear the voice of the child.

The Joint Health & Wellbeing Board and Integrated Care Partnership noted the community story.

4. Health and Wellbeing Board Integrated Care Strategy Priorities and Action Plans

The Joint Health & Wellbeing Board and Integrated Care Partnership received a report seeking approval for the Cambridgeshire & Peterborough Health and Wellbeing Integrated Care Strategy Priorities and Action Plans.

The meeting was advised that the Chairs and Officers had met informally at the beginning of the year to discuss how the four priorities were developing. The action plans associated with the four priorities were noted as a starting point and these are expected to develop further as early products such as evidence reviews, and behavioural insights come to fruition. It was highlighted that the action plans had been led by the Senior Responsible Officers.

The meeting received a presentation from the Senior Responsible Officers for each priority and action plan. Brief summaries were provided for each priority.

After the presentations, the following points were raised in the discussion.

- The interconnectivity between elements of the strategy was highlighted. Workforce was acknowledged as a key issue for every organisation within the system.
- Clarification was sought on how the system would ensure that children have the best start in life. Access to childcare was acknowledged to be a key issue in resolving workforce challenges. Ensuring that pay within the childcare sector was competitive was noted as key

priority, alongside training and support. It was noted that details around the government changes around childcare were awaited and this would require workforce changes.

- It was highlighted that there was clear evidence that a pathway into employment could be via volunteering and there was a need for this to be acknowledged in the strategy.
- The meeting recognised that the statutory local transport authority role within Cambridgeshire and Peterborough is held by the Combined Authority. There was agreement that the strategy needed to align with the Local Transport and Connectivity Plan. There was a commitment to pursue key themes such as workforce transport.
- Concerns were raised regarding how people were managed while on -waiting lists especially young people coping with ill mental health, as this responsibility may fall on the education sector. The meeting was advised that one of the deliverables of priority 1 was setting up a new group that will involve school leadership to ensure the support offered is coordinated.
- The Senior Responsible Officers were asked to feedback to the meeting on where the system can add distinctive value to the development of the strategies.

The Joint Health & Wellbeing Board and Integrated Care Partnership approved the content of the four strategic priorities and their initial action plans.

5. Joint Forward Plan for Integrated Care Board

The Chief Officer of Partnerships & Strategy, Integrated Care Board presented the first draft of the Joint Forward Plan (JFP). It was noted that further iterations were planned, involving ongoing engagement with system partners.

It was noted that the JFP had been aligned to the four principles of the Integrated Care System (ICS) and is underpinned by a set of clear delivery plans.

H&WB/ICP colleagues were advised of the requirement to provide feedback and input into the draft JFP, and for the ICB to be able to be demonstrate that proper account of the feedback has been undertaken in the final version.

The following points were raised in discussion.

- It was acknowledged that the JFP does reflect the collaborative work completed over the last year, however members were encouraged to consider what was different in practice.
- Concerns were raised around the health-focussed nature of the language in the JFP, and it was suggested that an opportunity to use alternative wording should be explored, with input from LA and other system colleagues to inform this.
- There was a suggestion to include offenders in the development of the delivery plan. It was acknowledged that although this cohort was not a large population, it does engage every single strand in the plan (for example housing, skills and employment issues) and there may be significant mental health issues within this population.

The Joint Health & Wellbeing Board and Integrated Care Partnership agreed to:

- Note the system approach to developing the JFP.
- Support the ongoing development of the JFP over the next few months.
- Consider its alignment with the broader strategic aims and aspirations as set out in the Health & Wellbeing Integrated Care Strategy and specifically, the discharge of health duties and obligations in support of the strategy.
- To reconvene informally in June to determine the mechanism for finalising the HWB/ICP's input and discharge of duties in signing off the plan.

6. Integrated Care System Estates Strategy

The Joint Health & Wellbeing Board and Integrated Care Partnerships received the Integrated Care System (ICS) Estates Strategy.

The meeting was advised that this was the first draft of the ICS Estates Strategy and there was an acknowledgement of data gaps, which will be addressed over time in collaboration with system partners.

There was an acknowledgment that the strategy is currently mainly health focused, but that the intention is to broaden its approach to the wider system estate.

The following points were raised in discussion.

- There was a general acknowledgement of the importance of the strategy.
- The meeting recognised the need to link the Net Zero Strategy into wider clinical practice and not to consider the Net Zero strategy as an estates issue only.
- Clarification was sought on the meaning of 'significantly under doctored'. It was clarified as the number of doctors per one thousand (1000) patients, so when a practice is deemed under doctored, it means they don't have a sufficient number of doctors to serve the population.
- It was highlighted that Cambridgeshire County Council are planning new independent living centres to provide extra care for older people and were working collaboratively with health partners. The possibility of identifying under-utilised public estates to support this endeavour was highlighted.
- A need to invest in digital and other remote means of enabling access for residents was highlighted.

The Joint Health & Wellbeing Board and Integrated Care Partnership agreed to:

- Note the system approach to developing the strategy.
- Support the ongoing development of the strategy and its alignment with the One Public Estate work.
- Note the broader strategic aims for estates considering wider system intent and aspirations as set out in the Health and Wellbeing Integrated Care Strategy.

7. Cambridgeshire & Peterborough Better Care Fund and Adult Social Care discharge plans

The Joint Health & Wellbeing Board and Integrated Care Partnerships received and noted the Better Care Fund and Adult Social Care Discharge plans.

The following points were raised in discussion.

- Further information on the outcome of the Better Care Fund and Adult Social Care discharge plans was requested. It was suggested that the outcome should be circulated to members before the next meeting.
- Senior Responsible Officer capacity challenges were acknowledged.
- It was highlighted that it will be helpful to know how the lessons learnt from this year's winter would be used for next winter planning cycle. There was also a need for the system to focus on admission avoidance and the two-hour rapid response.

- The meeting was advised that this item could be discussed further at a future development session.
- Multi-agency working was acknowledged to be stronger than in previous years and system colleagues where commended for all their hard work.

The Joint Health & Wellbeing Board and Integrated Care Partnership agreed to retrospectively approve the plan on the Adult Social Care Discharge Fund 2022/2023.

8. HWB ICP Forward Agenda Plan

The Joint Health & Wellbeing Board and Integrated Care Partnerships received and noted the Forward Agenda Plan.

9. AOB

There was no further business to be discussed.

10. Date of the next meeting

The date of the next meeting was confirmed as Friday 21st July at 10:30 am.

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13 April 2023
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Agenda Item No:

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Health and Wellbeing Board / Integrated Care Partnership Annual Report 2022-23

To:	County Council
Meeting Date:	
From:	Chair of the Health and Wellbeing Board
Electoral division(s):	All
Key decision:	No
Forward Plan ref:	N/A
Outcome:	The Health and Wellbeing Board / Integrated Care Partnership presents an annual report to Full Council, outlining the work the board has undertaken throughout the year.
Recommendation:	The HWB is requested to review and comment on the Annual Report for 2022/23 before its submission to both local authority Full Council meetings in October 2023.

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April 2023

Health and Wellbeing Board
and
Integrated Care Partnership
Annual Report 2022-23

1. Background

1.1 Under the Health and Social Care Act 2012 Upper Tier Local Authorities have a statutory function to have Health and Wellbeing Board (HWB) as a formal committee of the local authority. Health and Wellbeing Boards have a vital role in promoting greater integration and partnership between bodies from the NHS, public health and local government. They have a statutory duty, with the former clinical commission groups (now the Integrated Care System) to produce a joint strategic needs assessment and a joint health and wellbeing strategy for their local population.

1.2 The landscape for HWBs has changed dramatically with the formation of the Integrated Care System nationally. Consideration was therefore given to how existing arrangements can provide the opportunity to build greater alignment between different system partners locally. Formal joint working relationships between Peterborough City Council and Cambridgeshire County Council were already in place in 2019 and in 2022 the establishment of a Joint Cambridgeshire and Peterborough Health and Wellbeing Board was agreed by both Upper Tier Local Authorities.

1.3 Development and Relationship with the Integrated Care Partnership

The White paper on Integration and Innovation: Working together to improve health and social care (published in 2021) establishes Integrated Care Systems (ICSs) on a statutory footing through both the NHS Integrated Care Board and an Integrated Care Partnership (ICP). Guidance from the DHSC issued in September 2021 made it clear that HWBs cannot act as ICPs because they are separate legal entities however, they may work in alignment allowing for continued focus on the wider determinants of health. It was agreed through the revised Terms of Reference that the Cambridgeshire & Peterborough Health and Wellbeing Board and the Cambridgeshire & Peterborough Integrated Care Partnership would be independent boards with shared agendas, aligned membership and meeting together. This approach reflects a genuine ambition across our local health and care system to develop innovative ways of working together.

2. Development of the Health and Wellbeing Integrated Care Strategy

2.1 The Integrated Care Partnership (ICP) is accountable for the delivery of the Integrated Care Strategy. The Health and Wellbeing Board is required to produce a health and wellbeing strategy. Following a series of workshops in late 2021/22 system partners a decision was made to use the Health and Wellbeing Strategy to form the basis of the Integrated Care Strategy, namely a Health & Wellbeing Integrated Care Strategy for Cambridgeshire & Peterborough.

2.2 Guidance published by the Department of Health and Social Care (DHSC) in November 2022 states HWBs will need to consider the integrated care strategies when preparing their

own strategy to ensure they are complementary. Conversely, HWBs should be active participants in the development of the Integrated Care Strategy as this may also be useful for HWBs to consider in their development of their strategy. Our local approach to a Joint Health and Wellbeing Integrated Care Board has enabled a strong active participation from a range of organisations that have an interest in the health, care and wellbeing of people and communities across Cambridgeshire and Peterborough.

2.3 Locally, system partners agreed they will have a shared Cambridgeshire and Peterborough Health and Wellbeing Integrated Care Strategy, owned by the whole system, that is based on the needs identified from the Joint Strategic Needs Assessments (JSNAs). The overarching goals and four contributing priorities were identified at development days in late 2021 and early 2022 with system partners, including HWB members, the Combined Authority, Clinical Commissioning Group and other emerging ICP membership. Subsequent events were held with District Council representatives in June and October 2022.

2.4 Work was undertaken with colleagues in the Integrated Care System to join up the engagement around the Health & Wellbeing Strategy priorities (July – Sept 2022) with the process around the wider Let's Talk: Your health and care campaign (Oct – Nov 2022).

2.5 <u>Let's Talk: Your health and Care</u>

Our "let's Talk: Your Health and Care" campaign was launched on 7th October 2022 to inform the content and ambitions of the Health and Wellbeing Integrated Care Strategy. It was the first large scale engagement campaign launched since the ICS was formed on the 1st July 2022. The aim was to reach a wide cross section of our community and to focus on hearing from communities whose voices we hear less often.

2.6 Feedback through the various events and workshops, including district council meetings, resulted in the importance of developing and identifying a shared leadership of the health and wellbeing priority areas. Our HWB priorities were developed during the engagement phase and to demonstrate the value of working at a system level senior responsible officers (SROs) from across the Cambridgeshire and Peterborough system were identified as leading on specific priority areas. Feedback from the various events including the district council workshops resulted in clarity around the ambitions and priority areas.

2.7 The HWB / Integrated Care Partnership identified three ambitions and four priority areas:

Our ambitions for 2030:

1. We will increase the number of years that people spend in good health.
2. We will reduce inequalities and preventable deaths before the age of 75.
3. We will achieve better outcomes for our children.

Priority areas and Senior Responsible Officers (SROs)

- **Priority 1**: Ensure our children are ready to enter education and exit, prepared for the next phase of their lives
  SRO: Matthew Winn (CEO) Cambridgeshire Community Services with Jonathan Lewis (Service Director Education) Cambridgeshire County Council and Peterborough City Council

- **Priority 2:** Create an environment to give people the opportunities to be as healthy as they can be.
  SRO: Jyoti Atri (Director of Public Health) Cambridgeshire County Council and Peterborough City Council with
  Louis Kamfer (Deputy CEO) Integrated Care System

- **Priority 3:** Reduce poverty through better employment, skills and better housing.
  SRO: Jo Lancaster (MD)* Huntingdonshire District Council and
  Liz Watts (CEO) South Cambs District Council **with**
  Fliss Miller Associate Director of Skills, C&P Combined Authority

*Oliver Morley (Interim MD) Huntingdonshire District Council has taken on this role since Feb 2023.

- **Priority 4:** Promote early intervention and prevention measures to improve mental health and wellbeing.
  SRO: Vicki Evans (Assistant Chief Constable) Cambridgeshire & Peterborough Constabulary with Stephen Legood, Director of People and Business Development, Cambridgeshire and Peterborough NHS Foundation Trust.

The diversity of leadership across a broad range of organisations is reflective of our Integrated Partnership. It also ensures the strategy development is truly integrated across Cambridgeshire and Peterborough, with shared ownership amongst healthcare and wider sectors. SROs roles and responsibilities were drawn up and each priority was allocated a senior public health lead to support the priority development of action plans.

2.8 HWB Priority Action Plans – Progress

Year 1 has largely been about scoping the priorities. This involved initial work on understanding what was already in place, current needs and areas for development. This work led to the development of plans for each of the priorities with the identification of early wins. The HWB ICP board received action plans from each of the priorities at their meeting in March 2023. The priority groups have now begun to deliver some progress against identified early wins, however more time is needed to deliver against some of our long-term ambitious outcomes. Some examples of achievements to date are provided below.

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

Entering Education

- Healthy Start Vitamins are now available in Child and Family Centres, this will support families who are struggling with the cost of living and improve nutritional intake for children in their early years.
- Start for Life offer has been published which sets out the services and support available to families from pregnancy to their child's second birthday Family Hubs - Start for Life offer - Cambridgeshire County Council; Family Hubs - Start for Life offer - Peterborough City Council (contensis.cloud). These will support families in improving health and development outcomes, laying the foundations for a good start to education.

April 2023

- Procurement is underway for “Community Infant Feeding and Emotional wellbeing Peer support service”
- A 4-week antenatal education programme “Pathway to Parenting” has been rolled out across all districts and Peterborough.
- In South Cambridgeshire the ‘#Free to Feed’ encouraging breast feeding across all hospitality venues has been established and roll out is underway in East Cambridgeshire and Peterborough.
- In July 23 a website to enable families to find appropriate infant feeding community support in their area is due to launch

Exiting Education

- New School Aged Health Transformation Board is being set up ready for September 2023, the aim of this is to draw together resources in order to improve outcomes for school aged children and prepare them for their onward journey
- Commissioning with VCSEs for additional preventative programmes has been undertaken e.g. Acorn, Fullscope, Red Hen, Romsey Mill, the Kite Trust and Branching Out.
- Focus of increasing apprenticeships in Anchor Institutions has been included in the Cambridgeshire and Peterborough Joint Forward Plan (Anchor institutes are: Councils, Combined Authority, NHS, Commissioned services)

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

The HWB ICP agreed to focus on tackling obesity in the first couple of years of the strategy. It is our ambition to use the opportunity afforded by the Joint Health and Wellbeing Integrated Care Strategy of incorporating ‘systems thinking’ into the approach.

- A delivery group for this work has been established with identified leads for the main areas of delivery e.g. schools, children's services, planners in local authorities and other voluntary services.
- A summit is planned from October / November and will bring evidence from national experts and from our local research along with local leaders and services to plan year 2 activity.
- Procurement is underway for behavioural insights research with the contract award expected at the end of July 2023. This will give us the information we need to shape our interventions to be effective.

Develop Improvements in the internal and external food environment

- Evidence review of environmental factors has been completed along with the school food survey which will be used as part of the local evidence for the summit (see above)

Increasing physical activity in schools

- A new safer street project to promote active travel and no-car zones around schools has been commissioned in Cambridgeshire.

- A schools fund has been established for schools to bid into and secure incentives if successful with projects to increase physical activity in schools and healthy eating practices

Develop integrated evidence-based interventions for the behavioural and clinical treatment/ management of obesity and associated clinical risk factors.

- A Local Enhanced Service specification has been developed for GPs to routinely with patients and identify / manage patients with hypertension and hyperlipidaemia.
- Increased access to weight management services through additional commissioning of adult and childhood weight management services.
- Uptake of adult weight management has increased significantly for 2022-23. For Cambridgeshire 2788 which was 140% of the target and 49% of completers achieved a 5% weight loss (national target is 30%). For Peterborough 851 started on a programme which was 121% of the target and 45% of completers achieved a 5% weight loss.

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

Reduce Poverty through Housing

- A Housing and Health summit was held in early 2023 with a range of stakeholders resulting in the production of a 2 year action plan.
- To inform the need for key working housing for staff working across the integrated care system (ICS) a key worker housing survey is underway.
- The ICS is working with District and City Councils on NHS infrastructure needs for NHS estates across Cambridgeshire and Peterborough.
- Investigations into digital connectivity is in progress.
- From July/ August 23 a check list for front line workers to identify cold, damp, mouldy homes will be trialled in Cambridge City.

Reduce Poverty through Employment and Health

- Primary care and employers have been consulted regarding the integration of services and their role in the development of a new integrated pathway to employment.
- Across Cambridgeshire and Peterborough mapping of services and hubs has been completed and funding has been secured to pilot an integrated model in two locations using existing hubs.
- Pilots have been progressed in Cambridge City and Fenland using a logic model, engagement with partners a project plan is in place.
- Development of an alternative model to pilot in Peterborough is underway.
- A marketplace event is planned for Autumn 2023 for employers to meet NHS and Local Authority leads to explore workplace models.
- Agreement to develop tools to support Small Medium Employers to adopt process to support and help employees experiencing health and disability.

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

- A mental health summit was attended in early 2023 with attendance from a range of groups and organisations across our system of care. There was strong representation from the community and voluntary sector organisations working in mental health and wellbeing. The summit began the process of mapping and scoping each of our four-priority themed areas; communications and information, enhancing relationships, motivation and wider mental health determinants.
- Preventative programmes to improve children and young peoples mental health and wellbeing are being expanded .e.g. Nessie (support for families of children and young people with mental health issues, self-harm or school avoidance), PSHE (anti-bullying training for primary schools), PEDs (eating disorders training)
- Commissioning with VCSEs for additional preventative programmes has been undertaken e.g. Acorn, Fullscope, Red Hen, Romsey Mill, the Kite Trust and Branching Out.
- Small grant funding programme has been set which funds a range of community activities linking to the four themed workstream areas in the mental health priority. These will help to explore and grow the evidence base for what works and what can be done locally to promote better mental health wellbeing and support children, young people and families.
- Exploring links to ensure that the HWB/ICS mental health prevention priority has recognition and equal positioning within the ABU structures as the other mental health boards. This also includes setting up steering group that will govern the progress of the workstreams

2.9 The above examples illustrate good progress over the last year in not only producing a joint Health and Wellbeing Integrated Care Strategy for Cambridgeshire and Peterborough but also starting to deliver on the ambitions. More work is required in 2023/24 to agree what measures are appropriate for the HWB Integrated strategy. The Public Health Intelligence team will be working on agreeing targets for improvement over the duration of the strategy.

3. Better Care Fund

3.1 The Better Care Fund (BCF), operating since 2014-15, is the government's national vehicles for driving health and social care integration. Spanning the NHS and local government the BCF seeks to join up health and care services, so that people can manage their own health and wellbeing and live independently in their communities for as long as possible. It requires integrated care boards (ICBs) and local government to agree a joint plan, owned by health and wellbeing board (HWB). These are joint plans for using pooled budgets to support integration governed by the agreement under section 75 of the NHS Act (2006).

3.2 <u>Adult Social Care Discharge Fund</u>

In September 2022, the Department of Health and Social Care (DHSC) announced its plans for patients committing £500m of funding to support timely and safe discharge from hospital into the community by reducing the number of people delayed in hospital awaiting social care. This equates to £7M local funding for Cambridgeshire & Peterborough. The focus on

the Adult Social Care Discharge fund is on but not limited to a 'home first' approach and discharge to assess.

In addition to national requirements, Cambridgeshire and Peterborough ICS and the local authorities agreed a set of principles for using the funding as set out below:

- Provide additionality beyond what is already in place.
- Be feasible / deliverable in the short term.
- Deliver sustainable impact, beyond the initial investment.
- Underpinned by data / evidence of need.
- Support system priority areas.
- Enable system to apply learning from previous initiatives.

3.3 Better Care Fund & Adult Social Discharge Fund Outputs

- The Adult Social Care Discharge invested an additional £7m into discharge support over the winter months 2022/23 which included:

  - £1M in the voluntary sector to commission a single point of access for discharge, work is underway with the voluntary sector alliance around developing and implementing the service model.
  - **Increased staffing capacity** in several areas, including transfer of care teams and brokerage:
  - **Community equipment;** 124 same day orders to support discharges (99% of same day deliveries met)
    - Additional 1,544 hours of broker capacity to place care when people are discharged.
    - Additional 2,454 reablement staffing hours
    - Increase by 6.8% in reablement hours of care delivered in Jan-Mar (compared to previous quarter)

  - **Rapid Incentive Payment:** During Jan -March 2023 rapid incentive payments were distributed to 5 care homes (within 48hrs) and 8 home care (within 24 hours) which supported a more rapid discharge for these more complex cases.
  - **Spot purchasing of care to support discharges** 24 care home beds and 2,733 spot purchased to support discharges in Peterborough
  - **Additional Patient Transport:** 339 journeys supporting discharge and A&E

- Between January and May 2023, a 22% reduction in numbers of patients with a Length of Stay >14 days post clinically fit date as well as a 21% reduction in stranded patients during the same period.

- The disabled facilities grant resulted in 644 people having a home adaptation and were supported to stay in their own home. (See Case study)

- Development of community and voluntary sector
  - £2m Healthier Future Funds
  - £275k Care Together grant funding distributed to a range of small local community groups. These projects will enable local groups and organisations to support

increasing numbers of older adults to do the things that the want tod in the place they call home, with the people they want to do them with. This is part of the vision for the Care Together programme.

- BCF 2022/23 funded reablement delivered:
  - In Peterborough – 19,707 care hours were delivered, 29,098 visits made and 731 clients supported. There was no ongoing care for 78.8% of cases
  - In Cambridgeshire – 202,282 care hours were delivered, 345,906 visits made

Case Study

Adaptations to Facilitate Discharge from PJ Care Neurological Centre

Mr B had a right sided brain haemorrhage in March 2019. This had a significant effect on his cognition and since his initial brain injury, his ability to engage further, deteriorated. Mr B is in a minimally aware state. He does not communicate, respond to any auditory or visual stimulus, initiate any activity, or have any active movement. He is considered to have a significant cognitive impairment.
Mr B is a full-time wheelchair user, is unable to weight bear and is fully hoisted for all transfers. He requires tilt and space seating and shower chair. He was discharged from hospital into PJ Care Neurological Centre, but his mother had secured a 2-bedroom bungalow from Cross Keys Homes and was desperate for him to be at home and cared for by her.

A feasibility visit took place and it was agreed to replace the existing low level shower tray with a level access shower; widen the bathroom doorway and install a sliding door to maximise space within the shower room for his tilt and space shower chair; widen both the living room doorway and bedroom doorway; re-site the radiator in the hall and reduce the size of the meter cupboard to maximise hallway space, install an internal threshold fillet at the front door to improve wheelchair access and install a ceiling track hoist in the bedroom. This work amounted to approximately £10,000 and was funded through the mandatory Disabled Facility Grant.

The application for grant funding was made on the 7th March 2022 and the work was completed on the 7th April 2022. In just 4 weeks, Mr B was able to be cared for at home by his mother in a full wheelchair accessible property. Mr B's mother commented "*We want to thank your amazing team. You made a very nice bungalow for J*

Case Study

An 87 year old woman with multiple LTCs had recently moved house and when contacted as part of the Winter Pressures Project said she would like some support. The personalised conversation about what mattered to her flagged that:

- her new housing better met her physical needs but she was still very lonely and worried about the future
- she was sleeping in her chair at night which raised concerns around her COPD and respiratory compromise
- she had previously refused a wheelchair because she was scared of going out which also meant she had not received her COVID-19 vaccination.

Bringing together partners at the Central Health and Wellbeing Hub allowed a different conversation to take place, flagging that:

- while she did not meet the financial thresholds for social care there were other options to support her
- she had not had a COPD review in a while and needed one
- a COVID-19 vaccination was needed but it was recognised that the root cause was that she was fearful of going out and not easily able to access the community which needed to be addressed
- voluntary and community sector partners identified a range of support to help reduce her social isolation and focus on what mattered to her – i.e. mobile library, warden scheme, befriending, and how to support her with accessing the community and
- a personal budget can now be used to provide a wheelchair to help improve her access to the community and support/services.

What was different and how we want to work differently:

- Facilitating open conversations and focusing on what mattered to the person
- Health, social care and voluntary and community sector professionals came together having a different discussion and identified gaps and opportunities for support that no one organisation could have done alone
- Preventative support could be put in place around LTCs and vaccination and wider health and wellbeing support could be put in place before the point of crisis.

4. Joint Forward Plan (JFP)

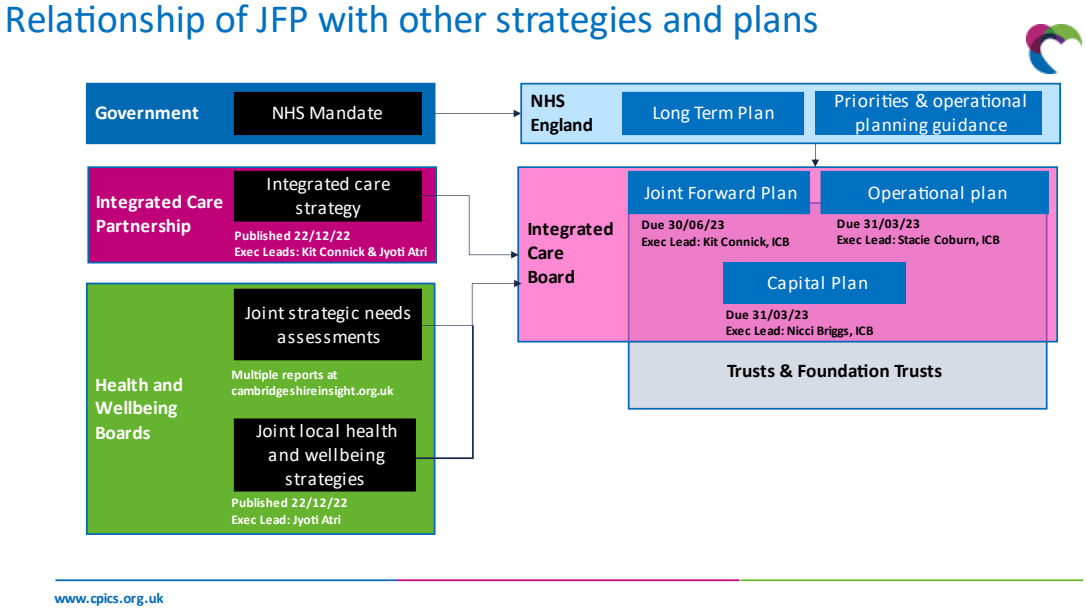
4.1 The Integrated Care Boards (ICBs) and their partner NHS Trusts and Foundation Trusts are required to prepare a five-year Joint Forward Plan (JFP). Systems have flexibility to determine the scope of their JFP but as a minimum the JFP should describe how the ICB and partner trusts intend to arrange and / or provide NHS services to meet their population's physical and mental health needs. The plan and its delivery sits with the ICB and its partner trusts.

4.2 The five year Joint Forward Plan is part of the overall strategic framework within which the ICB operates. It addresses the specific NHS operational priorities as well as contributing to wider system priorities. This means that JFP should outline how the NHS partners will contribute to the delivery of priorities in the Joint Health and Wellbeing Integrated Care Strategies and nationally defined NHS priorities.

4.3 The Cambridgeshire & Peterborough Joint Forward Plan was developed with significant engagement of partners across the system. The Joint HWB Integrated Care Partnership had a key role in this engagement and was involved in providing input into the development of the JFP during the past few months. Update reports were received by board members at regular intervals, and it was agreed that an interactive development session would benefit all members. This was held on 6th June 2023 (see Section 6.1) and provided the opportunity to examine the plan and how it related to the HWB Integrated Care Strategy. Following the development session the JFP was signed off with delegated authority to the

HWB/ICP chairs on the 6th June 2023. The JFP was formally ratified by the ICB on 30th June.

4.4 The complex integrated relationships of the JFP with the Health and Wellbeing Board and Integrated Care strategies is demonstrated in the diagram below. Our current arrangements for a Joint Health and Wellbeing Integrated Care Partnership have enabled a more integrated approach to developing local strategies and plans.



5. Pharmaceutical Needs Assessment (PNA)

5.1 Under Section 128A of the NHS Act 2006 each HWB has a statutory duty to assess the needs for pharmaceutical services in its area and publish a statement of its first assessment and of any revised versions. This statement is referred to as the Pharmaceutical Needs Assessment (PNA).

The PNA is a statutory requirement every three years but in Cambridgeshire and Peterborough like many other places the process was paused during the Covid-19 pandemic. In June 2022 the PNA went out for public consultation for 60 days, seeking the views on whether the public agree that no more pharmacies are needed over the next three years, how often and what times people prefer to access pharmacy services, what services people use pharmacies for and how do people normally travel to pharmacies.

5.2 <u>Outcomes from the Cambridgeshire & Peterborough Pharmaceutical Needs Assessment</u>

The main outcome of the consultation with a range of stakeholders, residents and pharmacy providers was that there was no need for additional pharmacies in Peterborough and Cambridgeshire. With 88% of respondents think pharmacy services are available at convenient opening hours. However, it was concluded that there had been a reduction in opening hours of pharmacies which may lead to reduction in access in future years.

April 2023

The full report can be found on the link below:
Joint Cambridgeshire & Peterborough Health & Wellbeing Board/ICP | CPICS Website

Since the PNA was approved by the HWB Integrated Care Partnership there have been some national changes. In January 2023 it was announced that Lloyds pharmacy is to shut down 237 branches within Sainsbury's supermarkets. More recently on the 28th June 2023, Boots has announced that it will close 300 locations in the UK explaining that it plans to consolidate a number of stores in close proximity to each other. Details of locations are currently not available. Therefore we do not know the impact on Cambridgeshire and Peterborough of these closures and this will have to be considered carefully over the next year.

6. Areas Of Development and Future Focus

6.1 As a newly formed joint HWB and Integrated Care Partnership consideration over the last year has been given to ensuring that the members of the board build effective working relationships and work together effectively towards common goals across a single footprint. An initial development session was held in October 2021 to set out this ambition. Member feedback has positively promoted the use of development sessions to facilitate wider understanding of the system issues for board members which have continued alongside formal meetings to build on our work together.

6.2 We have had a number of well attended development sessions which started in 2022 with the wider engagement of our District and City Council colleagues in Cambridgeshire. The first event in May 2022 was part of the initial engagement around the HWB Integrated Care Strategy four priorities. The second event in June 2022 included representation from the ICS accountable business units (ABUs) and focused on the development of the four priority areas in the strategy.

6.3 A number of development sessions have been provided to board members and these included in January 2023 a discussion on universal and targeted approaches to the Health and Wellbeing priorities led by the Director of Public Health. In March colleagues in the ICS provided an online session on the ICB governance strategy and decision making processes.

6.4 Following completion of the HWB ICP Priority action plans a workshop with the SROs, Public Health leads and representatives from the Accountable Business Units (ABUs) was held to examine the areas of crossover themes emerging from the defined four priority action plans. The workshop started the process of ensuring a co-ordinated approach to working with stakeholders across the system.

6.4 Plans for 2023 / 2024

In September 2023 a Joint Strategic Needs Assessment (JSNA) development session is being planned to demonstrate our new web-based interactive approach to an overarching JSNA for Cambridgeshire and Peterborough. This will help us gather insight into what is most useful for business planning and decision making but will also help us shape the further development of the HWB Integrated Care Strategy.

April 2023

Section 2.9 has described some of the work needed to measure how we know we are making progress and what expected areas of improvement we should start to see in the next few years.

7. Significant Implications

7.1 Resources
There are no direct resource implications as a result of this report.

7.2 Statutory, Legal and Risk Implications
There are no direct statutory, legal and risk implications as a result of this report.

7.3 Equality and Diversity Implications
There are no direct implications as a result of this report.

This report has been signed off by the Executive Director of Public Health.

8. Source Documents

8.1 HWB Integrated Care Partnership Key Documents

Joint Health & Wellbeing Integrated Care Strategy
Joint Health and Wellbeing Integrated Care Strategy - Cambridgeshire County Council

Health and Wellbeing Board agendas and minutes
Joint Cambridgeshire & Peterborough Health & Wellbeing Board/ICP | CPICS Website

Let's Talk Engagement Campaign
Let's Talk: Your Health & Care | CPICS Website

Guidance Documents

White Paper on Health and social care integration
Health and social care integration: joining up care for people, places and populations - GOV.UK (www.gov.uk)

Health & Wellbeing Board Guidance
Health and wellbeing boards: draft guidance for engagement - GOV.UK (www.gov.uk)

Better Care Fund
2022 to 2023 Better Care Fund policy framework - GOV.UK (www.gov.uk)

April 2023

Health and Well Being and Integrated Care System Board

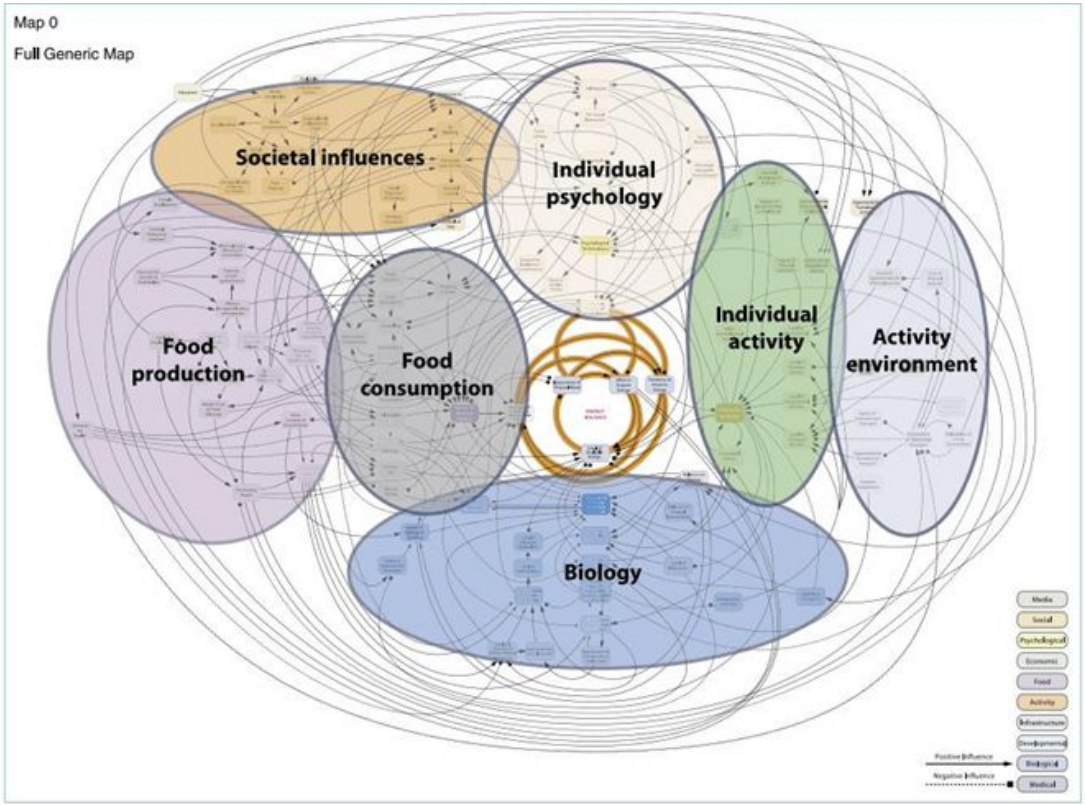
Progress Report Priority 2- Environment/Obesity

July 21 2023

Cambridgeshire & Peterborough Integrated Care System

Cambridgeshire County Council

PETERBOROUGH CITY COUNCIL



What the Strategy says:

Our approach

Pragmatic approach to universal and targeted approaches that meets the needs of the population and different communities.

Adoption of local strategies, policies and investment that tackle the obesogenic environment and support the adoption of healthier behaviours

Develop and establish interventions based on evidence based behavioural insights that drive positive health related behaviours .

Early years and school-based interventions to:

- **Improve the internal and external food environment: school food survey, fast food free zones, reduction in local advertising.**
- **Increase physical activity in schools: active travel.**

Identify the financial, cultural, emotional, peer pressure etc. barriers to adopting healthy behaviours:

- **Commission behavioural insights research to identify barriers to behaviour change.**
- **Develop Behaviour Insight research-based interventions that have impact and traction on health behaviours.**

Increase the identification and management of obesity and related health conditions:

- **Establish in primary care routine weighing of patients.**
- **Develop integrated evidence-based interventions for the behavioural and clinical treatment/management of obesity and associated clinical risk factors and mental health.**

Preparing for delivery 2023/24

Focus

- Children and Young People
- Obesity and clinical risk factors

Target setting and evidence

- Evidence review
- Behaviour science research
- School Food Survey
- Needs assessment

Engagement

- Key partners, oversight delivery group
- Summit Autumn 2023

New interventions

In place and planned

Refining our targets

Achieve a 5% decrease in childhood overweight/obesity by 2030.

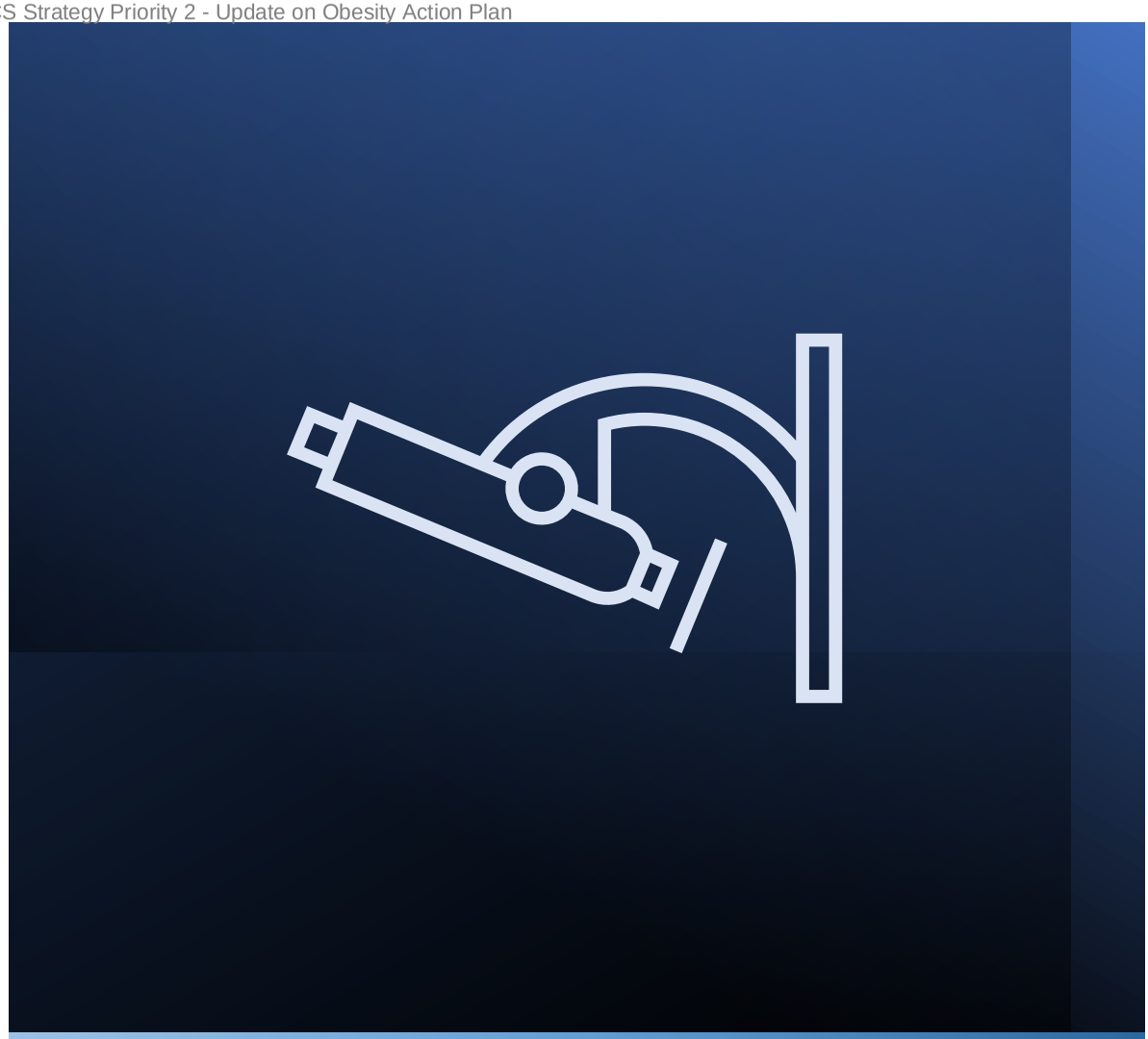
Reduce childhood overweight/obesity rates to pre-COVID-19 pandemic levels by 2026.

Reduce adult overweight/obesity rates to pre-COVID pandemic levels by 2030.

20% more children meet the physical activity recommendations by 2030.

Achieve a 10% increase in the number of adults who undertake 150 minutes of physical activity per week by 2030.

Reduce inequalities in overweight/obesity.



Evidence for Change

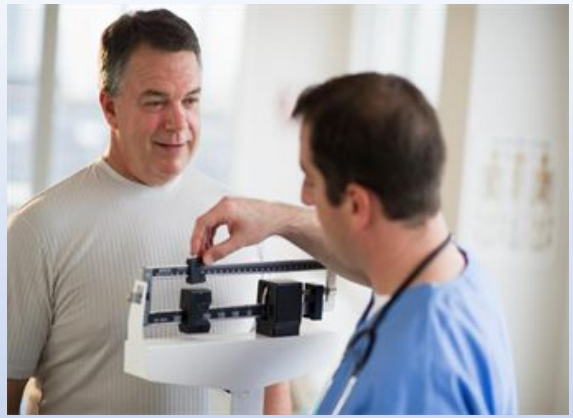
What have we done so far?

Evidence review: the built & food environments

- Built e.g. active travel
- Food e.g. schools, hospitals

Behaviours

- Behaviour science research commissioned: motivators for behaviour
- Behaviour change services needs assessment: qualitative information
- School Food Survey



Obesity related clinical risk factors

- GP Local Enhanced Services contract – patient weighing BP and cholesterol
- NHS Health Checks expanded
- NHS Forward Plan – focus on obesity and risk factors

Engaging partners

- **Organisation leads identified to form Delivery Oversight Group**
- **Project incentives**
- **Planned Summit for Autumn 2023**

What else this year?

In place

- Expansion of Active Travel programmes
- School based innovation fund for physical activity
- Increase in children's and adult weight management intervention/services: additional commissioned services, very low-calorie diets pilot, new drug therapies

Planned

- NHS/LA workforce programme: workplace support for weight management
- NHS food environment: reducing fast food options
- Autumn Summit – bring together national and local expertise/evidence to plan priorities and actions for 2024 onwards


Built and Food Environments: Content and timelines for Local Plans
System wide issues: e.g. cost of living/inflation, workforce capacity
Changing policies and practice: e.g. schools including academies, special schools, food concourses e.g. NHS Services
NHS/LA workforce: onsite access to weight management, physical activity, healthy food options
CHALLENGES! Our immediate priorities! that require Board and system-wide support for implementation
Obesity and associated risk factors: primary care active engagement
Interdependencies across the priorities: Embedding, owning, differing development stages
Autumn Summit: commitment to attendance and subsequent action

Challenge example: School Food Survey and implications for schools

Positives

- Onsite school provision overall healthy & pupil-centred
- Whole school approach

Challenges

- Shorter lunchtimes (learning time demands) impacting mealtime environment and food provision
- External food environments
- Financial pressures impacting on food provision. Some evidence that areas of deprivation experience them more, but the pressures are universal

Support required for mitigation/change

- Good nutrition key to learning outcomes – investment in school meals
- Increased engagement with parents/carers, increased information, monitoring/incentives of packed lunches. Penalizes low-income families.
- Producing larger numbers of meals makes each meal cheaper
- Shared catering with other schools, reduction in fixed costs and buying power increased
- Market research analysis for best catering options and to secure best value for money
- "Smart" cooking allows food to be carried over to another day, measuring wastage to gauge meal popularity to inform planning and reduce costs
- Increase uptake of school meals – 4,642 pupils eligible for school meals do not take them up, new approach to promoting them is required.
- External food environment: planning authorities

Cambridgeshire & Peterborough Integrated Care System

Cambridgeshire County Council

PETERBOROUGH CITY COUNCIL

4

Agenda Item No:

Report title: Progress Report Priority 2 Environment/Obesity Priority 2023/24

To:	Cambridgeshire and Peterborough Health & Wellbeing Board / Integrated Care Partnership
Meeting Date:	July 21, 2023
From:	Jyoti Atri (Director of Public Health – CCC & PCC), Louis Kamfer (Deputy CEO & Managing Director of Strategic Commissioning – ICS)
Outcome:	This paper is to provide the Board with a progress update on the action plan for delivering the ambitions for the Environment/Obesity Priority. 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. b) Identify how the HWB/ICP and wider system can provide support to progress the areas identified in the paper and accompanying presentation.

Officer contact:
Name: Val Thomas
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Email: val.thomas@cambridgeshire.gov.uk
Tel: 07884 183374

Member contacts:
Names: John O'Brien (ICP), Councillors Wayne Fitzgerald (PCC) & Susan van de Ven (CCC)
Post: Lead Members for Health and Wellbeing
Email: john.obrien5@nhs.net; susan.vandeven@cambridgeshire.gov.uk; wayne.fitzgerald@peterborough.gov.uk
Tel: 07592 594776 and 01223 706398 (office)

1. Background

1.1 The HWB has requested that each of the priority areas provide an update on progress against the delivery of their action plans.

1.2 The report describes progress that has been made against the 2023/24 delivery plan for the Environment /Obesity priority. The action plan has previously been presented to the HWB and is outlined in the slides attached to this paper.

2. Main Issues

2.1 The Environment/Obesity Action in its first year is focused upon children and young people along with obesity related cardio-vascular risk factors.

2.2 This first year is about collecting intelligence to inform and develop interventions but also engagement with partner organisations from across the system that have key roles in delivering the obesity ambition.

2.3 We reviewed the evidence base for interventions especially in relation to environmental factors that influence behaviours. In support of this we have commissioned behavioural insight research that will provide an understanding of the motivators for health-related behaviours. Later in the year we will be undertaking a needs assessment for the re-commissioning of our current behaviour change services that will include qualitative research which will increase the richness of the intelligence. These developments will be triangulated to inform interventions.

2.4 Schools are key environments for shaping children and young people's behaviours. We have completed a survey of the policies and practices relating to the school food environment in schools across Cambridgeshire and Peterborough. The key results can be found in the slides that accompany this paper.

2.5 In terms of new specific projects an innovation fund for primary schools across Cambridgeshire and Peterborough has been established for them to introduce physical activity and nutrition interventions in schools. Schools with projects that evaluate positively will receive an incentive payment.

2.6 In recent years there has been a focus upon Active Travel which has been further developed this year and a project that addresses car use in the vicinity of schools will shortly be launched.

2.7 Work is underway with planning authorities to influence their Local Plans, which are able shape local food environments as well as opportunities for Active Travel. This however is a longer-term ambition due to the need to garner support from different stakeholders and schedules for new plans are long term and do necessarily align with the Strategy timetable.

2.8 Addressing obesity related clinical risk factors has been progressed through working with primary care. A GP contract known a Local Enhanced Service (LES) has been developed whereby practices will weigh their patients and identify any high blood pressure (hypertension) and high cholesterol levels. This will receive final sign off by the Local Medical Committee and ICB in September for implementation from October.

2.9 The expansion and focus upon NHS Health Checks through different commissioning approaches and the NHS Forward Plan also impacts on obesity and associated risk factors.

2.10 The strategic approach for obesity is weighted towards prevention but it does include treatment. Additional weight management services/interventions have been commissioned for adults and children. For adult services this includes the introduction of new NICE approved drug treatments that are associated with improved outcomes but there are concerns about demand and cost along with the potential for longer term treatment being considered.

2.11 Also planned for this year.

- NHS/LA workforce programme: workplace support for weight management
- NHS food environment: reducing fast food options.

2.12 Securing the support of partners across the system and identifying leads from different sectors has been part of the process of ensuring system wide support and participation in delivering the action plan. These leads represent the key areas and will review and reflect on the information collected during this first year to develop and implement plans for subsequent years.
To socialise this work across the system we are planning a Summit for the autumn that will bring together our collected local evidence with national and local leads from academia along with organisations that have implemented innovative new approaches. It will provide the opportunity to review and reflect on the intelligence which will inform and clarify our focus, interventions, and the barriers.

2.l3 The evidence/intelligence that we have collected, and the planned interventions require support from the HWB and ICP along with the wider system. The immediate priorities are found in the accompanying slide set and include organisational/planning policies, specific interventions, and engagement challenges.

There are system wide challenges that all organisations and local communities are experiencing. Workforce capacity and cost living/inflation pressures can be demotivating and affect the development of new initiatives. These cost-of-living pressures also affect the choices people make about what they eat and the activities in which they participate. The Local Plans that can shape the built and food environments have lengthy timescales and considerable efforts are necessary to ensure that all partners support any evidence-based recommendations.

2.14 A challenge shared by all the priorities is to ensure that their interdependencies are identified. That there is a commitment where ambitions are shared to delivering interventions that complement and increase impact across the different priorities. Work has commenced but delivery groups are at different stages which makes it important that communication between the priority groups is proactive and transparent.

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

3.1 This recommendation is relevant to priorities (XXX) 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 Resources

This report does not address the financial implications of recommendations. However it does refer to the cost of living and workforce pressures (2.12) that are impacting upon delivery

4.2 Statutory, Legal and Risk Implications

Implementation of activities in this report will include where appropriate assessment of any statutory, legal and risk implications to ensure that any mandatory requirements are met, and risks are mitigated.

4.3 Equality and Diversity Implications

Implementation of any of the activities described in this report will have due regard to the Council's equalities duties under the Equality Act 2010 and where appropriate a community impact assessment will be completed.

This report has been signed off by the Executive Director of Public Health.

5. Appendices

5.1 Presentation Slides to complement this Report.

6. Source documents

6.1 Source documents

Cambridgeshire and Peterborough Joint Health and Well Being / Integrated Care Strategy (Priority 2 Strategy and Action Plan)
Joint Health and Wellbeing Integrated Care Strategy - Cambridgeshire County Council

NHS Forward Plan. NHS England » NHS Long Term Plan
A Review into Early Years & School Food Provision June 2023. PAG Consultancy- not yet published.

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)

Cambridgeshire & Peterborough Integrated Care System

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5

Cambridgeshire and Peterborough Joint Forward Plan

To:	Cambridgeshire and Peterborough Health & Wellbeing Board / Integrated Care Partnership
Meeting Date:	21st July 2023
From:	Kit Connick (Chief Officer of Strategy and Partnerships – ICB)
Outcome:	To receive the Joint Forward Plan for Cambridgeshire & Peterborough ICS
Recommendation:	The HWB /ICP is being asked to note the report around the ICS Joint Forward Plan (JFP): a) to **note** the outcomes from the Health & Wellbeing Board / Integrated Care Partnership Development Session b) to **note** the approval of the JFP by the Integrated Care Board, and c) to **note** the next steps in progressing the Joint Forward Plan

Officer contact:
Name: Kit Connick
Post: Chief Officer of Strategy and Partnerships – ICB
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Member contacts:
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Post: Lead Members for Health and Wellbeing
Email: john.obrien5@nhs.net;wayne.fitzgerald@peterborough.gov.uk ; susan.vandeven@cambridgeshire.gov.uk
Tel: 07592 594776 and 01223 706398 (office)

1. Background

1.1 Integrated Care Boards (ICBs) and their partner NHS Trusts and Foundation Trusts are required to prepare a five-year Joint Forward Plan (JFP) before the start of the financial year. For this first year, the publication deadline is 30 June 2023. The first draft was submitted on 30th March 2023.

1.2 Systems have flexibility to determine the scope of their Joint Forward Plan. Whilst the guidance is comprehensive in the list of recommended content, as a minimum, the JFP should describe how the ICB and its partner trusts intend to arrange and/or provide NHS services to meet their population's physical and mental health needs, including delivering the universal NHS commitments, addressing the ICS's four core purposes and meeting legal requirements.

1.3 The five-year Joint Forward Plan fits as part of the overall strategic framework within which the ICB operates. It addresses the specific NHS operational priorities, as well as contributing to the wider system priorities.

1.4 Objectives of the C&P Joint Forward Plan:

- To direct the collective endeavour of the ICB & partner trusts towards system priorities (immediate priorities and longer-term ambitions)
- To 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)
- To demonstrate how the ICB and partner trusts will meet the health needs of the population and the priorities of the C&P health and wellbeing and integrated care strategy

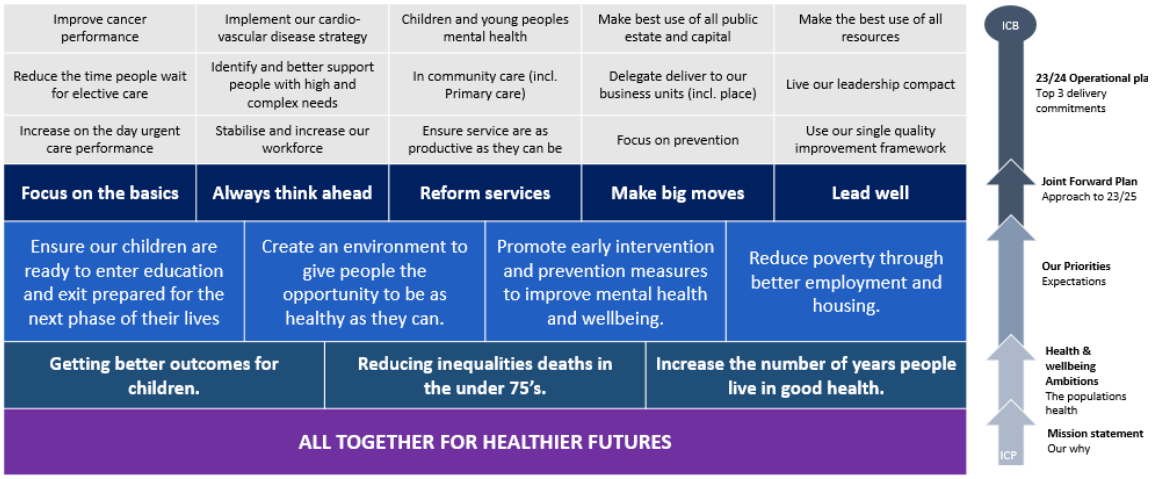
1.5 This paper sets out how the system has discharged its duties for the Joint Forward Plan, reflected the feedback from the HWB/ICP development session that took place on 6th June 2023 and to present the final version of the Joint Forward Plan for information.

2. Main Issues

2.1 As referenced in the previous paper of 24th March 2023, accountability for the Plan and its delivery sits with the ICB and its partner trusts. The JFP is the main strategic plan for the ICB, directing the collective endeavour of the NHS against system priorities (as set out in our Health & Wellbeing Integrated Care Strategy) and the ICB role in providing system leadership and assurance.

2.2 The Plan addresses the four priorities of the joint Health and Wellbeing and Integrated Care Strategy and demonstrated how together we are taking collaborative action and focusing on prevention at every level of delivery.

2.3 The JFP is aligned with the NHS operational plan and is built on the foundations set out below:



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3 Progress to date

3.1 A brief summary of progress is set out below:

There has been significant engagement work with strategy and planning leads across the system for the development of the joint forward plan. We agreed the principles and approach for strategic planning, which directly align with the NHSE JFP principles of alignment, subsidiarity and focus on delivery:

- **Think local:** Constituent plans are developed and owned at a local level, with the right expertise and insight.
- **Keep it simple:** We ensured co-ordination and alignment across the integrated care strategy, joint forward plan, operational plans and local strategies.
- **Do it together:** Collaborative planning and shared accountability is ensured through established system groups.
- **Prove it:** The JFP is delivery focused, with measurable outcomes and milestones.

3.2 Delivery plans have been developed alongside the narrative document and will be used internally within the ICS for planning and tracking progress. Each delivery plan has been informed by engagement with the relevant communities and service users, alongside the Lets Talk engagement programme.

3.3 The Joint Forward Plan was approved by the Integrated Care Board on 30th June 2023, with unanimous feedback on the quality of the product and the level of engagement to inform its development.

4 Engagement

4.1 There was a significant engagement campaign to inform the contents of the Joint Forward Plan via our Let's talk Campaign. The insights from this campaign have been widely shared with system partners and have also informed the development of the plan itself.

4.2 We continue to meet with partner trusts to ensure oversight of the JFP deliverables, give visibility across the system and offer support where required.

4.3 A workshop was held with ICP and HWB members on 6th of June, providing an opportunity

for debate and ideas on the Joint Forward Plan.

Members acknowledged the strong engagement and development work that had taken place for the JFP, reflecting the aspirations and plans of the system across a broad range of priorities.

There was discussion about the reality of the challenges ahead, the need to set out how we aim to make a difference through integration and new working arrangements and the shared accountability for delivering the JFP. This has been signalled this more clearly in the introduction and foreword of the published JFP. The ICB will continue to work with partners to better understand and communicate what success will look like in practice in specific areas of delivery, and to take forward the organisational development that will support the required culture change.

A number of ideas and suggestions emerged during the workshop, which we will be exploring further through our joint working groups, including:

- workforce integration opportunities across the health, social care and VCSE sectors
- developing consistency in our approach to VCSE, with aligned processes, shared expectations and reduced duplication
- proactively identifying inefficient processes in the patient journey, with all organisations committing to breaking down institutionalised barriers and finding solutions
- enabling local innovation while maintaining appropriate levels of assurance
- learning from things that work and spreading good practice
- communicating and engaging with our patients and communities

5 Next Steps

5.1 We will work with all our partners, particularly through the system strategy leads groups, to review lessons learned from the process of developing the JFP to inform future strategy and planning work.

5.2 We will also work with our delivery partners to develop a mechanism to track progress against the high-level milestones in the Joint Forward Plan, linking to an ICB outcomes framework. This will ensure visibility and oversight without duplication and enable support where required to strengthen integration and connections to achieve the best outcomes.

5.3 We will ensure there are progress updates to the Integrated Care Board, and to the Integrated Care Partnership and Health & Wellbeing Board.

5.4 Additional requirements are expected and in train for:

- Joint capital plans - ICBs and their partner NHS trusts are required to share their joint capital resource use plans and any revisions with the HWB. The content of the JFP should be consistent with this capital plan.
- ICB annual report - ICB annual reports need to review steps they have taken to implement the Health & Wellbeing Integrated Care Strategy

6. Recommendations

The Integrated Care Partnership and Health & Wellbeing Board is asked to note the outcomes from the Development Session that have informed the final Joint Forward Plan

that can be found on the ICS website: Joint Forward Plan | CPICS Website

7 Significant Implications

7.1 Resources
There will be financial implications as part of the delivery of the Joint Forward Plan, as well as the supporting Capital Plan

7.2 Statutory, Legal and Risk Implications
Will be continually reviewed and reported as necessary.

7.3 Equality and Diversity Implications
There are no direct implications as a result of this report. Work has been undertaken to ensure that where possible, this first draft meets accessibility standards. The final version will be fully accessible.

This report has been signed off by Kit Connick, Chief Officer of Strategy and Partnerships, ICB

8. Appendices

8.1 Appendix 1 ICS Joint Forward Plan 2023-28
Appendix 2 Delivery Plans- ALL
Appendix 3 ICS Executive Summary

9. Source documents

9.1 Source documents

B1940-guidance-on-developing-the-joint-forward-plan-december-2022.pdf (england.nhs.uk)

9.2 Location

Available electronically

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)

Cambridgeshire & Peterborough Integrated Care System

Joint Forward Plan: Executive Summary

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cpics.org.uk

June 2023 | Version 1.0

Joint Forward Plan: Executive Summary

Our Joint Forward Plan sets out our vision for the next five years of health and care services across Cambridgeshire, Peterborough and Royston.

It is a requirement of each Integrated Care Board in England to complete by June 2023.

It is an ambitious vision shared across all partners of Cambridgeshire & Peterborough Integrated Care System (ICS), who have collective responsibility in making a demonstrable and sustainable impact on the lives of local people. 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.

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.

Over the next five years we will integrate health and care services more, address inequalities that exist across our area and put more focus on prevention to help people stay well for longer.

We know it won't always be easy. We need more people working in health and care, we must effectively manage day to day services whilst shifting the focus of our activity towards prevention, improving areas that are not working well and operating 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.

Our areas of strategic delivery and reform

Improve cancer performance	Implement our cardio-vascular disease strategy	Children and young people's mental health	Make best use of all public estate and capital	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 service 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				

Statutory functions and duties

There are a host of specific policies, regulations and quality standards across the areas below where the Integrated Care Board (ICB) has responsibility for delivery or assurance.

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

Health and wellbeing priorities

We have a shared vision, set out in our joint Health & Wellbeing Integrated Care Strategy, centred around four priorities. Our Joint Forward Plan demonstrates how together we are turning these priorities into actions, by focusing on prevention at every level of health care delivery.

Our priorities

- Creating an environment to give people the opportunity to be as healthy as they can be.
- Promoting early intervention and prevention measures to improve mental health and wellbeing.
- Our children are ready to enter education and exit, prepared for the next phase of their lives.
- Reducing poverty through better employment, skills and housing.

Access and waiting times

We have seen unprecedented challenges across health and care over the past few years, with significant workforce challenges and cost pressures. We will tackle these challenges by reducing waiting times for access to services and improving performance for quality and delivery across elective and urgent care (in hospital and the community). We have developed robust recovery action plans for planned care and cancer services, and are implementing improvements in pathways to deliver efficiencies, reduce waits and most importantly deliver better patient outcomes.

We continue to support Primary Care to meet both urgent care needs and the maintenance of long-term condition care, through an integrated community-based response and reduced bureaucracy. In taking on commissioning responsibilities for wider primary care services, we will work with local clinical and non-clinical leaders, and our local communities, to ensure the same robust support for service investment, integration, and improvement.

Reduce waiting times

Improve performance for quality & delivery

Inequalities

Whilst deprivation is more widespread in the North than the South, there are significant pockets of deprivation across our area and rural communities experiencing geographic isolation. We have groups that experience poorer than average access and outcomes, for example people from minority ethnic communities, people with learning disabilities and/or autism, people with severe mental illness, and rough sleepers. Here are some examples of how we will tackle these inequalities:

Screening
Increasing uptake of cancer screening and access to diagnostic cancer services for people living in the most deprived communities.

Maternity services
Improving access and outcomes for maternity service users, by implementing the actions set out in our Better Births Equality and Equity Plan.

Groups and communities
Ensuring vulnerable groups and the most deprived communities have access to information and services to support effective blood pressure and lipid management (key risks for heart attacks and strokes).

Vaccinations
Promoting vaccinations for eligible respiratory patients and building on the COVID-19 vaccination outreach programme to target specific communities.

Health checks
Ensuring annual health checks for people living with serious mental illness, to tackle inequalities in physical health outcomes.

We are also:
- Monitoring elective care waiting times from an inequality perspective
- Improving our data to identify areas of concern
- Working with communities to help deliver services in an accessible way
- Focused on the risks of digital exclusion and the need for choice in how people access care, as well as support for people to use digital tools.

A final key area of reform for our area is to promote proactive, integrated and personalised approaches, particularly for people with complex or high intensity needs, to improve outcomes.

Case study

Healthier Futures Fund

We have committed an additional £2.25 million to support our Voluntary, Community and Social Enterprise (VCSE) sector across Cambridgeshire and 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.

Healthier Futures Fund

We have committed an additional £2.25 million to support our Voluntary, Community and Social Enterprise (VCSE) sector across Cambridgeshire and Peterborough.

Cardiovascular disease

1/4 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.

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. We want to reduce rates of CVD through preventative lifestyle changes whilst optimising diagnosis and treatment by:

- Ensuring monitoring and screening for co-morbidities and complications for patients with a diagnosis of diabetes, and management in line with NICE treatment targets.
- Expanding the NHS Treating Tobacco Dependency Programme across all acute inpatient services by March 2026 and with a focus on deprived communities and disadvantaged groups, in collaboration with community services.
- Preventing and reducing the risk of alcohol harm by identifying people at risk, providing targeted support and strengthening the integration of alcohol care services between primary, secondary and community services.

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.

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

Children and young people

We are 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, by:

- Implementing improvements to maternity and neonatal care following the findings from the Ockenden and Kirkup reports, making it safer, more personalised, and more equitable.
- Ensuring local services including midwifery, health visiting, and community, provide effective support to new families for the development of good parent/infant relationships.
- Introducing new roles and support through the Family Hubs programme to improve perinatal and infant-parent mental health, promoting good attachment and bonding, infant feeding support and early childhood development.

We will support CYP social communication, neurodevelopment and special education needs and disabilities by:

- Identifying and responding to neurodiverse and special educational needs early and delivering the right care in the right place at the right time.
- Simplifying autism diagnostic processes and providing better post diagnostic support.
- Reducing the health inequalities of people with learning disabilities (LD) and autism through health checks, workforce upskilling and other targeted service improvements.

In addition, we are improving the monitoring and treatment of childhood asthma, diabetes and obesity, in line with NICE guidelines and with a focus on inequalities.

We will support children and young people (CYP) emotional wellbeing and mental health by:

- Improving access and equity to emotional wellbeing and mental health help and treatment for 0–25-year-olds, providing targeted support those who are known to the Justice System and improving the safety and experience of young people moving from children's to adult mental health services.
- Ensuring children and young people requiring support with high risk or complex behaviours and relationships have more choice about different approaches to getting help.

Mental health and learning disabilities

The detrimental effect of COVID-19 has seen unprecedented levels of people experiencing a mental health crisis, resulting in significant pressures now and an anticipated increase in future needs. We will seek areas for reform, including:

- Building integrated community mental health provision via a stepped care model to improve treatment options and increase access to mental health services.
- Ensuring waiting times and recovery rates for Talking Therapies continue to meet national expectations.
- Working with partner organisations including the voluntary sector, to address the needs of specific groups.
- Prioritising and enacting the recommendations from our All Age Autism Strategy to transform adult autism services and improve access and treatment options.
- Reducing health inequalities for people with a learning disability through improved quality and delivery of health interventions such as vaccination programmes, and completion of annual physical health checks.

Integrated, personalised and prevention-focused care in the community

Working through neighbourhood teams and our place-based partnerships, we will support integrated delivery of services, centred around each person's needs, with a focus on early intervention and prevention. We will support the development of a resilient community and primary-care based infrastructure to facilitate these ways of working and will target resources and interventions to address risks and inequalities.

Opportunity

Our system is committed to promoting Equality, Diversity and Inclusion (EDI). This includes a clear focus on EDI outcomes for our workforce as well as interventions targeted at under-represented and marginalised communities.

Together with our partners, we have a significant opportunity to make a positive impact on our communities - as employers, purchasers of local goods and services, and through the social and environmental impact of our work. We are looking to strengthen and formalise this approach to maximising social value through our role as an "anchor system".

Engagement and co-production

This plan is underpinned by a commitment to put people at the heart of everything we do. It has been shaped by the insights and feedback we've received from local communities through our Let's Talk campaign and has been created with the needs of the people we care for at its heart. We have listened and understand that people want a better experience when they need health or care services, as well as better health outcomes throughout their lives. This is why our plan sets out our key priorities for reforming services and bringing care closer to people's homes.

Looking ahead, we know that we can find better, more creative solutions by working together to create healthier futures for all. We are committed to co-producing decisions about what services and support are needed locally with local people and communities.

We will continue to work with Healthwatch and the voluntary, community and social enterprise (VCSE) sector, including via our co-funded Community Researcher roles, to ensure we have a continuous dialogue with our local communities about what matters most to them when it comes to health and care services. Future developments include a Community Representative Group, Quality Champions and an insight bank to collate feedback in a way that all of our partners can access it when making future plans, alongside our ongoing engagement work with our communities.

Research, innovation and continuous improvement

We have world-leading, local NHS, academic and commercial research and innovation organisations on its doorstep. It is important we harness these assets and make the most of excellence, evidence and innovations for all our local communities.

We want to be at the forefront of digital innovation and use technology and digital innovation to improve outcomes for local people, by empowering them to control 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.

We support all our partners across care and health to adopt a continuous improvement culture - from our most senior leaders to everyone involved in delivering care. We want our staff to 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 and which will improve people's experiences of our services.

Environmental sustainability

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 net zero carbon reduction goals of the NHS. Our commitment to sustainability is reflected in our Green Strategy, our governance arrangements, development of carbon literacy skills, and integration of sustainability as part of our decision making on policies, programmes and contracts. We are working with our Local Authority partners to act together on joint agendas and to share learning.

Case study

Better Care Fund

Delivering the right kind of personalised care to our local people is the focus of the Better Care Fund across Cambridgeshire and Peterborough. The ICB and local authorities work together to ensure this pooled funding supports people to stay well, safe, and independent at home for longer.

Around 90% of the funding pays for services across Cambridgeshire and Peterborough that help to reduce pressures on the NHS. This includes funding to support an increase in staffing, such as almost 3,000 of broker hours, and 11,000 reablement staff hours. To support hospital discharges, the Better Care Fund also covered the cost of nearly 340 additional patient journeys, alongside 290 same day deliveries of community requested equipment orders to ensure patients had the equipment and support to enable them to continue their care at home.

This includes funding to support an increase in staffing, such as almost 3,000 of broker hours, and 11,000 reablement staff hours.

Workforce

Workforce capacity is a key challenge for our area. The labour market remains constrained, with particular local challenges due to the cost of living and lack of affordable accommodation. The national workforce challenges of long term sickness, early retirement and ageing workforce demographics are also felt locally.

Our plan has a focus on supply and retention activities, including pastoral support, new recruitment pathways and Apprenticeship schemes, with the aim of reducing vacancy rates.

We have a plan to increase the number of those who remain at work, reduce turnover and improve workforce satisfaction and productivity. We will achieve this through:

- Flexible working policies
- Targeted action on Equality, Diversity and Inclusion
- Health and Wellbeing Services
- Identifying key worker housing needs and improving availability of affordable accommodation

Together, through our leadership, training, policies and programmes we are building a culture that is collaborative, inclusive and focused on continuous improvement.

How we will deliver

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

This cultural shift will develop as relationships strengthen and mature. It will be enabled by:

A strong focus on our culture and organisational development at all levels.

Supporting all leaders to compassionately lead and drive the culture change we need to bring about reform at pace.

Living and embedding our values and leadership compact in all that we do:

- **Put people 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**

Opportunity

We have five partnerships that we call Accountable Business Units (ABUs). These partnerships will take the integrated care even closer to the local people and communities by bringing together health and care organisations with the voluntary sector to jointly plan and deliver services. They are the key mechanisms to deliver on our shared priorities, drive delivery, performance and change.

They are the Children's & Maternity Partnership; the Mental Health, Learning Disabilities & Autism Partnership; two place based partnerships; the North Cambridgeshire & Peterborough Care Partnership, the Cambridgeshire South Care Partnership and the Strategic Commisioning Unit.

We have established a clear performance and assurance governance framework, supported by a structure of informal and formal groups, where there is appropriate involvement of local stakeholders, professional expertise and the patient voice.

We are reviewing and consolidating our assurance functions through fostering safe and supportive environments to share emerging risks across all partners. We have agreed specific areas of focus at system level and are establishing an integrated quality assurance peer review process.

We also work with other statutory organisations to deliver our safeguarding responsibilities and to ensure that vulnerable people are safeguarded from harm. This includes victims of abuse and supporting the reduction of violence in our local communities.

Children & Maternity Partnership

Mental Health, Learning Disabilities & Autism Partnership

North Cambridgeshire & Peterborough Care Partnership

Cambridgeshire South Care Partnership

Strategic Commisioning Unit

Summary

This Joint Forward Plan for Cambridgeshire & Peterborough demonstrates how we are working together to sustainably tackle the strategic aims for our system and deliver the statutory key duties required of an ICB for our people and communities.

We will 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 reform and improve the way we provide health and care so local people and communities can lead happier and healthier lives.

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Cambridgeshire & Peterborough Integrated Care System

NHS Cambridgeshire & Peterborough

Joint Forward Plan 2023 - 28

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June 2023

Contents

Welcome

Thank you for taking the time to read this plan. It's called the Joint Forward Plan and is a requirement of each Integrated Care Board in England to complete by June 2023. 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 5 years we will 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 lists 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

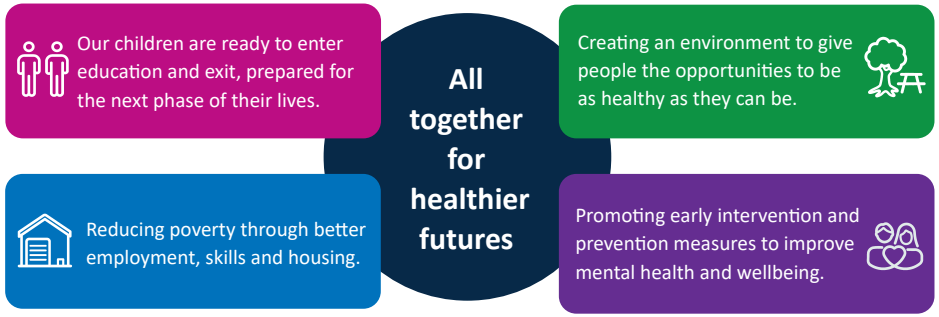
Section 1: Introduction

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	Increase on the day urgent care performance	Ensure service 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 lists 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. 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.

There is still more to do. Our financial plan for 2023/24 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.

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 to inform our plan.

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 are 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 NHSE 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, there is further engagement work to do as a significant proportion were unsure. This underpins the need to continue to develop our co-production efforts to engage our local people in focus areas and how 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.

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 10-year life expectancy gap between those living in the most deprived areas compared to those living in the least deprived. The difference in life expectancy is 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 and 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. There 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 (who form 21 Primary Care Networks)

East of England Ambulance Service

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, 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 and Peterborough Combined Authority.

Within the ICS, we have five partnerships 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. We call these partnerships Accountable Business Units.

There are two place-based partnerships, one in the North, hosted by North West Anglia NHS Foundation Trust (NWAngliaFT) 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 and Peterborough NHS Foundation Trust (CPFT). The Strategic Commissioning Unit is hosted by the Integrated Care Board (ICB).

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

North Cambridgeshire & Peterborough Care Partnership **Population 586,049**

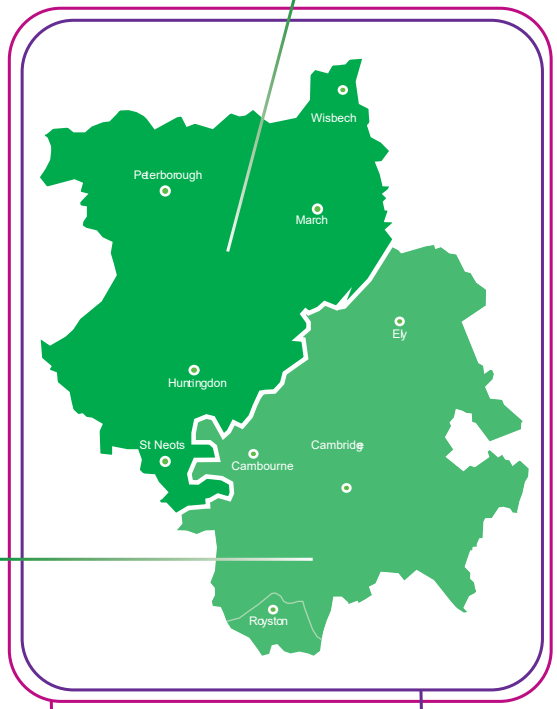
Partnerships:

- 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** - approximately 10 years between the most and least deprived areas. Across the ICS, 50-60% of the gap in life expectancy between the most deprived and least deprived areas is due to circulatory conditions, cancer and respiratory conditions. In Peterborough, approximately 40% of the gap in life expectancy in men is due to circulatory conditions, compared to 18.5% in Cambridgeshire. 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.

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

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 are developing an outcomes framework to demonstrate how the Joint Forward Plan supports the delivery of these high-level ambitions.

The framework will provide 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.

We will continue to work with our ICS partners and our ICB Board to develop this framework so that it provides a clear overall picture of our progress against our strategic priorities and core purposes.

The outcomes framework will describe the broad outcomes we want to deliver in the longer term. Through work with partners, subject matter experts and wider stakeholders we will break these broad outcomes down into more measurable components and set ambitions for achievement with fixed timescales. As it is sometimes difficult to measure outcomes, we will develop 'proxy measures' which will help us understand if we are succeeding in our ambition – these may measure several facets of an outcome, or process elements, and assess their impact. The outcomes framework will need a degree of consistency to track change over the medium to long term, but its scope will be dynamic as we learn from experience. The framework will encompass not just clinical, care and service quality outcomes, but also the patient / user experience and workforce, culture and leadership elements, and will cover the four core purposes of the ICS.

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.

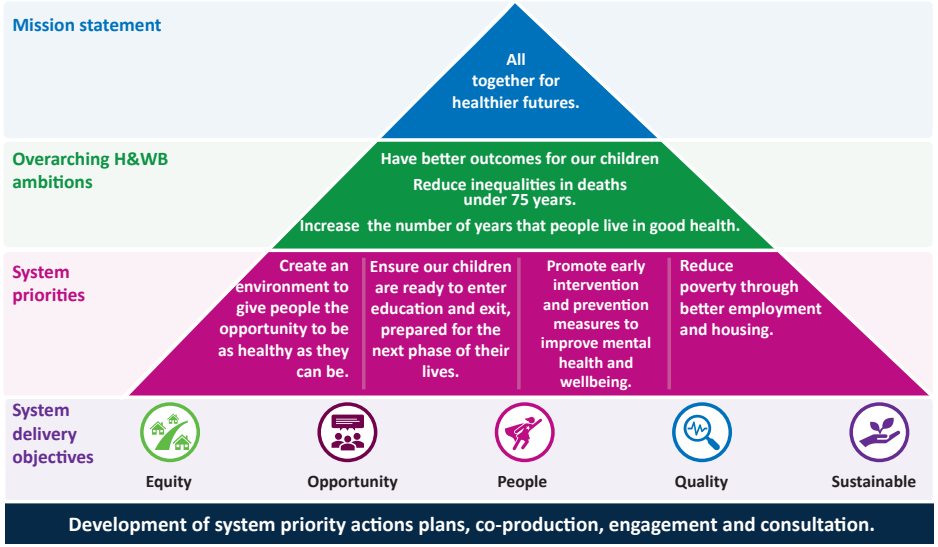
Phase 1 – Data intelligence gathering around priorities.

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 working 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 and 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. These should be considered a key part of the context for our Joint Forward Plan.

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.

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:

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

This priority has now entered phase 2 and discussions have been held with relevant stakeholders and established boards. A draft action plan identifies key activities and is currently subject to engagement. Once feedback has been collated, this will move to phase 3, implementation of the action plan, to be delivered throughout the life of this Joint Forward Plan with key leads across the ICS and ICB.

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. Further details are provided in the children and young people delivery plans.

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

This priority is specifically focussing on addressing obesity and is targeting the environments that impact on obesity. This is at phase 2 where the individual sub-groups (planners, leisure, schools, environmental health, primary care/clinicians) have identified some priority actions for their areas. These sub-groups are represented on a delivery oversight group that is driving the development of the action plan and its subsequent implementation.

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. Furthermore, the role of the ICB as an anchor institution and its wider influence within our system is aligned to this work.

Reduce poverty through better employment, skills, and better housing.

A housing and health summit has been held to support completion of the action plan focusing on identification of immediate deliverables for 23/24. In addition, the system has a well-developed draft Work & Health Strategy that has involved significant partner engagement. The strategy group (involving public health, district council, upper tier local authority, ICB representatives and wider partners) has identified key areas of focus which will form the action plan for this strategic priority.

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.

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

Priority 4 has entered into phase 2, with a Mental Health Summit to support the final development of the action plan.

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.

Health inequalities are multifaceted, with a complex set of social determinants that can result in differences in health outcomes, including life expectancy, morbidity, and mortality rates.

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.

We are committed to addressing health inequalities and improving the health and wellbeing of all local people. 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:

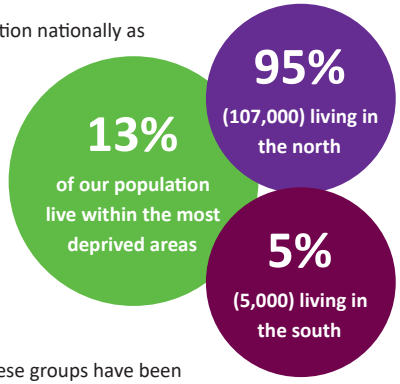
- Reduce the gap in health outcomes between different population groups, including those from disadvantaged backgrounds.
- Promote healthy lifestyles and behaviours and increase access to early intervention services.
- Improve access to healthcare services for vulnerable and marginalised populations.
- Improve the quality of care and patient experience across the ICS.
- Ensure resources are allocated effectively to address health inequalities, taking a Core20PLUS approach.
- 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 2020.

Core20PLUS5 approaches

Core20PLUS5 is an NHSE 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 and 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.

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 –** To ensure continuity of care for 75% of women from ethnically diverse communities and 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. 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)** – To ensure annual health checks for those living with SMI (bringing in line with the successes seen in learning disabilities). 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 in Peterborough and Fenland; establish Community Diagnostic Centres (CDCs) to provide diagnostic services closer to patients who need it most (this is covered in more detail in the Community Diagnostic Centres delivery plan); 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); and 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, such as the establishment of a new Lipid Management pathway in 2023/24 through 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 AsthmaApp pilot, commenced in 2022/23 which supported self-care in our most deprived adult populations. We plan to extend this pilot in 2023/24 to broader population groups, taking a Core20PLUS approach.
- **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.
- **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. In 2023/24, we will pilot an innovative model of care where epilepsy nursing is delivered across primary care networks, through our children's community provider (Cambridgeshire Community Services) and in special schools. By 2028, we envisage this model being adopted more widely to ensure children and young people living in our most deprived areas receive access to epilepsy specialist nursing.
- **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 reduce tooth extractions due to decay for children admitted as inpatients in hospital, aged 10 years and under. Our analysis from 2022 has shown that Peterborough has the highest prevalence of dental decay in 5-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 5-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.

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

Restoring services inclusively. We will:

- Continue to monitor and evaluate waiting list data by ethnicity and deprivation to help identify and address differences between groups.
- 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.

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 and 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.

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.

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 will also establish High Intensity Use (HIU) services in 2023/24 (see the HIU delivery plan for more information). 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.

Strengthening leadership and accountability:

- 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.
- Evolve the existing Health Inequalities Board to incorporate or align wider strategic priorities such as implementation of Population Health Management Strategy.
- We will Utilise the Health Inequalities 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 health inequalities between different population groups, as measured by a range of indicators for life expectancy, healthy life expectancy, infant mortality and disease prevalence. People from disadvantaged backgrounds will experience better health outcomes and quality of life.
- 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 of 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.

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 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.

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 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.
- 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.

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 are due to be completed by the end of September 2023 in preparation for full implementation from April 2024.

Case study

Data in action: Eclipse

- Across Cambridgeshire and 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.

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.

10% reduction in CVD deaths within our worst quintile of death rates.

To support those outcomes, new pathways are being developed with an integrated team based out of a Peterborough hub to start to address the whole heart failure pathway. This approach will then be adapted and modelled in Cambridgeshire. 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. The Population Health Management section earlier in this narrative supports the outcomes set out above.

Key risk factors and areas of focus for CVD prevention:

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 (22.5%), East Cambridgeshire (23.4%) and Fenland (31.7%) is higher compared to other areas of Cambridgeshire and Peterborough, with Fenland higher than the national average (25.3%). 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, complementing other prevention work. We also need to consider, with our Local Authority colleagues, planning decisions and the implications these have on population obesity.

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.

Smoking cessation

Although smoking prevalence is decreasing nationally, the prevalence of smoking in Fenland is increasing and is the highest in England. Improving smoking cessation rates is a core part of our CVD prevention strategy. We will continue implementation of the NHS Treating Tobacco Dependency Programme and increase referrals and quits from acute and community services. We will also incorporate into future plans the learning from Local Authority commissioned Behavioural Insights research, carried out in 2023/24, which will include insights into smoking behaviours.

- By March 2024, we will have fully implemented the NHS Long Term Plan Treating Tobacco Dependency Programme (TTDP) across all maternity and mental health inpatient services.
- By March 2025, we will have piloted and commenced a new community mental health tobacco cessation pathway aligning this to the annual 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.

Alcohol treatment

In 2023/24, we will evaluate the effectiveness of the optimised Alcohol Care Team (ACT) at CUH, which has been established to provide a 7-day-a-week service. We aim to establish other ACTs across the system by 2028 to support implementation of the wider Cambridgeshire and 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 and 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.

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:

- 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.
- Through the development of the Maternity Strategy in 2023, introduce a single framework response to the quality and safety improvements required as a result of findings from the Ockenden and Kirkup reports.
- Promote the Healthy Start Scheme and Best Start for Life to support a healthy pregnancy for all and tackle health inequalities through early identification and support of vulnerable parents.
- Ensure local service providers including midwifery, health visiting, and community partners have an aligned approach to supporting new families with their mental health during the perinatal period and to develop good parent/infant relationships.
- Introduce new roles and digital solutions through the Family Hubs programme to improve perinatal and infant-parent mental health, promoting good attachment and bonding, infant feeding support and early childhood development.
- Use place-based approaches to co-produce solutions which match the individual needs of young people, their families and the communities they live in, joining up services through Integrated Neighbourhoods and outcome-based joint commissioning.
- Implement the 2022-25 priorities of the Cambridgeshire & Peterborough Children and Young People's Mental Health Strategy; improve access and equity to emotional wellbeing and mental health help and treatment for 0–25-year-olds, target children and young people who are known to the Justice System and improve the safety and experience of young people moving from children's to adult mental health services.
- Improve mental health, emotional wellbeing and resilience among the school-aged population.
- Increase immunisation rates at entry into school and exit from school.
- Ensure that everyone who works with children and young people who have special educational needs and disabilities (SEND) embodies the vision and culture of our SEND strategy, recognising that SEND is everyone's business.
- Identify and respond to neurodiverse and special educational needs early and deliver care in the right place at the right time, through best use of jointly commissioned resources. Ensure a graduated, integrated and high-quality SEND Local Offer to support children to flourish and achieve their potential.
- Deliver consistent, evidence based integrated neurodevelopmental care pathways to simplify autism diagnostic processes and provide better post diagnostic support to reduce long term poor health outcomes, including mental health.
- Reduce the health inequalities of people with learning disabilities (LD) and autism through improved uptake of Annual Health Checks, train and upskill the workforce to support the specific needs of people with LD&A, increase the use of digital solutions to monitor health; and implement ICB LeDeR (Learning from Lives and Deaths) review action plans to embed sustained and targeted service improvements across the ICS.
- Promote the Homes Not Hospitals programme, 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.
- Ensure that every child attending a special school is given the option to access their routine health review appointments at their school rather than in a hospital when this is clinically appropriate.

- Prepare for the Cambridge Children's Hospital by 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.
- Increase the advice, guidance and direct support available to parents, carers and the child or young person's naturally connected support network in order to improve outcomes.
- Increase apprenticeships through Anchor institutions (Councils, Combined Authority, NHS, commissioned services).
- Improve access to Children's Epilepsy Specialist Nurses to decrease emergency epilepsy admissions to hospital, improve mental health and provide better continuity of care between settings for children with learning disabilities and autism who have epilepsy.
- Improve outcomes for childhood asthma through community respiratory services, training and support to primary care and families and medicines optimisation. Ensure damp free accommodation for children with a respiratory condition.
- Ensure improved monitoring and treatment of diabetes, in line with NICE recommended care processes, leading to better outcomes and reduced complications from excess weight.
- Ensure holistic individualised plans and support for children and young people with obesity.
- Improve oral health and reduce tooth extractions in young children, focussing on deprived areas where rates of tooth decay are highest.
- Ensure children and young people requiring support with high risk or complex behaviours and relationships will have more choice about different approaches to getting help.

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.

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 support equitable access, experience and outcomes.

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 will focus 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.

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 as one of our Accountable Business Units (ABUs) 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 and people with lived experience, improve the lives of the local population by driving the transformation of health and care services.

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. Its four key aims are:

- To develop strong collaborative leadership where mental health, learning disabilities & autism features throughout the ICS to support holistic Population Health Management by making mental health everyone's business.
- To drive the transformation of the design and delivery of care to improve service provision and population health.
- To support reductions in health inequalities which are caused by a complex mix of societal factors through advancing place-based approaches which address the wider determinants of health.
- To support improvements of service users' and carer's experience and recovery through evidence-based interventions, outcome measures, promoting shared decision making and personalised care.

The MHLDA Partnership is hosted by Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) and is accountable to the CPFT and ICB Boards through an aligned governance framework.

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

[2] NHS Long Term Plan, 2019

Work is in progress, led by Public Health, to develop an all-age mental health and learning disabilities health needs assessment, which will help 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.

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.

We also recognise the value and contribution that VCSE organisations bring to deliver support and treatments for mental health, learning disabilities and autism across our system. Building on our existing involvement and engagement, work with this sector will continue to be our priority. We will look at how their role can continue to grow and enhance care within local communities, which in turn will also help reduce the burden on primary and secondary care services. Specifically, we have:

- Engaged with local voice organisations and representative groups of service users and carers, which has highlighted areas such as access to services, continuity of care, areas of improvement for specific pathways and transformation around identified priorities such as transitions.
- Worked with the Co-Production Collaborative, an established forum which brings together a representative group of service users, carers and organisations from across the system, to ensure that service user and carer voices are embedded in the structures of the partnership to shape and influence the development of priorities in all forums.
- Engagement events have taken place involving partners, service users and carers to shape priority areas such as Community Mental Health Transformation to develop a vision for the future of services. Further events are planned to support the on-going delivery of the priority areas and to ensure that engagement and co-production are embedded in all work streams throughout their life cycle.

Across our area we continue to deliver services and seek areas of innovation to ensure individuals are able to access high quality health and care services when they need them, including:

- Ensuring waiting times and recovery rates for Talking Therapies continue to meet national expectations, as well as focussing on removing barriers to access for local populations such as older people who would benefit from the support offered by Talking Therapies.
- Continuing 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.
- Increasing capacity of services which provide digital access to proactively support hard to reach target communities using evidence from the MH Needs Assessment.
- Continuing to work with Local Authority partners to develop alternative places of safety to increase community resilience and access to crisis support.
- Continuing to respond to local needs such as developing relationships with local Universities to model student mental health services to improve access and early intervention for this cohort.

- Ensuring 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.

The following are key areas of action for tackling inequalities and improving health outcomes 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. This includes roll out of successful interventions from the Exemplar Pilot in Peterborough and delivering a community rehab model with access to new treatment options.
- 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.
- Lead the implementation of specific areas 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 access to services for 18-24 year-olds is developmentally appropriate. A transitions working group has been established and further engagement activity will take place in Years 1-2 of this plan to identify and support implementation of improvements.
- Maintaining a focus on reducing out of area placements to ensure people are receiving treatment as close to home as possible, improving discharge pathways and quality through the MHLDA Quality Transformation Programme, and reducing reliance on inpatient settings both for people with mental health needs and people with a learning disability or autism.
- Improving pathways for older people and with focus on 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.
- Prioritising and enacting the recommendations from the All Age Autism Strategy to transform adult autism services and improve access and treatment options.
- Reduce health inequalities for people with a learning disability through improved quality and delivery of health interventions such as vaccination programmes, and completion of annual physical health checks.

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.

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.
  - Embedding the “no more tick boxes” approach to recruitment, retention and progression within our ICS organisations.
  - 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 will finalise 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.

We will build on our innovation fund approach. In 2023/24 the ICB will fund further innovation initiatives; we will build on the success of the Health Inequalities Challenge Prize by repeating the programme with a new area of focus; provide another District Council innovation fund to target prevention initiatives through integrated approaches; and introduce 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.

Case Study

Healthier Futures Fund

We have committed an additional £2.25 million to support our Voluntary, Community and Social Enterprise (VCSE) sector across Cambridgeshire and 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.

We believe that this work will consolidate Cambridgeshire and 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.

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.

Key principles:

- The Armed Forces community should not face disadvantage compared to other people in the provision of public and commercial services in the area where they live.
- Special consideration is appropriate in some cases, especially for those who have given most such as the injured and the bereaved.

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 support GP practices to become veteran friendly based on those with the highest levels of veterans for our ICS.
- Implement a personalised care and support plan co-produced with veterans to be used to prevent veterans having to repeat their stories (thereby causing additional trauma) and to improve understanding of their needs.
- Utilise Healthwatch and Veteran organisations to enable partners to listen directly to the veteran voice, understand their requirements and work together to develop a better of understanding of any change requirements.
- Review and further develop the ICS website and partner websites to include greater accessibility and visibility of linkages to services that would support the veteran community.
- Develop awareness of sleep problems that may be caused by PTSD in veterans and the need to support diagnosing sleep disorders and providing treatment to improve wider health and social outcomes.

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.

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. The public will also have access to the JOY app to self-refer into local support services. 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/)

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. We will achieve this in the following way:

Year 1 - 2023/2024

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

Year 3 - 2025/2026

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

Year 5 - 2027/2028

- Personalised Care Support Plans 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.

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.

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.

In total, we heard from 2,315 people

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 version of our Joint Forward Plan further.

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:

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.

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 in the planning stages to launch our Community Representative Group and are 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 voluntary, community and social enterprise (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.

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.

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, 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. 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.

The role of the ICB is to champion adoption of that CQI culture across our partners and to coordinate the programmes of CQI, innovation and transformation that are best delivered together across the whole system.

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.

Six elements of our CQI strategy

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

- Strategic intent for CQI: Support leaders to explore and identify CQI opportunities linked to strategic and annual planning.
- 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.
- Leadership for CQI: Provide clear leadership for delivering quality improvements. Senior leaders, who model appropriate improvement focussed leadership behaviours and visible hands-on-approach.
- Building CQI skills at all levels: Demonstrate an accessible approach to providing CQI to every level of the system.
- Building CQI engagement all levels: Be more inclusive in our approaches, ensuring everyone has a voice in making improvements.
- 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. 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 QSIR College programme, (though not exclusively) 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.

Research

We are fortunate in having a range of world-leading, local NHS, academic and commercial research and innovation organisations locally. The challenge for us is to enable prompt, equitable access to these assets for our local population. This will be achieved by ensuring new evidence and tools are harnessed to meet priority health and care needs, and opportunities for involvement are appropriately shared.

ICB Research and Innovation Strategy

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, including reducing health inequalities. This will be achieved by working more closely with our research and innovation partners and local communities, supporting wider efforts to build a thriving innovation ecosystem, and making the most of excellence, evidence and innovations for our population. The overarching aims are to:

- Expand research and innovation activity and opportunities.
- Focus on local priority areas and population needs.
- Make participation more inclusive and accessible to local people, especially from communities experiencing the worst outcomes.
- Grow support and participation across all professional groups, specialties and care settings.
- Improve clinical adoption of the most important research evidence and proven innovations.
- These aims will be accompanied by annual action plans and progress reviews, including evidence of progress against every strategic target.

Facilitating and promoting research

We will build on the work of the hosted Research and Development Office to grow and embed high-quality, local research in primary, community and care settings, and with a range of partner organisations, growing capacity and capability. This includes:

- Supporting National Institute for Health and Care Research (NIHR) research delivery and hosting NIHR research grants and contracts.
- Acting as research advisers and sponsors.
- Promoting research findings and evidence, especially in support of ICB strategic themes.
- Championing opportunities for patient, public and health professional involvement in research.
- Deploying research capability funding and supporting health and care research in new NHS and non-NHS settings.
- Working collaboratively with system and research partners, including the NIHR East of England Clinical Research Network and NIHR Applied Research Collaborative East of England.

Increasing diversity in research and tackling health inequalities

Alongside wider efforts to underpin robust preventive, public health and social care research across the region, we will pay particular attention to supporting efforts to increase the diversity of patient and public participation in research, working with partners in the VCSE sector on initiatives to promote, explain and boost recruitment to varied research projects and to help facilitate access for seldom heard and vulnerable groups.

Efforts to widen co-creation of research and innovation will include encouraging the widest possible involvement of local partners, communities and service users, and helping researchers to optimise the design and delivery of research to maximise accessibility.

The Research and Development Office will also support health and care professionals and primary care practices from areas where research participation is low, to get involved in relevant research, especially where this is focused on disease prevention and reducing health inequalities. A new Inequalities Research Network will form the basis for interested professionals to identify local research priorities, learn about new opportunities, receive tailored advice and support, and share experience and best practice.

Our ambition is that across the ICS, research and innovation skills will be recognised and incentivised, including closer links with education and training, to boost the ability to support commercial and non-NHS research collaborations.

Measures of success

The measures of success for these plans will include:

- Evidence of increased research activity across our ICS, including the number of research active sites, hosted NIHR grants and sponsored research studies.
- Alignment of research activity with our strategic priorities, including health inequalities.
- Evidence of increased engagement with local people and communities in regard to research.
- Improvements in outreach to and awareness of research opportunities for professionals across different roles, specialties and locations.

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.

Working with Eastern AHSN, Cambridge University Health Partners (CUHP), the Adopting Innovation Hub (funded by the Heath Foundation) and two of our main providers (Cambridge University Hospitals and Cambridgeshire & Peterborough FT), we have already started to plan this out. Over the next year we will:

1. Formalise the ICS's vision as a health and care system that consistently adopts and scales innovation as a response to challenge;
2. Plan and budget for innovation (capital and revenue impacts); and
3. Support the delivery of the mechanisms for adoption of innovation that will further the ICS's objectives and aims.

The ICS already has many of the components required to do the above. We will not seek to duplicate structures and groups already in place and will seek to simplify structures and roles wherever possible.

Our key tasks for 2023-24 are to finalise the remaining roles and infrastructure that we need, and then to rapidly identify and start finding solutions to some key issues as proof that we are deploying our expertise differently. The deployment will build on a major CVD and lipids management programme, including the roll-out of Inclisiran, and a genetic testing pathway for familial hypercholesterolemia currently being delivered in partnership with Eastern AHSN.

In terms of our infrastructure, the ICS has recently recruited two major roles – a Chief Clinical Improvement Officer (in post from last July) and an Innovation Manager, jointly funded with Eastern AHSN, who starts shortly. These colleagues will work right across the ICS and partner organisations to identify the problems most in need of innovative solutions, and bring the resources of our providers, clinicians, Eastern AHSN and others to solve them. We are also working on the following two items:

- Health Foundation Adopting Innovation Hub - This small team has helpfully created networks, including the Citizen Participation Group and Adopters' Network to support the ICS to collaborate with citizen and patient groups. The Hub is also supporting the creation of a digital platform to support the prioritisation of available innovations. It is our intention, subject to budget and support, to mainstream both these activities into the ICS when the Hub's funding concludes early in 2024.
- Landing Zones - CUHP are working with provider organisations and primary care to develop Innovation Landing Zones, which are a coordinated network of colleagues to support innovators, investors and providers to facilitate the uptake of early innovations by 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.

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 get the digital basics 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

Our digital vision is to use technology to improve outcomes for local people by empowering them to control 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 staffs' 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 to achieve 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.

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.

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 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).
- 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.

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 are building 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. We have worked with wider ICS partners to develop a system-wide approach, which we will further strengthen through shared learning, working through established forums, including the Cambridgeshire & Peterborough Climate Partnership Group, 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 further 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 sustainability impact assessments and social value assessments to ensure that carbon impact and wider environmental factors are a key consideration in our decision-making and contract awards. We will develop and review 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. We are building on our Leadership Compact and established leadership development programmes to develop carbon literacy and sustainability skills among our leaders and staff at all levels.
- **Estates and facilities:** Measures to reduce energy consumption and work towards decarbonising the NHS estate. We will work towards the decarbonisation of our existing estate and embed circular economy and design principles into all new capital developments. This will be achieved by aligning our Estates Strategy with the Estates Net Zero Carbon delivery plan 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. We will support active travel policies and 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 Local Authority 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 through targeted campaigns and initiatives, for example effective waste separation, food waste, plastics and medical devices reuse/remanufacture.
- **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.

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 NHSE England.

Monthly monitoring of the system financial position has also been established over the last three years, which has supported the system achievement of financial breakeven each year. A monthly financial monitoring report has been developed and 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 both 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 should be supported by the organisations Board and the Quality, Performance and Finance Committee. The monthly financial monitoring pack will be further developed through 23/24 to incorporate trend analysis, benchmarking, statistical process control and long-term forecasting to further support improvement of efficiency, productivity and long-term financial planning.

As the system develops and matures, we will develop and embed a capital prioritisation process to support the allocation of capital resource across the system. This process should take account of the ongoing maintenance required to our collective NHS estate, to ensure compliance with statutory requirements and that the estate is fit for purpose to provide services to our local people. It should also incorporate our Estates Strategy, providing resources at the right time, in the right place to provide improved, efficient services to our people. To support this a system-wide capital group, including finance and clinical representation, is being established to provide oversight and assurance on all capital business cases and plans.

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 23/24 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.

Alongside this new primary care funding model, the ICB have also commissioned PA Consulting to undertake a review of our revenue resource allocation across our commissioned services to support the ICB to design and implement an Allocation Resource Strategy. The strategy will address the levelling up and improvement of health inequalities across the system to provide the revenue resources in the right place for the right service and at the right time for our population. The strategy will utilise our population health data as well as taking account of efficient use of our system-wide estate, workforce requirements and joint working with all our system partners to drive up our efficiency and productivity and creating a sustainable financial model. Medicines and pharmacy will be positioned as a strategic enabler of improved patient outcomes, NHS productivity and efficiencies across the system as well as a clinical intervention.

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 two years 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 will allow commissioning to be considered at a local level to reflect the needs of the local populations. 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, closer to home.

The commissioning of specialised services is moving to ICBs from 1 April 2024. This will allow the ICB to focus on managing Cambridgeshire & 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. There will be a period of shadow running with a Joint Commissioning Board from 1 April 2023.

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 has commenced in 22/23 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 remains 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. These plans have made a tangible impact on our UEC position in 22/23 and in mitigating long wait breaches (104ww). We will continue to review and benchmark our performance relative to others, striving for national median and then top quartile performance over the coming two years.

A system-wide group is being 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 23/24 Operational Plan has 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 outputs from this review are factored into our plan for 2023/24. 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 the RCN sickness rates have also increased by 2% to 5.7% and nursing support staff sickness has increased by 4.9% to 7.1%. At the same time staff stress levels and satisfaction have deteriorated; 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 IP has increased by over 20% since pre-COVID 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 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:** Lost productivity within diagnostics across the system due to administrators leaving has had a large impact across all Trusts, directly impacting upon availability of staff to work with patients to coordinate appointments, plus delayed reaction time to respond to dealing with DNAs/CNAs. Cost of living has also had a high impact on registered staff coming into the system (especially around Cambridge) who have then relocated outside of the region. Oversees recruitment has shown some benefit but lead in times (visas) has compounded delays in reacting to staff departures.

Our ICS has an increased workforce since 2018/19 as detailed above. We will need to address the key challenges in the workforce that reduces sickness and increases staff morale that will support the transformational changes required in care models, and changes 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, North West 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:

We will optimise the 23/24 Supply and Retention activity to reduce our Health care support worker vacancy rate by 40% across our area. Specifically, we will:

- Create Pastoral Support roles to support the retention of our workforce.
- Develop Collaborative recruitment plans.
- Develop co-produced HCSW Retention plans.
- Undertake a gap analysis of the HCSW roles across the system.

Pastoral Coordination supports preceptorship, mentorship and coaching for those in health and care roles, in turn aiding retention and workforce productivity.

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.

We will build our domestic workforce supply through 23/24 and beyond by exploring all supply routes for domestic and international recruitment, to build a strong, resilient workforce plan.

- Refresh ICS Attraction branding.
- Use the intelligence from the 23/24 Operational plans to inform workforce transformation.
- Develop a robust Apprenticeship Strategy.
- Design and implement a Clinical 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 the 'It's all coming together' 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.

We will implement NHSE's Five High Impact Retention Interventions to create a resilient workforce.

- Complete the NHSE Assessment tool.
- 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.

We are implementing the NHSE 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. 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.

Support supply, attraction and retention through affordable accommodation in our system to improve the availability of affordable accommodation for international and domestic recruits in 23/24 and beyond.

We will:

- Produce an ICS Accommodation Strategy.
- Develop and deliver a Housing Needs Survey.
- Deliver and evaluate Homestay Pilot.
- Explore adoption of Homestay Model.

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 experience, 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. Homestay provides our workforce with a possible interim accommodation solution where suitable. 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.

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 September 2021 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.

- 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.

The five additional workforce enabling groups comprise:

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 Local People Board 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.

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 NHSE 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.

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. • 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.

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 in surge capacity; increased 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, with the aim of reducing the burden of reporting at practice level and providing financial security as the ICS moves to a needs-based model of funding.
- Utilising local discretionary General Practice spend 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:

Working with the Local Medical Committee (LMC), the ICB is in the process of developing a Primary Care Local Commissioning and Investment Plan for 2023/24, (in line with the commitments we set out in the Primary Care Roadmap) to continue to invest in General Practice to support the sustainability and integration of primary care. During 2023/24 we will carry out more extensive reviews, looking to implement a levelling up model from April 2024.

We have now assumed the commissioning responsibilities for wider primary care services and with that the associated challenges and opportunities that brings. We will work 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.

Primary care leadership is already represented on the Professional and Clinical Leadership Assembly, the Joint Clinical & Professionals Executive Group and the 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 whilst 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 1-2 years by broadening the criteria for patients referred into the service and improving digital mechanisms for referral.
- Increase referrals via the Community Pharmacy Consultation 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 local and national 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 1-5 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 Pathfinder for the management of hypertension which will be piloted during year one.
- 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), e.g. the insect bite service, enabling community pharmacies to provide treatments for specified conditions without the need for a doctor prescription. We are currently piloting ICB commissioned PGDs, for example for the treatment of uncomplicated Urinary Tract Infections in women.
- 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.
- 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, AF 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 128 primary care properties (87 GP practices), four main acute hospitals and eight main community and mental health hospitals/main sites. At this stage, the review did not cover other public or VCSE sector estate, however we will continue the work with partners through the System Estates Group and One Public Estate to maximise the opportunities for efficiencies and integration through joined up working. 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.
- NHSE require assurances from each ICB that all their General Practice buildings are not constructed of Reinforced Autoclaved Aerated Concrete (RAAC). If any are found to be, then plans need to be submitted to NHSE on mitigating the risks.
- Structural problems at Hinchingbrooke (RAAC) requiring reprovision of services.
- Strategic developments at the Cambridge Biomedical Campus (Cancer and Children's Hospitals and the wider masterplan).
- Underutilised back-office accommodation.
- Lack of comprehensive and consolidated data to support strategic planning.

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, we need to make sure it is aligned with our strategic aims, but it also meets the needs of our communities, and responds positively to the challenges put forward in national guidance, such as the Fuller Stocktake Report. In our Let's Talk campaign (targeted at getting the views of our people and communities on this plan), when asked about using estate to deliver better outcomes for local people, reduce inequalities for our most deprived areas and increase healthy life expectancy and whether they agree with this approach, 90% of people agreed this was the right approach.

We will seek to use our Estates Strategy to inform key decisions over the next 12 months about how best to use our existing and future infrastructure to deliver on our strategic aims. There is much to tackle, and finite financial and capacity to do so. We therefore need to identify where we will focus our efforts in the first 12 months, 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.
- Develop solutions for areas of highest population growth. 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.
- 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.
- Develop a cost transformation programme to review under-performing assets to identify what estate is coming to the end of its useful life and what provides us with what we need now and into the future.

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, sustainable urban drainage, active travel and shade potential.

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.
- Develop an ICS capital planning strategy, with a clear definition around the prioritisation of projects set against the availability of capital.
- Develop 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 (https://www.cpics.org.uk/estates-strategy)

Our proposed focus for 2023/24:

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
- CUH Cancer and Children's Hospitals
- Princess of Wales Hospital, Ely
- Royston
- Doddington Hospital
- North Cambs Hospital

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

- Priors Field, Sutton
- March Practices (Cornerstone, Mercheford and Riverside)
- Alconbury Weald Development (Interim and Health Hub)
- Park Medical Centre, Peterborough
- Royston Health Centre (Granta expansion)

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

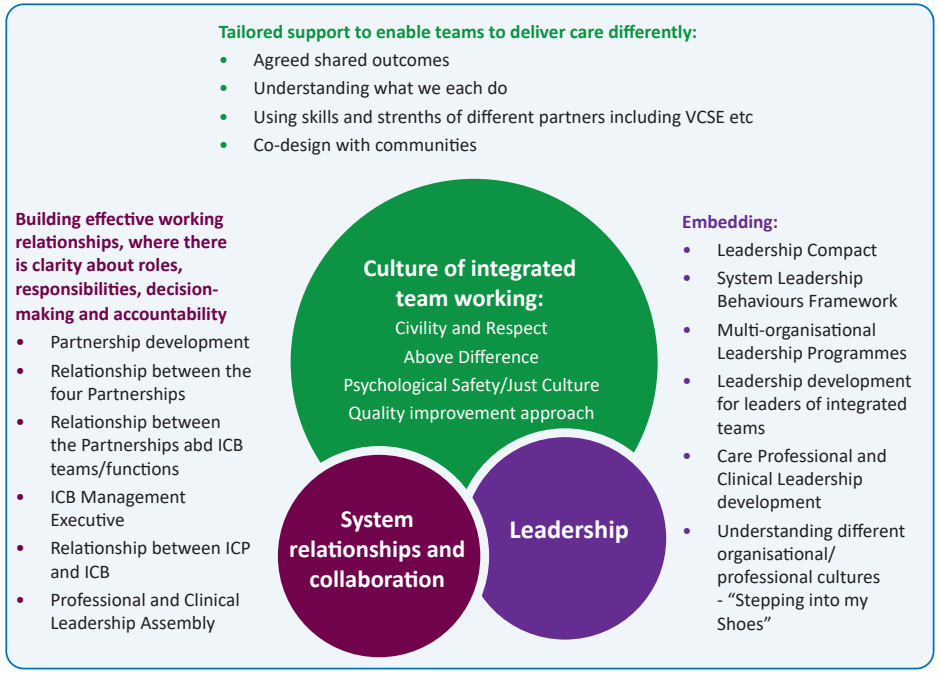
Organisational Development

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.



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 – NHSE, 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 NHSE).

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 and Investment Committee.
- 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 ICS Management Executive is responsible for collaboration and alignment of activities across the Place and Collaborative Partnerships and the ICB Executive Team, prior to making recommendations to formal sub-board and board committees to support delivery against our short-and long-term objectives. Management Executive is our shared senior leadership forum which is responsible for supporting translation of ICS / ICB strategy into operational delivery, supporting and role modelling the behaviours and culture of our ICS.

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 at https://www.cpics.org.uk/constitution-for-cambridgeshire-and-peterborough-icb

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.

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 2021 – 2026, 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.

The strategy sets out our commitment to working together in collaboration, to ensure all people, from pre-conception to end of life, living in our area receive high quality care and proportionate universal services that are equitable and targeted to reduce health inequalities.

System-wide learning is the highest priority to support innovation across the whole ICS area. Success will be built on collaboration using an evidence-based approach in the design of our pathways and services with all providers and patient engagement and involvement.

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.

It is important the Governance supporting Quality Oversight lends itself to a culture of learning and quality improvement. We are maturing our system partner accountability and ownership as well as consolidating the role of the System Quality Group in its assurance function and further developing its surveillance through fostering safe and supportive environments for Executives to share emerging risks across all partners.

Objectives:

- Maturing the System Quality Group and quality governance structure for partner accountability and ownership.
- Patients, Service Users and their families are integral to the patient safety agenda.
- System assurance of high-quality safe care where evidence is centrally collated and partners work together to learn, improve and enhance care standards.

Measurable and evidenced safe quality care across the system

The standards measured at the System Quality Group 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 will maximise a safety culture by working collaboratively and alongside partners within their quality and safety meeting. As part of this collaboration and by end of March 2024 we will have implemented an integrated quality assurance peer review process.

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
Reduce the incidence of restrictive practice 50% and improve the sexual safety of patients and staff by 50% above baseline by March 2024	March 2024	Chief Nurse	• Individual Provider Quality Committees • System Quality Group • ICB Performance, Quality 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.

System quality improvement by learning from incidents

As a system we will learn from our own incidents and near misses, as well as those from others. The NHS England Patient Safety Strategy (2019) and specifically the implementation of the Patient Safety Incident Response Framework (PSIRF) is an integral tool to facilitate this learning. Identification of themes and trends of incidents will lead to focused improvement of care pathways and hosting system learning events will foster and enable learning across organisational boundaries. Our objectives are:

- Implementation of the Patient Safety Incident Response Framework.
- System identifies selected outcomes based on risk, triangulation of safety data, learning from deaths programme and potential improvements.
- Learning events.
- Evaluate impact of learning events.
- Promote and support Just Culture.

Deliverable	Timeline	SRO	Oversight groups
Commencement of orientation phase for cohort 2 of providers, which includes Primary Care	April 2023 to March 2025	Chief Nurse	• Provider Quality Governance • System Quality Group • Quality, Performance and Finance Committee • ICB Board
Sign off PSIRF policies for individual providers in Cohort 1	July 2023 to March 2024	Provider & ICB Chief Nurses	• Community of Practice • Individual Trust quality committees • System Quality Group • Quality, Performance & Finance Committee • ICB Board
Implementation of PSIRF for cohort 1 providers	Sept 2023 to March 2025	Chief Nurse	• Community of Practice • Individual Trust quality committees • System Quality Group • Quality, Performance & Finance Committee • ICB Board
Commencement of use of the new Learning from Patient Safety Events reporting system for Cohort 1 providers	April 2024 onwards	Provider & ICB Chief Nurse	• Community of Practice • Individual Trust quality committees • System Quality Group • Quality, Performance & Finance Committee • ICB Board

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 and Domestic Abuse and Sexual Violence Boards. Effective safeguarding arrangements seek to prevent and protect individuals from harm or abuse, regardless of their circumstances.

We will achieve 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.
- Understanding and robust multi-agency response to children who are victims of 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.
- Imbedding the Mental Capacity Act to ensure that individuals who lack capacity have their human rights met and receive appropriate care and support.
- 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.
- 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 launched in December 2022.

Funded by the Home Office, the duty brings key partners across health, police and the local authorities together to form specialist teams, which will design and implement strategies to protect our local communities across the life course.

The ICB will work 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 Prevent, Female Genital Mutilation and Modern Slavery to share insight and gain a fuller picture of what is happening locally.

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 will be 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.

To assess readiness to tackle and prevent serious violence a training skills analysis will be completed to determine any training needs for healthcare professionals. 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.

We will work as part of the specialist team to embed lessons learned from Child Safeguarding Practice Reviews, Safeguarding Adult Reviews and Domestic Homicides. We will engage with 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 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 training analysis of healthcare staff requirements to meet Serious Violence Duty	March 2024	Chief Nurse	• Individual Provider Quality Committees • System Quality Group • ICB Performance Quality and Finance Committee • ICB Board • Cambridgeshire and Peterborough Safeguarding Board
Safeguarding Audit to demonstrate learning from case reviews (as part of Section 11 Audit)	March 2024	Chief Nurse	• Individual Provider Quality Committees • 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 • 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 • 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.

The main functions of the group 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 Partnership (focusing on care for people living in Peterborough, Fenland and Huntingdonshire).
- Cambridgeshire South 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).

We have a robust development programme that supports the transition and the establishment of the four Partnership teams as they develop their approach to partnership working, co-production and integrated delivery for services. The programme aims to:

- Oversee the implementation of the assurance and delegation of services to ABUs.
- Support the development of the ABUs and their readiness to take on these responsibilities.
- Facilitate integrated leadership and governance across ICS providers and partners.
- Drive a strong culture of integrated delivery and transformation that improves health outcomes for all our local communities.
- Accelerate 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 NHSE 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 NHSE 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 NHSE 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 Joint Forward Plan demonstrates 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.

We will 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 Trusts and Accountable Business Units:

"We collectively confirm our support for the Cambridgeshire and 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 and 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
- Cambridgeshire South Care Partnership
- Children's and Maternity Partnership
- Mental Health, Learning Disabilities and Autism Partnership

Statement of support from the Cambridgeshire and Peterborough Health and Wellbeing Board:

"The Cambridgeshire and Peterborough Health and Wellbeing Board confirms its support for the first Cambridgeshire and 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."

Hertfordshire and West Essex Health and Wellbeing Board have also confirmed their support for this plan in relation to the area of Royston.

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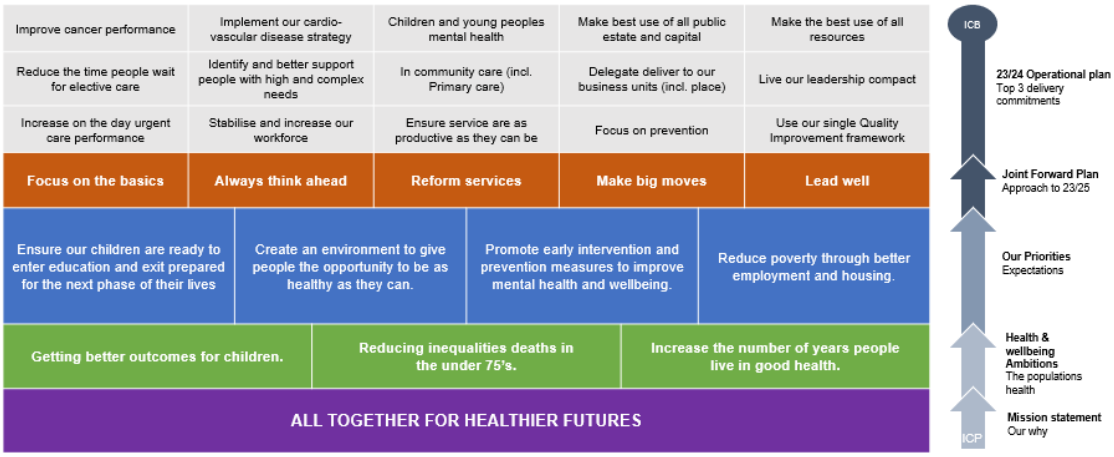
June 2023

Delivery Plans

Introduction

Our delivery plans aim to provide clarity for our key priority areas for NHS and system commitments, a core element of our 5-year Joint Forward Plan in Cambridgeshire and Peterborough. They describe an overview of each plan and objectives for each area within the plan, including key deliverables and milestones, leadership, and governance over the next 5 years.

The delivery plans we have developed demonstrate the clear alignment with our overarching vision, ambitions, and priorities across the integrated care system. This is described in the figure 1 below:



There is more work to be done in this first year of our joint forward plan to refine many of deliverables and actions. The delivery plans are working documents which will continue to evolve and be reviewed on a regular basis.

The full list of plans is detailed here:

Focus on the basics:

- Cancer services – improve cancer performance.
- Planned care – reduce the time people wait for elective care.
- Urgent and emergency care – increase on the day urgent care performance.
- Maternity and neonatal services – also referenced in the babies, children, and young people delivery plan.

Always think ahead:

- CVD – implement our cardio-vascular disease strategy.
- Population Health Management
- Identify and better support people with high or complex needs (high intensity users, advanced illness, end of life care - in development).
- Workforce – stabilise and increase our workforce.

Reform Services:

- Babies, children, and young people
- Mental health, learning disabilities and autism
- Diagnostics and Community Diagnostic Centres – ensure services are as productive as they can be.

- Primary care transformation
- "Ensure services are as productive as they can be" is also a theme throughout our delivery plans (in progress).

Make big moves:

- Estates – make best use of all public estate and capital.
- Digital
- Cambridgeshire South Care Partnership – delegate delivery to partnerships.
- North Cambridgeshire and Peterborough Place Partnership – delegate delivery to partnerships.
- NB Our children's and maternity and mental health, learning disability and autism delivery plans above also cover "delegate delivery to partnerships".
- Four strategic priorities action plans - Focus on prevention.

Lead well:

- Green plan (sustainability) – make the best use of all resources.
- Procurement – make the best use of all resources.
- Organisational Development – live our leadership compact.
- Quality improvement – use our single Quality Improvement framework.

Cancer services

Overview

C&P ICS continues to prioritise cancer services across the system with a key focus on optimising access and improving outcomes, recovery, and patient experience, whilst reducing potential harm. During 2022/23, work across the system has been undertaken to develop robust recovery action plans at the provider and system level, including reviewing care pathways, undertaking deep dives into referrals, and implementing new pathways or services such as the Rapid Access Pathway for Lower GI to embed FIT tests within the referral and breast pain pathways. This has supported an improvement in waiting times and reductions in over 62 waiting list backlogs, particularly at North West Anglia Foundation Trust. Key challenges to delivery have been workforce availability, diagnostic and histopathology capacity, coupled with an increase in demand.

Cambridge University Hospital NHS Foundation Trust is the largest provider of specialist cancer treatment in the East of England, and the provider in the region that can offer cellular therapies and genomics. The proposed Cambridge Cancer Research Hospital (CCRH) aims to accelerate improvements and contribute to improved outcomes through bringing together scientific and clinical expertise within pathways bringing the lab bench to the patient bedside, whilst working with other providers across the system and wider region to support improved outcomes. The CCRH offers the system and our local population a unique opportunity and will be critical in the continued transformation of how cancer services are delivered in the future. The CCRH will work with all cancer providers both within Cambridgeshire and Peterborough and the wider region.

With The Royal Papworth Hospital NHS Foundation Trust providing specialist services for people with lung cancer and Northwest Anglia NHS Foundation Trust receiving one of the highest volumes of cancer referrals in the Alliance, the system is well positioned to deliver wide reaching changes for people affected by cancer.

The ICB has developed, with all system partners, a Cancer Delivery Vision and key objectives which aim to improve patient experience, outcomes, and access, looking at care closer to home where possible. Within the delivery we want to address health inequalities as well as provide sustainable models of care that improve current workforce recruitment/retention challenges.

Our C&P ICS vision is to:

- Improve access and waiting times across all our cancer services.
- Be the first ICS in the country to achieve 75% faster diagnosis at stage 1 and 2.
- Recover 62-day backlogs to pre-pandemic levels (or better) by March 2024.
- Co-develop personalised care, psychological support and community provision with our patients living with cancer and beyond.

Our key objectives of the Cancer Delivery Vision are:

- To improve early diagnosis through improvements in screening, earlier access to diagnostics, patient education, and primary care pathways.
- To improve recovery rates by implementing best practice and reducing unwarranted variation in services; expanding tele dermatology services; and ensuring diagnostic capacity to meet needs.
- To improve the experience for people living with cancer and beyond, through better support in the community, a strong personalised care approach, psychological support, and access to high quality palliative care.

- To maximise the opportunities and expected benefits of the Cambridge Cancer Research Hospital for our patients and our local workforce.

There are a number of key principles that will be considered when developing services and detailed deliverables:

- Workforce – maximise opportunities to jointly develop new roles, explore opportunities for joint appointments, training to support recruitment and retention.
- Health Inequalities – to ensure that C&P ICS have accessible services across the system and that developments/service improvements address health inequalities.
- Innovations– to identify opportunities to maximise digital services and other innovations to support services and increase capacity, for example through the use of Artificial Intelligence (AI), Robotic Process Automation (RPA) and Machine Learning (ML).
- Patient engagement – we will work closely with our partners across the VCSE and closely involve our local patient participation groups as we develop plans to ensure that they meet local needs.
- Communication – ensure timely and robust communication is available to all system partners and our population on our developments advising how to access appropriate and timely cancer services.

The ICB will work with all partners across the system and the Cancer Alliance to deliver the vision and the objectives. This will be monitored through the System Cancer Board.

Delivery plans:

Improve access and waiting times across all cancer services.

Across the system there is ongoing work to improve access and waiting times across all cancer services. The key objective in 2023/24 will be to reduce our current 62-day backlog to pre-pandemic levels or better and successfully achieve the Faster Diagnosis Standard (FDS). This will support patients without cancer being confirmed and advised of this sooner, reducing their anxieties whilst waiting for a diagnosis, whilst also improving the journey of patients confirmed with cancer to be treated in a timely way, improving their outcomes and experience. Longer term we want to continue to improve waiting times and improve access, providing care closer to home where possible and addressing current health inequalities. Areas of focus will be:

- Delivering cancer diagnostic tests and routine imaging within Community Diagnostic Centres.
- A non-specific symptom service to be embedded across the system.
- Improving direct access for primary care into diagnostic service leading to faster diagnosis (CT and MRI).
- Delivering against the optimal timed pathways for each tumour site.
- Introducing new pathways of care, maximising digital opportunities including a teledermatology solution and the use of AI in histopathology services.

The delivery of the improvements is also co-dependent on workstreams within the wider Planned Care and Community Diagnostic delivery plans.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Deliver and sustain Faster Diagnosis Standard of 75% at a system level	End of March 2024	Kate Hopcraft, Director of Performance and Delivery	Cancer Board and Planned Care Board
Achieve 62-day backlog target	End of March 2024	Kate Hopcraft, Director of Performance and Delivery	Cancer Board and Planned Care Board
Achieve 90% of lower GI suspected referrals with an accompanying FIT Result	End of March 2024	Kate Hopcraft, Director of Performance and Delivery	Cancer Board and Planned Care Board
100% population to have access to Non-Specific Symptom service by 31 March 2023 and to embed referral processes during 2023/24	End of March 2024	Kate Hopcraft, Director of Performance and Delivery	Cancer Board
Improve direct access to diagnostics leading to faster diagnosis (CT, US & MRI)	End of March 2025	Kate Hopcraft, Director of Performance and Delivery	Cancer Board and Diagnostic Board
Ensure sustained delivery of the optimal timed pathway for prostate cancer including mpMRI	End of March 2025	Kate Hopcraft, Director of Performance and Delivery	Cancer Board
Ensure at least 65% of urgent cancer referrals for suspected prostate, colorectal cancer meet timed pathway milestones	End of March 2025	Kate Hopcraft, Director of Performance and Delivery	Cancer Board
Delivery / expansion of Community Diagnostic Centres (Ely and Wisbech, and Peterborough) including access for suspected cancer referrals, incorporating the Rapid Diagnosis model	End of March 2026	Kate Hopcraft, Director of Performance and Delivery	Cancer Board and Diagnostic Board

To achieve faster diagnosis of stage 1 and 2 cancers

The ambition of the system is to be the first in the country to deliver 75% of cancers being diagnosed at Stage 1 and 2 by 2028. Through earlier diagnosis there are improved outcomes and survival rates. To deliver this ambition we will work with all system partners and our local population to:

- Improve access to screening programmes through:
    - Rolling out additional programmes and age extensions in line with national expectations, for example Targeted Lung Health Checks.
    - Identify current health inequalities within screening programmes across Cambridgeshire and Peterborough and work with partners to improve access to programmes.
    - Work with the Cancer Alliance and Public Health England on campaigns and promoting the benefits of screening and promote access.
    - Maximising opportunities for opportunistic screening services when accessing other services, for example cervical screening when accessing other women's health services.
- Work with primary and secondary care to improve access to specialist advice, information and training.
- Improve information and patient education to support earlier identification of suspicious symptoms.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Commence Targeted Lung Health Check service as part of the national lung cancer screening programme	March 2024	Kate Hopcraft, Director of Performance and Delivery	Cancer Board
Delivery of national screening programmes including extension to NHS bowel screening	March 2025	Kate Hopcraft, Director of Performance and Delivery	Cancer Board
75% of cancer diagnosis to be at Stage 1 and 2	2028	Kate Hopcraft, Director of Performance and Delivery	Cancer Board

To develop personalised care, psychological support and community provision with our patients living with cancer and beyond

For our population that is living with cancer and beyond we want to ensure that services provide a holistic and personalised approach, support, and care for people at each stage of their cancer journey; supporting them to manage the wider impact living with cancer can have on their physical and mental health, finances, and social and family aspects of their lives. We will be working with our partners and patients with lived experiences to improve on the current services and models available through:

- Developing psychological support services that meet individual needs of cancer patients by improving:
    - Access and availability
    - Education and training within mental health services about the impact of cancer
    - Enhancing current services within hospital setting cancer services
- Providing personalised, holistic support for people by working with social prescribers, voluntary services and signposting people to wider support services within communities and neighbourhoods.
- Exploring opportunities to maximise community provision for cancer care through neighbourhood teams, community diagnostic centres and mobile care.
- Ensuring people towards the end of their life are empowered to access the care and support they need, including choosing their preferred place of care.

The delivery of elements of this plan are co-dependent and linked into the wider Community Diagnostic Centre and End of Life delivery plans.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Increased access to psychological support through bespoke and mainstream Mental Health services	2025	Kate Hopcraft, Director of Performance and Delivery	Cancer Board
Clear pathways to access personalised care through social prescribers, voluntary sector provision and cancer services	2025	Kate Hopcraft, Director of Performance and Delivery	Cancer Board

To maximise the benefits of the Cambridge Cancer Research Hospitals

The Cambridge Cancer Research Hospital (CCRH) will bring many benefits and opportunities for the population and workforce within C&P as well as the wider region. It will be focused on the early detection of cancer and novel precision medicine treatments, bringing together the clinical excellence of Cambridge University Hospitals, scientific expertise of the University of Cambridge and the Cancer Research UK Cambridge Centre, as well as industry partners under one roof. It will support with transformation of pathways, attract, and retain workforce into the region and improve patient cancer outcomes through early detection, and interventions.

Wider benefits for local patients will be through the improved environment and facilities. Plans are in place to increase digital offers to support patients for example through remote monitoring.

The ICB will work with the Cambridge University Hospital NHS Foundation Trust, the CCRH team, NHS England and wider system partners to maximise the benefits that the new hospital will bring for our local population. These include:

- New models of care and pathways improving access, patient experience, and outcomes.
- Increased telemedicine and virtual clinics reducing travel and appointment times for patients as well as supporting the ICS Green plan.
- Greater use of ambulatory pathways for Bone Marrow Transplant patients, and cellular therapies supporting patients to return home earlier for ongoing care.
- Increased capacity to reflect the predicted future needs of the services, including the Cancer Assessment Unit (CAU) which provides access to emergency and urgent care for cancer patients who are deteriorating, decreasing the need for them to attend the Emergency Department.
- Innovation being driven forward and accelerated through the co-location of clinical teams for both early detection and integrated cancer medicine research.
- Greater access to regional trials, whole genome sequencing and wider research for patients from across the system and region through integrated working with local hospitals.
- Workforce benefits both at Cambridge University Hospital NHS Foundation Trust and other hospitals in the system and region including:
    - Improved staff satisfaction through modern facilities and integrated working
    - Improved recruitment and retention through collocation with partners, research opportunities and potential models for joint working/appointments with other hospitals
    - First class education and training locally, across the system and region including specialist advice via telemedicine, digital pathology, and networking.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Full Business Case to be completed	2024	CCRH Exec Lead	CCRH Programme Board/Cancer Board
Construction to start	2025	CCRH Exec Lead	CCRH Programme Board/Cancer Board
Completion of build	2027	CCRH Exec Lead	CCRH Programme Board/Cancer Board

Planned Care

Overview

C&P ICS is continuing to address elective recovery to reduce overall waiting lists in line with national delivery standards. We are introducing and embedding new ways of working to further improve services and patient outcomes and to increase productivity and efficiencies. Through our work we aim to reduce identified health inequalities, embed personalised care, and look at opportunities to bring care closer to people's home.

Post-covid waiting lists across the system have increased with wait times across multiple specialties at an all-time high. During 2022/23 excellent progress was made in reducing waiting times from over 2 years to under 18 months in most specialties. This has been through increased capacity, maximising resources across the system and looking at new ways of working together. We are committed to further reducing wait times and improving access to services for all our population.

Working with all system partners the ICB's Planned Care objectives are to:

- Improve access and waiting times, so no patients are waiting more than 65 weeks by the end of March 2024 and year on year improvements thereafter.
- Embed a personalised care approach across services.
- Support our population to access holistic care to improve their overall wellbeing and outcomes whilst they wait for treatment.
- Deliver planned care closer to home, through greater development of community pathways and provision.

We aim to deliver this through several programmes of work:

- Elective Recovery
- Health inequalities and improved access to elective care
- Personalised care and support
- Pathway improvements and redesign
- Increasing productivity and efficiency
- Outpatient transformation

Oversight for delivery is through the C&P ICS Planned Care Board, with clinical and operational representatives from across the system.

Delivery plans:

Elective recovery:

Within this plan there is a continued focus to reduce the long waits within the system and reduce the overall size of the waiting list. Working closely with our secondary care providers we will maximise opportunities to increase and share capacity. There will be a focus on additional actions that need to be taken to reduce the wait times for our children and young people across the system to minimise the impact delays can have on their overall development. Key actions will be:

- Maximise mutual aid across the system to ensure equitable waits and reductions in waiting lists.
- Work with our independent sector providers to increase capacity for specialties under increasing pressure within our acute Providers.
- Work with clinical teams to provide additional capacity within secondary care providers.

- Increase diagnostic capacity and reduce wait times through increasing capacity within community diagnostic centres and improve overall productivity of other diagnostic capacity.

The delivery of the elective recovery plans is co-dependent on other elective delivery plans and the community diagnostic centre delivery plan.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Reduction of acute, community and mental health waiting lists to ensure no one waits more than 65 weeks by March 24	March 2024	Kate Hopcraft, Director of Performance and Delivery	Planned Care Board
Develop clear children and young people's services recovery plan and commence delivery. Paediatric ENT waiting lists for elective surgery reduced.	March 2024	Karlene Allen, Deputy Director of Maternity and Childrens Commissioning / Deputy Chief Nurse & Kate Hopcraft, Director of Performance and Delivery	Planned Care Board
Offer meaningful patient choice at point of referral and subsequent points in the pathway, using alternative providers to minimise waits, embedding mutual aid as routine practice	March 2024	Kate Hopcraft, Director of Performance and Delivery	Planned Care Board
Improve diagnostic wait times across the system	March 2025	Kate Hopcraft, Director of Performance and Delivery	Planned Care Board and System Diagnostic Board

Reduce health inequalities and improve access to elective care:

C&P ICS are committed to reducing health inequalities across planned care services. Utilising local data, we will identify where we have current health inequalities and work with partners and communities to develop plans to address them. For example, during 2022/23 an MSK health inequalities project has commenced with an action plan to address the findings in development.

Within this delivery plan we will also look at opportunities to provide care closer to home through the development and utilisation of community pathways, identifying services or tests that can be carried out in different settings (Point of Care) for example the community diagnostic centres and neighbourhood teams.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Develop MSK Health Inequalities plan following data review	March 2024	Kate Hopcraft, Director of Performance and Delivery	Planned Care Board
Wider data review	March 2024	Kate Hopcraft, Director of Performance and Delivery	Planned Care Board
Engagement and plans developed	March 2025	Kate Hopcraft, Director of Performance and Delivery	Planned Care Board

Embedding personalised care within planned care pathways:

We want to further embed a personalised care approach across our elective services; promote shared decision making and provide access to holistic services to support individuals' well-being.

With the current increases in waiting times, we want to ensure that people are 'waiting well' for their treatment, being supported to access wider services that can support with finances, home, family, and isolation. We also want to provide people with access to information, education and services that will support them with other aspects of their physical or mental health that may cause further deterioration in their condition, impact their ability to have timely treatment or negatively impact their health outcome or recovery time. For example, helping people to stay active or managing another long-term condition (like diabetes). To do all of this we will work with partners across health, social care, local authority, and voluntary sector to promote current services, develop self-care information and sign post to national information. We will work with our population to co-produce information, and future services that meet the local needs.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Work with our population and system partners to develop wrap around services to ensure people 'wait well'	March 2024	Kate Hopcraft, Director of Performance and Delivery	Planned Care Board
Embed a personalised care approach across all planned care, including cancer services	2026	Kate Hopcraft, Director of Performance and Delivery	Planned Care and Cancer Board

Pathway improvement and redesign key deliverables:

There are opportunities across our current pathways to redesign and improve services for the benefit of both our population and our workforce. These include moving services out of hospital and into community settings as well as introducing more 'one stop' clinics, new models of care and new technology. The system will look at best practice pathways, Getting it Right First Time (GIRFT) recommendations and 'best practice' models as we develop our plans.

The ICB will identify pathway reviews through the Planned Care Board and establish system working parties with clinical, operational, and patient representation to identify opportunities and develop impactful delivery plans. Pathways currently under review are:

- Dermatology
- ENT
- Cardiology
- MSK including Orthopaedics and Rheumatology
- Ophthalmology
- Urology

In addition to pathway improvements the system wants to protect secondary care elective work from being impacted by emergency care pressures, particularly through winter. To support this ambition the ICB will work with system partners to develop a strategy for a system wide elective hub, aligned to Hinchingbrooke theatres build and the Hinchingbrooke Hospital redevelopment programme. This will improve system access to elective services, reduce cancellations and disruption for patients and support recruitment and retention of staff through improved staff satisfaction.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Pathway redesign on key specialties to achieve greater integration and outcomes (ENT, dermatology, Urology, MSK and Ophthalmology and cardiology)	2024-2026	Kate Hopcraft, Director of Performance and Delivery	Planned Care Board
Develop a strategy for the C&P ICS Elective hub, aligned to Hinchingbrooke theatres build and Hinchingbrooke Hospital redevelopment programme	2025	Kate Hopcraft, Director of Performance and Delivery	Planned Care Board

Increasing productivity and efficiency:

To ensure that we are maximising all our current capacity across Planned Care services several productivity and efficiency programmes will continue to run across our providers utilising national best practice, and GIRFT. We will ensure that there is shared learning across the system and where there are opportunities for joint working across providers, we will develop joint plans.

Areas of focus are:

- Theatre productivity
- High volume low complexity procedures (HVLC)
- Outpatient productivity
- Right Procedure, Right Place
- Day Case optimisation

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Productivity and efficiency focus to maximise existing capacity, implementation of national benchmarking and best practice including GIRFT	2024-2025	Kate Hopcraft, Director of Performance and Delivery	Planned Care Board and Diagnostic Board
Achieve 85% Theatre Productivity	March 2024	Kate Hopcraft, Director of Performance and Delivery	Planned Care Board
Achieve 85% Day case optimisation	March 2024	Kate Hopcraft, Director of Performance and Delivery	Planned Care Board

Outpatient transformation:

Working with system partners the ICB will continue to improve our outpatient services. Good progress has already been made with rolling out Patient Initiated Follow Ups (PIFU), which supports patients to access services post discharge if needed, but reducing attendance of any unnecessary appointments. Work will continue to increase the use of PIFU across specialties.

We will utilise the GIRFT outpatient specialty guidance to develop specialty-based outpatient transformation plans. We will work with clinical and operational teams from primary, community and secondary care to develop these; exploring how we easily provide more specialist advice and guidance to primary and community care, move more services into a community setting, improve

communication to patients, introduce new pathways/models and ultimately improve patient experience.

This work will be closely linked and embedded into the pathway redesign.

Deliverable/ milestone	**Timeline**	**SRO**	**Oversight group/s**
Achieve >5% of outpatients being discharged to a PIFU pathway	March 2024	Kate Hopcraft, Director of Performance and Delivery	Planned Care Board
Increase the use of specialist advice and guidance	March 2025	Kate Hopcraft, Director of Performance and Delivery	Planned Care Board

Urgent and Emergency Care

Overview

Our UEC Delivery Strategy sets out the priority areas for C&P ICS. Our focus is on keeping people safe and well, and we will deliver this through preventative initiatives, action to deliver services quickly and close to home where possible, and when hospital treatment is required, by ensuring the delivery of safe care, minimising time spent in hospital thus supporting people to return home at the earliest opportunity. We also recognise the ongoing pressure and challenges our staff face, and we want to enhance their ability to work efficiently, effectively, and safely with confidence and full system support. Our plan maps to the national strategic aims and actions.

C&P ICS invested winter funds into a range of schemes to deliver discharge support, enhanced urgent community response and admission avoidance, support for High Intensity Users, as well as additional bed capacity. Where these schemes have demonstrated impact, the system has agreed to sustainably fund these schemes through the additional capacity funding in 2023/24.

In addition, we aim to improve and maintain our grip on daily UEC operations to manage peaks in demand and effective escalation processes through our C&P Surge & Escalation Plan, working together with all ICS partners, and implementation of our System Coordination Centre operating 7 days a week.

The ICB will work with all partners, but in particular via our North and South Place-based Partnerships, and two Collaboratives to deliver the UEC strategic aims and objectives outlined in the following sections.

The C&P UEC delivery strategy objectives are summarised as ensuring that:

1. Patients experience a well-coordinated integrated community urgent care service which enables them to be supported at home where it is clinically safe, instead of attending emergency hospital services. This includes Call Before You Convey as part of our Care Coordination hub model and boosting our Urgent Community Response services including Falls Cars. It also covers continuing work with our 111 service to improve timely access, and to integrate more effectively with on the day urgent care services in line with the Fuller Stocktake vision.
2. Ambulances reach patients in line with national target response times and are able to handover their patients over to appropriate hospital services quickly. This includes the Cat 2 30-minute response time for 2023/24 and improving further in subsequent years, and implementing our handover improvement plan.
3. Patients who do attend hospital Emergency Departments are assessed, treated, and discharged or admitted with 4 hours, delivering the 76% target by March 2024, and improving further in subsequent years in line with national expectations.
4. Patients who are admitted to hospital do not experience delays at any stage in their stay. The net effect of all of our system flow work will reduce hospital bed occupancy which supports delivery of the ED 4 hour wait target, improved handovers and also elective recovery.
5. When their acute care is completed, patients are transferred home first for assessment, or to virtual wards or other intermediate care services to complete their rehabilitation.
6. The system as a whole is well coordinated with tight day to day grip on flow and effective escalation as required. This includes embedding and refining our System Control Centre model and implementing our System Assurance Framework.
7. Making it easier to access the right care – ensuring healthcare works more effectively for the public, so people can more easily access the care they need, when they need it.

The UEC Recovery Plan is dependent on successful recruitment and retention to improve capacity and resilience of existing UEC services and to develop new services such as virtual wards. Our aim is to reduce UEC vacancies and reliance on agency staffing over time. There will be a focus on identifying opportunities to improve productivity and stabilising the workforce in terms of supply, retention and wellbeing following the impact of COVID-19. We will maximise the efficiency and effectiveness of our workforce focusing on a revised temporary workforce model, shared resources, and rostering efficiencies.

Delivery plans:

Emergency Department 4 hour wait performance

We will work with our acute providers to reduce demand, improve ED processes and overall flow to deliver at least 76% patients being treated, admitted, or discharged within 4 hours by March 2024, and deliver further improvements in subsequent years.

Key actions:

- **Increasing sustainable capacity within hospital:** Sustaining additional capacity funded through 22/23 to increase overall bed availability, reducing occupancy and improving flow, specifically on the PCH site. Creating additional capacity for ambulance offloads, increasing Same Day Emergency Activity capacity and new models of care at the front door to accelerate patient journeys such as Frailty models.
- **Improving operational processes, clinical decision making and flow:** Focus on implementation of best practice site management models, effective surge and escalation plans at provider level, appropriate utilisation of escalation spaces and full capacity protocols, including adaption of North Bristol continuous flow model, supported via the ICB SCC. Investment and development in operational and clinical teams, recognising the challenging nature of these roles.
- **Increasing community capacity and alternative models:** Maximising occupancy of virtual wards, expanding available pathways to address core population requirements (i.e. falls, CVD). Ensure front door and inpatient pull and push model into this additional capacity. Sustainable additional investment in falls vehicles and overall increase in our UCRT provision to increase admission avoidance, facilitated through our care coordination hub. Right care first time should reduce number of patients conveyed into hospital and reduce avoidable admissions, supporting better flow and reduced bed occupancy within acute footprints.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
76% 4 hour wait performance	31.3.24	Stacie Coburn, Director of Performance and Assurance, ICB	Unplanned Care Board
95% 4 hour wait performance (subject to national guidance)	TBC	Stacie Coburn, Director of Performance and Assurance, ICB	Unplanned Care Board

Expand new services out of hospital and avoid admission to hospital

As set out in the UEC Recovery Plan Objectives above, our aim is that patients experience a well-coordinated integrated community urgent care service which enables them to be supported at home where it is clinically safe, instead of attending emergency hospital services. This includes Call Before You Convey as part of our Care Coordination hub model and boosting our Urgent Community Response services including Falls Cars. It also covers continuing work with our 111 service to improve

timely access, and to integrate more effectively with on the day urgent care services in line with the Fuller Stocktake vision.

Key actions:

- Expand the Care Coordination Hub scope and capacity, moving beyond the current focus on ambulance services to care homes and primary care, provide coordination across a wider range of UEC services, and reach out beyond C&P boundaries to help manage the impact of border system demand.
- Develop the Urgent Community Response (UCR) service. Our UCR service delivers clinical assessment, treatment, and care at home, avoiding unnecessary hospital admissions. We will work to ensure a UCR response which is consistently under 2 hours where clinically appropriate for at least 70% of patients. We will work with referring services and clinicians to increase use of UCR to avoid hospital admissions and reduce ambulance conveyances. We will develop a more integrated and multi-disciplinary approach to UCR which will provide effective care coordination. This will include simple options and rapid response for referring clinicians. We will develop our Falls Programme, which will include enhancing the UCR offer to encompass more patients who have fallen, reducing the incidence of 'long lies', and supporting multi-agency falls prevention work. We will also develop integrated response pathways Frailty and for specific conditions such as Urinary Tract Infections.
- Develop an ICS-wide frailty strategy in 23/24 to deliver greater consistency in patient experience, integration across community and acute settings and effective multi-disciplinary team working. This will link with work on prevention and proactive primary care to identify frail residents earlier and reduce the risks of hospital admission.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
2-hour response for >70% patients needing UCR	2023/24	Stacie Coburn, Director of Performance and Assurance, ICB	Unplanned Care Board
Sustained reduction in conveyance to ED rate	2023 - 28	Stacie Coburn, Director of Performance and Assurance, ICB	Unplanned Care Board

Increase bed capacity

C&P has consistently overperformed against national targets for increased bed capacity against expected winter demands. We will continue to plan to meet surge demand through a hybrid model, to include:

- General & Acute Hospital beds
- Other beds (i.e., intermediate care)
- Virtual ward beds
- Reduction in demand (admission avoidance schemes)
- Improvements in length of stay and reduction in Criteria to Reside numbers through increased community capacity and improvement in processes to manage patient flow

Deliverable/ milestone	Timeline	SRO	Oversight group/s
92% acute bed occupancy sustained	2024-28	Stacie Coburn, Director of Performance and Assurance, ICB	Unplanned Care Board

Improving discharge from hospital

C&P ICS is committed to the principles of Home First and to support this we will continue to develop our ICS transfer of care hub. We recognise that as a system our developments in this area are not as mature as we would like them to be and are behind other systems who have established models, accelerated through COVID. We have an extensive programme of activity in place for 23/25 to deliver the following outcomes:

- Reduction in number of patients who do not meet criteria to reside for reasons related to Pathway capacity.
- Reduction in length of stay from Clinically fit for discharge date to actual discharge date for complex discharge patients.
- An overall reduction in Emergency Medicine length of stay.
- Improved patient outcomes and reduction of Harm events associated with extended length of stay once clinically discharge ready - reduction in number of Harm events related to extended length of stay.

Our core work streams within this programme are:

- Implementation of a single ICS wide digital solution for patient discharge data. This will aid patient pathway management, visibility of progress, scrutiny, and accuracy of data to drive both operational and tactical efficiencies in how we work as a system and also inform future care models.
- Sustainably investing in additional discharge resources both at a provider and collective Transfer of Care Hub level.
- Reviewing current discharge pathways (delirium/ neuro rehab/ stroke/ IPR) to identify pathway challenges and opportunities to deliver care more effectively and efficiently.
- Building on the Pathway 1 Trusted Assessor principles.
- Full system capacity and demand review to inform future focus areas.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Increase in Pathway 1 capacity (ref Operational Plan 23-24)	31.3.24	Stacie Coburn, Director of Performance and Assurance, ICB	Unplanned Care Board
Reduction in discharge delays (method work in progress)	TBC	Stacie Coburn, Director of Performance and Assurance, ICB	Unplanned Care Board

Virtual wards

C&P ICS have completed demand and capacity modelling to develop a Virtual ward model of approximately 160 beds by 1st April 23, and we will work towards the national target over the next 2-3 years. We are now focussed on increasing utilisation of the available capacity. In line with NHSE's Virtual Ward scaling up plan(s), the priority specialty areas have been:

- Frailty, Respiratory and Heart Failure (North & South)
- Additional pathways have been created for admission avoidance (North) and multi-general specialties within CUHFT.

- Papworth Hospital (RPH) has been developing two pathways, one for Respiratory and the other for pre-cardiothoracic surgery high-risk diabetic patients, although comparatively these are smaller numbers.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
>80% bed occupancy for VW	31.3.24	Stacie Coburn, Director of Performance and Assurance, ICB	Unplanned Care Board
Trajectory to national VW bed target	2024-28	Stacie Coburn, Director of Performance and Assurance, ICB	Unplanned Care Board

Ambulance Response Times and Handover Improvement

The ICS has made good progress in reducing ambulance handover delays and accelerating ambulance response times, specifically for Category 2. The net effect of all of the interventions described above feed into the Ambulance Handover Improvement plan, and joint work with EEAST and EMAS to improve ambulance response times.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Category 2 response <30 mins	2023/24	Stacie Coburn, Director of Performance and Assurance, ICB	Unplanned Care Board
Category 2 response <18 mins in line with nat guidance	2024/25	Stacie Coburn, Director of Performance and Assurance, ICB	Unplanned Care Board
Ambulance handover average <15 mins	TBC	Stacie Coburn, Director of Performance and Assurance, ICB	Unplanned Care Board

Maternity and Neonatal services

Overview

The national, regional, and local maternity and neonatal aim is to provide safer, more personalised, and more equitable care achieved through the following objectives:

- Reduction in stillbirths, neonatal mortality, maternal mortality, and serious brain injury.
- Increase fill rates against funded establishment for maternity staff.
- Improvements to physical and mental health outcomes.
- Reduce health inequalities for pregnant people and babies through an integrated approach to providing care.

The Local Maternity and Neonatal System (LMNS) is the maternity and neonatal arm of the ICS. Cambridgeshire and Peterborough Local Maternity and Neonatal System (LMNS) brings together providers, commissioners, local authorities, service user voice representatives and other local partners to deliver a system plan. Between April 2022 and March 2023 there were 11,474 babies born across Cambridgeshire and Peterborough's Local Maternity and Neonatal System (LMNS) footprint (Cambridge University Hospitals Foundation Trust and North West Anglia Foundation Trust (NWAFT).

To support Cambridgeshire and Peterborough Local Maternity and Neonatal System (LMNS) in delivering the national, regional, and local aims, a three-to-five-year strategy is being coproduced. It is due for completion in September 2023. The overarching objective of the strategy is to follow the national direction of travel through utilisation of local intelligence. This will address maternity and neonatal service challenges and inform the Local Maternity and Neonatal System (LMNS) where to prioritise, integrate and maximise resources.

Key work programmes

Providing safe care is the basis to all maternity and neonatal restoration and service transformation. The overarching work programmes identified to enable safety improvements are:

- Better Births
- NHS Long Term Plan
- Ockenden (independent investigation at Shrewsbury and Telford NHS Trust) report actions.
- East Kent (independent investigation into maternity and neonatal services) report actions.

Within these, here are additional programmes, measures and targets.

To streamline these schemes, a single plan was published in March 2023. The three-year delivery plan for maternity and neonatal services (also known as the single delivery plan) sets out clear responsibilities and measures of success across services and systems and provides measures for what "good will look like" within the focus areas identified below. The Local Maternity and Neonatal System (LMNS) will be working to this plan over the next three years.

Within the key programmes of work the following areas are to be focused upon:

- Listening to and working with women, birthing people, and families with compassion.
- Growing retaining and supporting our workforce with the resources and teams they need to excel.
- Developing a culture of safety, learning and support.
- Standards and structures that underpin safer more personalised and more equitable care.

It has been indicated that equity and equality must be the prioritised when planning, monitoring, and responding to the key work programmes, priorities and focus areas. This is because indicators are that health inequities continue to increase.

Governance and reporting

The Revised Perinatal Surveillance Model is the nationally recognised maternity and neonatal quality governance framework. This has been implemented and embedded locally, as recommended by the Ockenden Immediate and Essential Actions. The Local Maternity and Neonatal System partners report to the Local Maternity and Neonatal System Programme Board. The Senior Responsible Officer (SRO) role facilitates the flow of reporting to and from the LMNS Board and ICB Board. This provides oversight and assurance of safety, quality and transformation work programmes.

Key interdependencies:

- All partners and departments working together to progress the maternity and neonatal safety and improvement agenda.
- Recognition of the lifelong benefits and social care outcomes resulting from good health during pregnancy.

Delivery Plans:

Reduction in stillbirths, neonatal mortality, maternal morbidity and mortality, and serious brain injury

Deliverable/ milestone	Timeline	SRO	Oversight Group
Preterm birth clinics to be operational (included in LTP) - Ockenden & East Kent response Deliverable: All elements to have been implemented, including the offer of Fetal Fibronectin	March 2024	LMNS SRO – Carol Anderson, Chief Nurse ICB CUH – Meg Wilkinson, Director of Midwifery NWAFT – Melissa Davis, Director of Midwifery	LMNS Board
Perinatal Pelvic Health Services (included in LTP) - Ockenden & East Kent response Deliverable: To embed evidence-based practice within antenatal, intrapartum and postnatal care to prevent and mitigate pelvic floor dysfunction resulting from pregnancy and childbirth.	April 2024	LMNS SRO – Carol Anderson Chief Nurse ICB CUH – Meg Wilkinson, Director of Midwifery NWAFT - Melissa Davis, Director of Midwifery	LMNS Board
Saving Babies Lives Care Bundle (SBLCB) focus upon pre-term birth – This is Safety Action 6 of the Clinical Negligence Scheme for Trusts (CNST) now known as the Maternity Incentive Scheme All elements to be implemented and maintained. Particular focus on compliance with all of Element 1	2023-24	LMNS SRO – Carol Anderson, Chief Nurse ICB CUH – Meg Wilkinson, Director of Midwifery NWAFT - Melissa Davis, Director of Midwifery	LMNS Board
Saving Babies Lives Care Bundle (SBLCB) focus upon pre-term birth	April 2024	LMNS SRO – Carol Anderson, Chief Nurse ICB CUH – Meg Wilkinson, Director of Midwifery	LMNS Board

Deliverable/ milestone	Timeline	SRO	Oversight Group
Deliverable: Service transition of the smoke free Pregnancy Service from ICB to provider Trusts. Service integrity preserved.		NWAFT - Melissa Davis, Director of Midwifery	
Maternal Medicine Networks (MMN) - NHS Long Term Plan Deliverable: To ensure that all women in the network's footprint with significant medical problems receive timely specialist care and advice before, during and after pregnancy.	2023-24	LMNS SRO – Carol Anderson, Chief Nurse ICB CUH – Meg Wilkinson, Director of Midwifery NWAFT - Melissa Davis, Director of Midwifery	LMNS Board
Clinical Negligence Scheme for Trusts (CNST) Annual Scheme - NHS Long Term Plan	2023-24 2024-25 2025-26	LMNS SRO – Carol Anderson, Chief Nurse ICB CUH – Meg Wilkinson, Director of Midwifery NWAFT - Melissa Davis, Director of Midwifery	LMNS Board
Midwifery Continuity of Care- focus upon building blocks and areas of inequity and inequality - NHS long Term Plan & Maternity Programme	2024-25	LMNS SRO – Carol Anderson, Chief Nurse ICB CUH – Meg Wilkinson, Director of Midwifery NWAFT – Melissa Davis, Director of Midwifery	LMNS Board
Midwifery Continuity of Care Deliverable: Implementation of the Midwifery Senior Equity Advocate (pilot) Role	2023-24	LMNS SRO – Carol Anderson, Chief Nurse ICB CUH – Meg Wilkinson, Director of Midwifery NWAFT – Melissa Davis, Director of Midwifery	LMNS Board
Midwifery Continuity of Care Deliverable: All women to be offered face to face booking	2024-25	LMNS SRO – Carol Anderson, Chief Nurse ICB CUH – Meg Wilkinson, Director of Midwifery NWAFT – Melissa Davis, Director of Midwifery	LMNS Board
Health Safety Investigation Branch (HSIB) - NHS long Term Plan & Maternity Programme	2024-25	LMNS SRO – Carol Anderson, Chief Nurse ICB CUH – Meg Wilkinson, Director of Midwifery NWAFT - Melissa Davis, Director of Midwifery	LMNS Board
Perinatal Mortality review Tool (PMRT) - NHS long Term Plan & Maternity Programme Deliverable: earlier identification and receipt of 1:1 care when in labour	2024-25	LMNS SRO – Carol Anderson, Chief Nurse ICB CUH – Meg Wilkinson, Director of Midwifery NWAFT - Melissa Davis, Director of Midwifery	LMNS Board
Neonatal critical care Review (NCCR) - NHS long Term Plan & Maternity Programme	2024-25	LMNS SRO – Carol Anderson, Chief Nurse ICB CUH – Meg Wilkinson, Director of Midwifery NWAFT - Melissa Davis, Director of Midwifery	LMNS Board
Maternity and Neonatal Safety Improvement Programme - NHS long Term Plan & Maternity Programme	2024-25	LMNS SRO – Carol Anderson, Chief Nurse ICB CUH – Meg Wilkinson, Director of Midwifery NWAFT - Melissa Davis, Director of Midwifery	LMNS Board
Reduction in smoking during pregnancy - NHS long Term Plan & Maternity Programme	2024-25	LMNS SRO – Carol Anderson, Chief Nurse ICB CUH – Meg Wilkinson, Director of midwifery NWAFT - Melissa Davis, Director of midwifery	LMNS Board

Deliverable/ milestone	Timeline	SRO	Oversight Group
Reducing avoidable admission of full-term babies - NHS long Term Plan & Maternity Programme Deliverable: Trust compliance with Safety Action 3	2023-24	LMNS SRO – Carol Anderson, Chief Nurse ICB CUH – Meg Wilkinson, Director of Midwifery NWAFT - Melissa Davis, Director of Midwifery	LMNS Board

Increase fill rates against funded establishment for maternity staff

Deliverable/ milestone	Timeline	SRO	Oversight Group
Increase Obstetric Leadership Capacity - Ockenden & East Kent response Deliverable: To have in place (x3) obstetric programmed activities	2023-26 April 24	LMNS SRO – Carol Anderson Chief Nurse ICB CUH – Meg Wilkinson, Director of Midwifery NWAFT - Melissa Davis, Director of Midwifery	LMNS Board
Bereavement provision - Ockenden & East Kent response Deliverables: • Daily bereavement service across all trusts • Increase in the number of staff trained in bereavement care •Staff trained in post mortem consent as well as purpose and procedures of post mortem examinations	2023-24	LMNS SRO – Carol Anderson, Chief Nurse ICB CUH – Meg Wilkinson, Director of midwifery NWAFT - Melissa Davis, Director of midwifery	LMNS Board
Accelerate the implementation of the NMC Principles for Preceptorship - Ockenden & East Kent response Deliverable: System benchmark against the NSHE midwifery preceptorship framework when published (later 2023)	2023-26 Apr 24	LMNS SRO – Carol Anderson, Chief Nurse ICB CUH – Meg Wilkinson, Director of Midwifery NWAFT - Melissa Davis, Director of Midwifery	LMNS Board
Unit based retention leads - Ockenden & East Kent response	2023-26	LMNS SRO – Carol Anderson, Chief Nurse ICB CUH – Meg Wilkinson, Director of Midwifery NWAFT - Melissa Davis, Director of Midwifery	LMNS Board
Increase Maternity Support Workers numbers - Ockenden & East Kent response Deliverables: • Evidence of increasing or improvement in fill rates • Increasing number of staff that meet HEE competency framework	2023-26 Apr 24	LMNS SRO – Carol Anderson, Chief Nurse ICB CUH – Meg Wilkinson, Director of Midwifery NWAFT - Melissa Davis, Director of Midwifery	LMNS Board

Deliverable/ milestone	Timeline	SRO	Oversight Group
Increase numbers of midwives (training, recruitment and retention) - Ockenden & East Kent response	2023-26	LMNS SRO – Carol Anderson, Chief Nurse ICB CUH – Meg Wilkinson, Director of Midwifery NWAFT - Melissa Davis, Director of Midwifery	LMNS Board
Capacity and Capability Framework - Ockenden & East Kent response	2023-26	LMNS SRO – Carol Anderson, Chief Nurse ICB CUH – Meg Wilkinson, Director of Midwifery NWAFT - Melissa Davis, Director of Midwifery	LMNS Board
Develop expert neonatal nursing workforce – NHS Long term plan	2023-26	LMNS SRO – Carol Anderson, Chief Nurse ICB CUH – Meg Wilkinson, Director of Midwifery NWAFT - Melissa Davis, Director of Midwifery	LMNS Board

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Improvements to physical and mental health outcomes

Deliverable/ milestone	Timeline	SRO	Oversight Group
Implementation and improvement of access to Perinatal Mental Health services - Ockenden, East Kent & NHS Long Term Plan Deliverable: Perinatal Health Commissioning manager to be in post, co-ordinating the delivery of the transformation plan for Perinatal Mental Health	2023-26 2023-234	LMNS SRO – Carol Anderson, Chief Nurse ICB CUH – Meg Wilkinson, Director of Midwifery NWAFT - Melissa Davis, Director of Midwifery	LMNS Board
Midwifery Continuity of Carer-focus upon building blocks and areas of inequity and inequality - Ockenden, East Kent & NHS Long Term Plan	Timeframe paused for complete roll out	LMNS SRO – Carol Anderson, Chief Nurse ICB CUH – Meg Wilkinson, Director of Midwifery NWAFT - Melissa Davis, Director of Midwifery	LMNS Board

Reduce health inequalities for pregnant women and babies through an integrated approach to providing care

Deliverable/ milestone	Timeline	SRO	Oversight Group
Utilising the Service User voice to ensure services are coproduced and accurately capture the experiences of the population they represent - Ockenden, East Kent & NHS Long Term Plan Deliverable: Scope and agree robust remuneration package for the Maternity and Neonatal Voices Partnership (pilot strategic role)	2023-24	LMNS SRO – Carol Anderson, Chief Nurse ICB CUH – Meg Wilkinson, Director of Midwifery NWAFT - Melissa Davis, Director of Midwifery	LMNS Board
Digital transformation (Access to digital records) - NHS Long Term Plan	2023	LMNS SRO – Carol Anderson, Chief Nurse ICB CUH – Meg Wilkinson, Director of Midwifery NWAFT - Melissa Davis, Director of Midwifery	LMNS Board

Deliverable/ milestone	Timeline	SRO	Oversight Group
Personalised Care and Support Plans (PCSPs) - NHS Long Term Plan Deliverable: Increase maternal uptake to 60%	2023	LMNS SRO – Carol Anderson, Chief Nurse ICB CUH – Meg Wilkinson, Director of Midwifery NWAFT - Melissa Davis, Director of Midwifery	LMNS Board
Midwifery Continuity of carer - focus upon BAME and most deprived 10% of neighbourhoods - Maternity Programme Deliverable: Trajectory and recovery measures in place so all women identified at greatest risk of poorer perinatal outcomes receive priority face to face antenatal bookings	2023-26 2023-24	LMNS SRO – Carol Anderson, Chief Nurse ICB CUH – Meg Wilkinson, Director of Midwifery NWAFT - Melissa Davis, Director of Midwifery	LMNS Board
Equity and Equality framework implementation - Maternity Programme Deliverable: Reduction in inequity through commissioned projects prioritisation of areas of inequity and inequality	2023-26	LMNS SRO – Carol Anderson, Chief Nurse ICB CUH – Meg Wilkinson, Director of Midwifery NWAFT - Melissa Davis, Director of Midwifery	LMNS Board

Cardiovascular disease

Overview

Cardiovascular diseases (CVD) are a group of disorders that affect the heart and blood vessels and are the leading cause of death globally.

According to the World Health Organization (WHO), 17.9 million deaths occur each year due to CVD, which is equivalent to 31% of all deaths worldwide. CVD can manifest as coronary heart disease (CHD), stroke, and heart failure, amongst others. Preventable under 75 years of age CVD mortality in Peterborough is significantly worse than England and regional average, ranked 26th highest district in England, with an increasing trend.

There are risk factors associated with a person's likelihood of developing CVD including age, family history, tobacco use, excess alcohol, excess weight, stress, diabetes, high cholesterol, and especially familial hypercholesterolemia. All these risk factors need to be identified, assessed, diagnosed, and treated to improve health outcomes.

CVD can be broadly prevented through lifestyle changes, such as following a healthy diet, being physically active, avoiding tobacco, and managing stress. Early detection and control of cardiovascular risk factors, such as high blood pressure and cholesterol, can also play a critical role in preventing CVD.

Implementing our cardio-vascular disease strategy is a priority as part of the CPICS ambitions to reduce health inequalities and improve health outcomes.

Our overall ambition for CVD is to reduce rates of CVD in Cambridgeshire and Peterborough through preventative lifestyle changes whilst optimising diagnosis and treatment.

The C&P ICS CVD strategy 21-26 aims to achieve the following outcomes:

- 5% reduction in deaths from cardiovascular disease by Dec 2026
- 5% reduction in acute admissions with heart failure (HF) by Dec 2026
- reduction in death from cardiovascular disease by 10% for PCNs within the worst quintile of death rates from cardiovascular disease by Dec 2026

Specific objectives and success measures to meet the 10-year cardiovascular disease ambition for England:

Atrial Fibrillation (AF)

- 85% of the expected number of people with AF are detected by 2029
- 90% of patients with AF who are already known as a high risk of a stroke to be adequately anticoagulated by 2029

High blood pressure

- 80% of the expected numbers of people with high blood pressure are diagnosed by 2029.
- 80% the total number of people already diagnosed with high blood pressure are treated to target as per NICE guidelines by 2029

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 5 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
- 25% of people with Familial hypercholesterolaemia (FH) are diagnosed and treated optimally according to NICE FH Guideline by 2024

Delivery plans

Optimising treatment of heart failure

Objectives:

- Enhanced joining up of care from integration of HF management pathways across hospital, community & primary care.
- Enhanced patient and carer experience for people with HF.
- Enhanced end of life care for people with HF.
- Enhanced access to care via innovative digital models for delivery of care for people with HF - virtual clinics, remote monitoring, telemedicine.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Implement ICS wide Heart Failure pathway with one stop clinics	2025	Patrick Calvert, Consultant Cardiologist & CVD Clinical Lead	CVD Board HF sub-group
Develop heart failure hub to cover secondary, community and primary care staff.	2024	Patrick Calvert, Consultant Cardiologist & CVD Clinical Lead	CVD Board HF sub-group
Develop six monthly reviews by Heart Failure specialist team	2025	Patrick Calvert, Consultant Cardiologist & CVD Clinical Lead	CVD Board HF sub-group
Develop end of life and palliative training with the heart failure team and establish joined up working with palliative teams	2024	Patrick Calvert, Consultant Cardiologist & CVD Clinical Lead	CVD Board HF sub-group
Integrate HF hub with VCSE and service users	2024	Patrick Calvert, Consultant Cardiologist & CVD Clinical Lead	CVD Board HF sub-group
Develop virtual wards pathway for heart failure	2023	Patrick Calvert, Consultant Cardiologist & CVD Clinical Lead	CVD Board HF sub-group
Develop capacity and workforce plans to support Echocardiography including the option of hand-held devices	2025	Patrick Calvert, Consultant Cardiologist & CVD Clinical Lead	CVD Board HF sub-group & CDC board

Tackling behaviour risk factors, including smoking, exercise and weight management, and improving the management of clinical risk factors, including hypertension, AF, diabetes and hyperlipidaemia

Objectives:

- Increase primary care identification of high-risk groups.
- Deliver improved proactive care to high-risk patient groups, through integrated pathways across all services.
- Maximise digital interventions to support self-management.
- Targeted action to improve hypertension management to NICE recommended levels.
- Further implement the Tobacco Dependency Programme and increase referrals and quits.
- Increase the number the number of NHS Health Checks Programme through diversification and increasing access opportunities.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Use of PHM, data extraction and monitoring e.g. System One, Eclipse, CVDPREVENT Audit to identify high-risk groups	TBC	Louis Kamfer, Dep Chief Exec Officer & Managing Director of Strategic Commissioning, Chris Gillings, Associate Director for BI	Strategic commissioning Group, ICB
Identification of high-risk groups through community pharmacy services	TBC	Sati Ubhi, Chief Pharmacist, ICB	TBC
Implement new model for CVD clinical risk management in primary care	TBC	Jessica Randall-Carrick, GP & CVD Prevention Lead	TBC
Evaluate the incentives programme for pregnant smokers and embed into wider services if positive	March 2024	Val Thomas, Deputy Director, Public Health & CVD Prevention Lead	Tobacco Control Alliance
Treating Tobacco Dependency Programme milestones and targets	March 2025	Jon Bartram, Programme Director, Strategic Commissioning Unit, ICB	Tobacco Control Partnership
Embedding integrated, proactive, and personalised care through place-based initiatives	TBC	South and North Partnerships	South and North Partnership Boards
Embed NHS Health Checks into new Primary Care CVD LES, targeted pharmacies and other providers	TBC	Val Thomas, Deputy Director, Public Health & CVD Prevention Lead	TBC
Managed care team approach	2024	Simon Howard/North Place	HI Board

Governance and reporting

Objectives:

- Agree consistent baselines and measures and track progress towards system outcomes.
- Establish robust reporting, communication and governance arrangements to deliver the 10-year programme.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Agree and monitor CVD prevention KPIs at system level	Dec 2023	Louis Kamfer, Dep Chief Exec Officer & Managing Director of Strategic Commissioning	TBC
Ensure clear leads and governance for CVD prevention and interface with CVD treatment	Jul 2023	Louis Kamfer, Dep Chief Exec Officer & Managing Director of Strategic Commissioning	TBC
Agree project/programme team to drive the systemwide changes	Jun 2023	Louis Kamfer, Dep Chief Exec Officer & Managing Director of Strategic Commissioning	TBC
Engage with service users and staff	Aug 2023	TBC	TBC

Key interdependencies:

Clinical strategy; Primary care transformation and sustainability; Quality, safety, and workforce strategies; Public Health; Health Inequalities Strategy

Population Health Management

Overview

Our joint Health and Wellbeing and Integrated Care strategy recognises that Population Health Management (PHM) is a key tool to support our goals on prevention of ill-health, reduced inequalities, improved outcomes, and quality of 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 long-term vision is that all organisations within the ICS have the skills, resource and information they need to use PHM approaches.

Delivery plans:

There are 4 key elements of successfully delivering Population Health Management capabilities (NHS England PHM Flatpack):

- Infrastructure
    - The infrastructure is the set of basic building blocks that are core for a system to manage the health and wellbeing of a population.
    - This includes having shared and effective leadership, defining the population in question, having an agreed information governance and basic elements of digital and data infrastructure.
- Intelligence
    - PHM involves intelligence-led planning and delivery of services, aligning services with population need to improve outcomes.
    - Once the right infrastructure is in place, the first step in the intelligence process is to understand population need. This is then followed by use of tools and techniques to align need with effective interventions.
- Interventions
    - It is not sufficient to only have the right infrastructure and do the analytics.
    - The next step is to build from the learnings of the analytics to make decisions on the services provided to the public; identifying effective, evidence-based interventions and implementing them.
- Incentives
    - We need to incentivise stakeholders to undertake PHM based initiatives in line with health and wellbeing and integrated care strategies aims and individual patient needs.

Where we want to be by 2026 and how we will measure success:

Phase 1 is all about the data. We have a secure data warehouse that currently contains Hospital, Mental Health, Community and Social Care data. To carry out PHM we need to expand that to include General Practice data and information on the wider determinants of health e.g. Housing and the environment we live in.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Talk to stakeholders and agree the data to be used and the Information Governance that supports its use.	January - April 2023	Louis Kamfer, Dep Chief Exec Officer & Managing	Strategic Commissioning Group &

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Submit Confidentiality Advisory Group application to use data for this purpose	May – July 2023	Director of Strategic Commissioning, Chris Gillings, Associate Director for BI	Strategic Analytics Group
Begin to collect the General Practice data and store it in our secure data warehouse.	August - December 2023		
Link that General Practice Data with the other data available e.g. A&E attendances, to understand patients needs.	August 2023		
Begin to carry out risk stratification and segmentation of our population to help redesign services.	September 2023		
Begin to share that analysis with system partners to enable change.	September 2023		
Pilot interventions and incentives using the PHM approach	2023/24		

Phase 2 is about building better intelligence using the data we pulled together in Phase 1. We will work with system partners to understand what we want PHM to do. We will build the use cases for PHM using all the points of view we have in the system, including that of patients. We will then look for the best solution to deliver that.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Procure a strategic partner to support the programme.	May 2023	Louis Kamfer, Dep Chief Exec Officer & Managing Director of Strategic Commissioning, Chris Gillings, Associate Director for BI	Strategic Commissioning Group & Strategic Analytics Group
Options appraisal	June – August 2023		
Develop specification	August - September 2023		
Shortlist suppliers using national framework and procure	September - October 2023		
Delivery phase	October 2023 – April 2024		

Phase 3 looks at what else we can do with the data and intelligence we have built during the earlier phases. Can we use it to forecast demand over the next 5, 10 and 15 years? Can we use it to build robust geospatial models of need? How can we use it to support research, making sure we do that in line with the views of our population? But overall it will be driving forward whole system analytics, bringing together system partners so we carry out analysis once but look at it from all angles. Not just health need but how that links to housing quality, air pollution, transport links etc.

Key interdependencies:

- Clinical strategy.
- Primary care transformation and sustainability.
- System and organisational Green plans.
- The system's Digital strategy (including virtual wards)
- Quality, safety and workforce strategies.

Source documents: CPICS PHM Delivery Roadmap, NHS England PHM Flatpack, CPICS Health and Wellbeing and Integrated Care Strategy

High Intensity Use Service

Overview

The effective identification and management of those who utilise NHS services more frequently, also known as high intensity use, 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. Those who frequently attend Accident and Emergency (A&E) departments are generally low in numbers, but their impact on the wider health system is significant[1]. For example, across the NHS Cambridgeshire and Peterborough ICS footprint, between November 2021 and December 2022, approximately 100 individuals (0.01% of the total registered population) attended A&E departments in the system 20 or more times, resulting in a total of 3,195 attendances (1.1% of the total A&E attendances).

Previous work to explore high intensity use has generally shown those who attend A&E most frequently are people living in the most deprived communities; are more likely to be admitted to hospital than people who attend less frequently; have poorer physical and mental health; and experience poorer than average health outcomes despite the high use of services.

Those who use NHS services on a more intense basis are 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 approach to supporting these individuals is an important part of improving health outcomes locally and in turn helping to reduce avoidable A&E attendances and admissions over time.

Vision and objectives

- To ensure a personalised care approach is central to the development and establishment of high intensity user services and thereby providing people with more control over their own health, and more personalised care when they need it.
- To better identify those at greatest risk of high frequent A&E attendances and non-elective admissions through existing and emerging data to get up-stream to provide early and more suitable interventions.
- To reduce demand on NHS services (A&E attendances, ambulance call outs, 111 services and GPs) and reduce avoidable non-elective admissions amongst the high intensity user cohort.
- To gain a comprehensive understanding of what is driving the high frequency of A&E attendances and non-elective admissions, thereby identifying specific patient needs which are not necessarily clinical.
- To coordinate links into other services provided by a local network of health and wellbeing support partners.
- To strengthen integrated neighbourhood approaches, through improved communication and partnership working.

[1] British Red Cross report, "Nowhere else to turn: Exploring high intensity use of Accident and Emergency services", November 2021: https://www.redcross.org.uk/about-us/what-we-do/we-speak-up-for-change/exploring-the-high-intensity-use-of-accident-and-emergency-services)

- To contribute to the Core20PLUS approach by tackling inequalities for those living in more deprived areas and who experience poorer than average health outcomes.

Deliverables / Anticipated outcomes:

Based on the success of other services concentrating on those who utilise services more intensely both regionally and nationally, the following are assumed deliverables and anticipated outcomes:

- 40% Decrease in A&E attendances in the selected cohort(s)
- 40% Decrease in non-elective admissions in the selected cohort(s)
- Reduction in avoidable 999 and 111 calls
- Reduction in ambulance conveyances within the selected cohort(s)
- Reduction in GP attendances within the selected cohort(s)
- An increase in Quality of Life as measured by the EQ5D tool (or another validated tool) in the selected cohort e.g. Outcome Star
- Improvement in patient physical and mental health within selected cohort(s)
- Increased number of Personalised Care Plans produced within the selected cohort(s)

Delivery plans

Implementation of a High Intensity User Service (Tier 1 – 'Specialist')

We will work with our place and collaborative partnerships, acute providers, and wider system partners to establish an HIU service focussing on those who attend A&E services more frequently and who are more likely to non-elective admissions. This service will be modelled on the NHSE approach to addressing high intensity use and will build upon existing structures / partnerships in place which are already supporting those people who are utilising A&E services more frequently.

Milestone	Timeline	SRO	Oversight group/s
Business case and service specification agreed and additional investment (if required) approved	Y1	Jon Bartram Programme Director SC	Accountable Business Units (ABUs) & Strategic Commissioning Unit (SCU)
Establishment and implementation of the Tier 1 HIU service	Y1	Jon Bartram Programme Director SC	ABUs & SCU
Initial evaluation and quality improvement of service through co-production and through embedding a personal	Y2	Jon Bartram Programme Director SC	ABUs & SCU
Integrate data from wider system partners and utilisation of population health management insights to better identify emerging HIU patients	Y3-5	Jon Bartram Programme Director SC	ABUs & SCU
Identify drivers (including behaviours, lifestyles, underlying social and emotional reasons) that lead to high intensity use of services to help identify gaps in existing services	Y3-5	Jon Bartram Programme Director SC	ABUs & SCU

Improving outcomes for those at 'rising risk' of utilising services more frequently (Tier 2 – 'Targeted')

Building upon what is included in the Urgent and Emergency Care (UEC) delivery plan and to contribute to the wider NHSE plan for recovering urgent and emergency care, we will develop and implement a Tier 2 'targeted' HIU service at the integrated neighbourhood level, which focuses on those patients who are considered to be 'at risk' of accessing services more frequently. A targeted population health management (PHM) approach will be adopted to identify persons 'at risk' of utilising services more intensely that the general population (i.e., aligning to higher than average A&E attendances, but not limited to this criteria alone) within each Integrated Neighbourhood footprint.

This service will build upon the work carried out over winter 2022/23 where integrated neighbourhood teams supported cohorts of people considered most vulnerable through personalised care approaches, including 'what matters to me' conversations and the development of personalised care plans.

Milestone	Timeline	SRO	Oversight group/s
Business case and service specification agreed and additional investment (if required) approved	Y1	Jon Bartram Programme Director SC	ABUs & SCU
Develop governance model for Targeted HIU Service and signed off	Y1	Jon Bartram Programme Director SC	ABUs & SCU
Work with Place to design, develop and implement a Tier 2 targeted HIU Service	Y1	Jon Bartram Programme Director SC	ABUs & SCU
Evaluation of progress, reporting metrics and outcomes at neighbourhood, place, and system levels	Y2	Jon Bartram Programme Director SC	ABUs & SCU
Refinement of the tier 2 HIU service, including evaluation of new approaches to financial allocations	Y3-5	Jon Bartram Programme Director SC	ABUs & SCU

Key interdependencies:

- Delivery plan for recovering UEC services
- Partnership delivery plans
- Core20PLUS5 approach to tackling health inequalities
- Primary and secondary prevention programmes
- Cambridgeshire and Peterborough drug & alcohol strategy
- Mental health strategy and delivery plans

Advanced Illness (End of Life)

Overview

Our Integrated Care System's Palliative and End of Life Care Strategy 2022-26 was co-produced in recognition of the projected growth in the demand for palliative care, the challenges due to increasing complexity and diversity of our population's needs. Our aim is to build on our existing palliative and end of life care provision to develop services that are equitable, sustainable, informed, and integrated.

The Strategy identified 6 objectives as priorities for the next three years to ensure that people of all ages will have fair access to personalised palliative and end of life care which is person centred, integrated, well led, and maximises comfort and wellbeing to meet, as far as possible, the individual's wishes and choices.

Objectives:

- Early identification and appropriate and accessible information provided.
- Individual's wishes are understood and respected, physical, emotional, social and spiritual.
- Care is coordinated by staff who are well trained and have access to resources.
- Access to end of life care, where possible in preferred place of care with empowerment to make decisions about that care.
- Early access to services for families and carers, including bereavement support.
- Communities are ready, willing, and able to provide support.

Where we want to be by 2026 and how we will get there: (Many of the actions cross more than one objective but will not be duplicated in each in this document.)

Objective 1

- Closer collaboration between all specialities, general health care and social care to ensure early identification of people with life limiting diagnoses.
- Improved access to and experience of palliative and end of life care for those who are neuro-diverse.
- Improved access to, and experience of, palliative and end of life care for those with poor mental health or cognitive impairment.
- Improved access to, and experience of, palliative and end of life care for those with poor mental health or cognitive impairment.
- Improved access to, and experience of, palliative and end of life care for those from different cultural backgrounds and those who are socially isolated.
- Improve the experience and support to families where there is maternal death, or death of a child.

Deliverables/ Milestone	Timeline	SRO	Oversight group
Recognition of the role of General Practice and Community Health, while enabling specialisms to understand the value of palliative care and how to discuss it with patients and families. Use of Eclipse data from GPs and Gold Standard Framework	2023	Palliative & End of Life Care Lead	ICB

Deliverables/ Milestone	Timeline	SRO	Oversight group
Close working with the Sue Ryder Health Inequalities Lead to build on links and listen to the needs of hard-to-reach groups	2023	Safia Akram, Health Inequalities lead	Sue Ryder
Work with LeDeR lead and the Learning Disability Partnerships to improve access to services and understanding of needs	2024	Isobel Wilkerson, Associate Director of Nursing and Quality (OPAC)	CPFT
Closer working between specialist services and generalist to provide holistic support and understanding	2024	Isobel Wilkerson, Associate Director of Nursing and Quality (OPAC)	CPFT
Review current provision and work with service users to agree improved processes where appropriate	2024	Palliative & End of Life Care Lead	ICS

Objective 2

- Continued training on honest and difficult conversations, to be widened to other specialisms
- Improved information provision for public and professionals

Deliverables/Milestone	Timeline	SRO	Oversight Group
Improved local website with information, signposting, and advice in easy read and different languages	2023	Palliative & End of Life Care Lead	ICB
Training Hub to look at rolling out training to specialisms	2025	Sara Robins, Clinical Services Director, Arthur Rank Hospice	Arthur Rank

Objective 3

- Shared Care Records to include all ICS partners
- Improved transition experience for you people and their families

Milestone	Timeline	SRO	Oversight Group
Joint working to improve protocols and provide clear guidance and expectations	2024	Palliative & End of Life Care Lead	ICS
Extension of use of Systm1 to include partners not currently accessing	2026	Palliative & End of Life Care Lead	ICS

Objective 4

- Improved understanding and delivery of patient's wishes
- Improved support to primary care and community health professionals to support them in maintaining patients at home

Milestone	Timeline	SRO	Oversight Group
Develop collaboration between generalist and specialist services. Implement System-wide anticipatory medicines approach. Improved out of hours provision	2023	Palliative & End of Life Care Lead	ICB
Continued ReSPECT training and implementation with system wide process	2024	Sara Robins, Clinical Services Director, Arthur Rank Hospice	Arthur Rank

Objective 5

- Bereavement support is available to all in different languages, age appropriate and to those with sensory impairment

Milestone	Timeline	SRO	Oversight Group
Review current provision, ensure directory is accessible and identify gaps and how to fill them.	2024	Palliative & End of Life Care Lead	ICS

Objective 6

- Engaging with communities and faith groups

Milestone	Timeline	SRO	Oversight Group
Working with Sue Ryder Health Inequalities Lead and North and South Partnerships to involve residents in the conversation and show how we respond to their feedback	2023	Safia Akram, Health Inequalities Lead	Sue Ryder

Key interdependencies:

- All partners and departments working together to progress the End of Life provision
- Recognition that Palliative and End of Life care touches all areas of health and social care
- Sharing of information and data to inform gaps and developments
- Continued development of the Palliative Care Hub

Workforce

Overview

Working to our shared vision of 'All Together for Healthier Futures' and the four pillars of the NHS People Plan, our workforce plans aim to shape an integrated workforce that is inclusive, healthy, flexible and resilient.

We want to ensure our workforce has 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.

Our workforce plans are vitally important to help address the transformational priorities of the system and to mitigate the staffing risks which are facing due to national shortages in many sectors, the strain of prolonged post COVID impact, demographic change, tight local labour markets and lack of affordable housing for health and care workers.

Delivery plans:

Leadership and culture: Developing compassionate and high performing leadership to drive a just and learning culture.

Objectives:

- Support local leaders to work together, learn and share knowledge from across the system with their teams and services to create public services that are more integrated based on the needs of the local population.
- Support inclusion and belonging for all and create a great experience for staff, using evaluation to better understand the needs of our workforce and improve leadership programmes.
- Raise awareness of the negative impact that incivility can have in healthcare, so that we can understand the impact of our behaviours.
- Enable and encourage all leaders to lead and drive these culture changes and address the challenges of leading across systems of care, as well as enable and encourage everyone to understand the new world that we are operating in, and their role in making it a success.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Ensure the sustainability of delivering system wide leadership offers	By 2025	Anita Pisani, Deputy CEO, CCS	Leadership and Culture
As a System work together to develop talent and succession plans	By 2025	Anita Pisani, Deputy CEO, CCS	Leadership and Culture

Equality, Diversity and Inclusion: Work towards driving out inequality, recognising we are stronger as a system that values difference and inclusion

Objectives:

- Develop and deliver EDI training for all staff, including senior leaders and managers.
- Utilise advanced models of culture change and establish a faculty to widen knowledge and reinforce the breadth of delivery across a wide range of leaders, to create a more supportive environment for staff from minoritized backgrounds, shifting away from the deficit model of EDI.

- Develop targeted recruitment strategies to increase diversity within the ICS workforce, with a particular focus on underrepresented and marginalised groups.
- Develop a consistent approach to combating violence and aggression within the Cambridgeshire and Peterborough ICS and throughout provider organisations.
- Engage with local communities and stakeholders through consultation events such as Equality Delivery System (EDS) programmes, focus groups, and other engagement activities to ensure that their voices are heard and their needs are met.
- Develop and implement standards for policies and procedures that promote EDI and ensure that all staff and patients are treated fairly and with respect.
- Develop targeted initiatives to improve health outcomes for underrepresented and marginalised communities through the Health Inequalities programme.
- Provide support and development opportunities for staff from underrepresented and marginalised communities.

As a result of this plan we expect to see:

- Staff will feel valued, supported, and empowered to deliver services that are inclusive and accessible. Equalities data collected as part of the annual staff surveys and other feedback processes will show a trajectory of improvement after several years of decline.

Deliverable/ milestone	**Timeline**	**SRO**	**Oversight group/s**
Implement and build on the "Above Difference programme" to develop EDI leadership and EDI culture	Implementation March 2024 then ongoing	Oonagh Monkhouse, Director of Workforce and OD, Royal Papworth	ED&I
Review and improve EDI training	By 2024	Oonagh Monkhouse, Director of Workforce and OD, Royal Papworth	ED&I
System zero tolerance framework and actions to tackle violence and abuse against staff	By 2024	Oonagh Monkhouse, Director of Workforce and OD, Royal Papworth	ED&I
We will review our policies through an anti-racist lens to ensure they reflect the needs our of people including the implementation of "fair recruitment" recommendations	By 2025	Oonagh Monkhouse, Director of Workforce and OD, Royal Papworth	ED&I

Recruitment and retention: Developing a sustainable supply of staff to meet the health and care needs of our communities.

Objectives:

- Improve retention and progression across our system, increasing social mobility and access to careers in care and health.
- Increase supply of health and care staff, including through international recruitment ensuring we have pastoral support will strengthen and develop our workforce to remain part of our team and thus retaining essential skills and experience.
- Develop one clear, supportive and affordable accommodation process for IRN's within C&P. We will identify the scale and profile of the housing needs amongst key workers, providing evidence of where the pressures are greatest, and work together to find affordable solutions.

- Develop clear system plans from providers, focusing on high-risk areas for workforce and to support integrated workforce planning, including data sharing agreements. Recruitment and retention initiatives to be focused against our C&P Operational workforce plans.

Deliverable/ milestone	**Timeline**	**SRO**	**Oversight group/s**
Development of new apprenticeship routes and expansion of the digital health & care academy	By 2024	Stephen Legood, Director of People and Business Development, CPFT	Recruitment & Retention
Implementation of reservist model	By 2024	Stephen Legood, Director of People and Business Development, CPFT	Recruitment & Retention
Build and implement an ICS retention plan	By 2024	Stephen Legood, Director of People and Business Development, CPFT	Recruitment & Retention
Develop structure and governance to support integrated workforce planning	By 2024	Stephen Legood, Director of People and Business Development, CPFT	Recruitment & Retention
Develop one clear, supportive and affordable accommodation process for IRN's within C&P	By 2025	Stephen Legood, Director of People and Business Development, CPFT	Recruitment & Retention

Babies, Children and Young People

Overview

The Children and Maternity Partnership are committed to work together to build strong families and communities, build capacity, and take a whole family approach, with early intervention to address specific needs. Our vision is to support children and young people to live their lives well and to achieve the highest possible levels of safety, happiness, education, training, physical health, and mental health.

Key strategies underpinning the work programmes:

- Joint health and wellbeing Integrated care strategy
- Special Education Needs and Disabilities Strategy (including early identification and prevention)
- The Maternity and Neonatal strategy will be available from September 2023.Cambridgeshire and Peterborough Equity and Equality plan, incorporating the infant feeding strategy.
- Strong Families, Strong Communities Strategy
- Best Start in Life Strategy (pre-birth to 5 years)/ Family Hubs
- Child and Young People Mental Health Strategy
- Contextual Safeguarding Strategy
- All age Autism Strategy

The programme of work is developed and overseen by the Partnership Executive Group, which includes the Director of Public Health, Director of Children's Services, the Chief Nurse from the ICB and Executive representatives from CPFT, CCS, NWAFT and CUH.

ICS outcomes:

- Reduce childhood overweight/obesity to pre-pandemic levels by 2026.
- Achieve 5% decrease in childhood overweight / obesity by 2030.
- Every child in school will meet the physical activity recommendations.
- Reduce inequalities in overweight / obesity.
- Increase the proportion of children who show a good level of development (GLD/School readiness) when they enter education and reduce inequalities in this outcome.
- Reduce the proportion of young people aged 16-17yrs who are not in Education, Employment or Training (NEET) and reduce inequalities in this outcome.
- Reduce inequalities in both these outcomes.
- Identify the blocks and enablers in the system pathways, especially in relation to investing upstream in prevention and supporting people while waiting for access to services.
- Reduce the proportion of children living in relative poverty.

Healthcare delivery KPIs:

Efficiency	Quality of care	Inequalities
• ED attendance • Re-presentation in ED • Number of unplanned admissions • Percentage of outpatient appointments conducted virtually and in person (by LTC) • Number of GP attendances • Percentage of 111 triage appointments	• Number of asthma deaths • Reduction in Asthma admissions • Number of unintentional injuries • Waiting time in A&E with mental health as a primary admission factor • Length of paediatric admission for CYP with mental health needs as a primary factor • CYP mortality • Number of tooth extractions	• Number of children accessing specialist MDTs for severe obesity (CEW)and or prevention services • Reduced prevalence of Y6 and Y8 obesity • Developmentally appropriate care is in place. • Access to speech and language support • Access to fluoride varnish – dental appointments uptake

Public health deliverables

- Increase uptake of the Healthy Start Scheme
- Promote the Start for Life offer through health and community settings.
- Ensure local service providers including midwifery, health visiting, and community partners have an aligned approach to supporting new families with their mental health during the perinatal period and to develop good parent/infant relationships.
- Ensure all new parents & parents-to-be receive good infant feeding support.
- Provide families with the support and advice they need to access Early Years and Childcare opportunities.
- Ensure damp free accommodation for children with a respiratory condition.
- Increase apprenticeships through Anchor institutions (Councils, Combined Authority, NHS, commissioned services). Consideration to how this crossover with other sections in the JFP as it relates to the HWB Priority 3 as well.
- Improve Mental Health, Emotional Wellbeing and Resilience among the school aged population.
- Improve immunisation rates at entry into school and exit from school.
- Establish a mechanism to improve health outcomes for our school-aged population through a School-Aged Health Transformation Board

Delivery plans:

Perinatal and the Early Years

Aims:

- A whole system approach to improving health and wellbeing of infants, toddlers, parents/carers, and families.
- Improving health equity and supporting foundations for positive health later in life
- Deliver a range of transformation objectives to make maternity and neonatal care safer, more personalised, and more equitable.

- Continue to deliver the actions from the final Ockenden report (safe staffing; workforce training; learning from incidents; listening to families)
- Ensure all women receive personalised care and are supported to make informed choices.
- Reduce inequalities in access and outcomes for the groups that experience the greatest inequalities (Black, Asian and Mixed ethnic groups and those living in the most deprived areas) Children in Care, Care leavers, young carers, young offenders, young parents, Children with SEND, Children in alternative education provision, LGBTQ+, certain Ethnicities, Socio-economic deprivation, Traveller communities.

Our local maternity and neonatal strategy, due to be completed in September 2023, will set out in more detail our approach to achieving these outcomes. The process will include engagement with the Maternity and Neonatal Voices Partnership and co-production activities with people who have lived experience.

More detail on key programmes and actions is set out in the separate delivery plan for maternity and neonatal services.

Family Hubs:

Objectives:

- Implementation of Parenting Support offer
- Parent-Infant relationships and perinatal mental health support
- Early language and home learning environment
- Infant feeding support

Deliverables/ Milestone	Timeline	SRO	Oversight group/s
• Employ Key Connectors • Baby Triple P training • Online Parenting Offer • Systemwide referral process	2023	John Peberdy, Service Director, CCS Helen Freeman, Commissioning Team Manager for Healthy Child Programme, Public Health	C&M Partnership Executive Group
Systemwide process for evaluation of parenting programmes to ensure impact	2024	John Peberdy, Service Director, CCS Helen Freeman, Commissioning Team Manager for Healthy Child Programme, Public Health	C&M Partnership Executive Group
• Systemwide antenatal education programme • Address inequalities and tackle stigma • Peer Support Programme • Parent-Infant pilot	2023	John Peberdy, Service Director, CCS Helen Freeman, Commissioning Team Manager for Healthy Child	C&M Partnership Executive Group
• Workforce training and supervision offer • Digital Parent Support offer	2024-2025	John Peberdy, Service Director, CCS Helen Freeman, Commissioning Team Manager for Healthy Child	C&M Partnership Executive Group
• Review HLE interventions access. • Review additional interventions in EIF guidebook • Enhance SLT offer to Early Years • Digital platform • Training Needs analysis	2023	John Peberdy, Service Director, CCS Helen Freeman, Commissioning Team Manager for Healthy Child	C&M Partnership Executive Group

Deliverables/ Milestone	Timeline	SRO	Oversight group/s
• REAL training • 50 Things App			
• Website launch • Unicef Baby Friendly training • Family Hubs website & physical site • Breastfeeding friendly spaces • Equipment loan scheme • Introducing Solids support (2023-24)	2023-2024	John Peberdy, Service Director, CCS Helen Freeman, Commissioning Team Manager for Healthy Child	C&M Partnership Executive Group

CYP emotional wellbeing and mental health

Where we want to be by 2028 compared to where we are now and how we will measure success:

- A whole system approach to supporting positive wellbeing and mental health across childhood, adolescence and early adulthood.
- Increase year on year access rates to children and young people's mental health services for 0-25s year olds, for certain ethnic groups, age, gender and deprivation.
- Improve transition arrangements, as measured by defined processes for transfer of children to adult mental health support and improved user experience.
- Improve access and waiting times for eating disorders to achieve national metrics of 95% access for urgent and routine cases.
- Improve infant-parent mental health and align with family hubs. Improve perinatal mental health through increased access to perinatal and maternal mental health support.
- Developed needs-led 'risk support' offer for children and young people showing behaviours that are risky, challenging or misunderstood, because current solutions are often expensive yet not meeting the needs of children, young people and families.
- Improve knowledge and delivery of trauma informed approach across services to support a range of CYP including children in care, those in risk support.

Objective:

- Deliver the 7 priorities of the Cambridgeshire and Peterborough Children and young people's mental health (CYPMH) strategy (2022 – 2025).
- CYPMH service improvement and transformation areas

Milestones	Timeline	SRO	Oversight group/s
1- Leadership, commissioning, and governance • Development of a data set for CYPMH system oversight and surveillance • Utilise information to inform future commissioning needs and facilitate joint commissioning of support as identified by the ICS	• 2024/25 • Y 3 - 5	Karlene Allen, Deputy Director of Maternity and Childrens Commissioning / Deputy Chief Nurse ICB Steve Bush, and John Webster, Managing Directors for Partnerships	Children and Young People's Mental Health Board Children and Young People's Partnership Board Mental Health, Learning Disabilities

Milestones	Timeline	SRO	Oversight group/s
			and Autism (MHLDA) Partnership Board
2- Access to timely help and treatment • Primary care training pilot roll out • Development of plans to implement self-referral across services • Develop resources for parent/carers/families whilst waiting for support • Deliver Nationally set waiting times for MH	• 2023–25 • 2023/24 • 2023/24 • Y 3- 5	Karlene Allen, Deputy Director of Maternity and Childrens Commissioning / Deputy Chief Nurse - ICB Steve Bush, and John Webster, Managing Directors for Partnerships	Children and Young People's Mental Health Board Children and Young People's Partnership Board MHLDA Partnership Board
3- Choice of help and treatment options • Implement Single session Thinking (Pilot, evaluate and system roll out) • Review digital options of support. • Deliver interventions based on population needs and updated guidance and research.	• 2023/24 • 2024/25 • Y 3 - 5	Elaine Deazley-Morgan YOUnited partners (CPFT, CCS, Ormiston Families)	Children and Young People's Mental Health Board Children and Young People's Partnership Board MHLDA Partnership Board
4- Meaningful voice and influence of children, young people, and their families (co-production) • Scope co-production activities • Define delivery model. • Utilise CYP/F voices in service developments. • Develop feedback processes to demonstrate involvement and impact of the voice of CYP/F. • Collation and dissemination of tools to embed effective coproduction practices.	• 2023/24 • 2023/24 • Year 1-5 • 2024 • 2024	Steve Bush, Managing Director for Childrens and Maternity Partnership Karlene Allen, Deputy Director of Maternity and Childrens Commissioning / Deputy Chief Nurse ICB lead CYP/M ABU	Children and Young People's Mental Health Board Children and Young People's Partnership Board MHLDA Partnership Board
5- Reaching out to the most at risk • Map available data of current service users • Review available support for high-risk groups. • Scope current inequalities work/projects and how links to COREPlus5 for CYP. • Delivery of identified requirements for our high-risk populations	• 2023/24 • 2024 • 2024 • Y 3-5	Karlene Allen, Deputy Director of Maternity and Childrens Commissioning / Deputy Chief Nurse - ICB Director of Childrens Services for PCC and CCC	Children and Young People's Mental Health Board Children and Young People's Partnership Board MHLDA Partnership Board
6- Confidence, knowledge and skills of the workforce • Implementation and evaluation of primary care training pilot.	• 2023/24 • 2024	Karlene Allen, Deputy Director of Maternity and Childrens Commissioning / Deputy Chief Nurse - ICB	Children and Young People's Mental Health Board

Milestones	Timeline	SRO	Oversight group/s
• Identify education sector need and adapt training options. • Support implementation of national MH roles (acute MH)	• Y 1 - 5		Children and Young People's Partnership Board MHLDA Partnership Board
7- Clarity about what is on offer and how to help yourself • Develop and implementation of communications strategy. • Redevelopment of Keep your head website.	• Y 1 - 5 • Nov 2023	Karlene Allen, Deputy Director of Maternity and Childrens Commissioning / Deputy Chief Nurse - ICB	Children and Young People's Mental Health Board Children and Young People's Partnership Board MHLDA Partnership Board
Transitions • Hold system event to identify workstreams and activities required to support transfer/transitions programme • Resource work streams • Carry out engagement activity • Deliver work programmes • Review changes required to commissioning and contracting • Implement new models and pathways	• Year 1 – 2 • Year 3 - 5	Steve Bush, and John Webster, Managing Directors for Partnerships	TBC
CYP Eating disorders. • Revised front door process to enable timely access Achieve and maintain National 95% target. • Deliver wider CYP ED priorities and adherence to current guidance	• 2023/24 • Y 2-5	Elaine Deazley-Morgan, Service Director for CYP and Families, CPFT	MHLDA Partnership
Perinatal and infant-parent mental health. • Develop and implement action plan. • Implement the Maternal Mental health service. (Loss and trauma service) • Refine and agree perinatal access targets for 23/24 and 24/25 • Deliver service enhancements in line with National guidance and population needs.	• 2023 • 2023/24 • 2023/24 • Y 3-5	Karlene Allen, Deputy Director of Maternity and Childrens Commissioning / Deputy Chief Nurse - ICB Adele McCormack, Service Director for Adults and Specialist MH Directorate, ICB/CPFT	Children and Young People's Mental Health Board Children and Young People's Partnership Board MHLDA Partnership Board
Trauma informed support • Scope demand and provision of trauma support	• 2024 • Y 2 - 4	Karlene Allen, Deputy Director of Maternity and Childrens Commissioning / Deputy Chief Nurse - ICB	Children and Young People's Mental Health Board

Milestones	Timeline	SRO	Oversight group/s
• Develop action plan to improve provision of support, awareness and understanding of childhood trauma		Director of Children's Services, PCC and CCC Steve Bush, and John Webster, Managing Directors for Partnerships	Children and Young People's Partnership Board MHLDA Partnership Board
Access and outcomes • Ensure sufficient capacity available to annually increase numbers of children accessing mental health support, • Improve CYPMH outcomes through increased use of and flowing of clinical outcome data via MHSDS.	• 2023 • Y 1-2	Karlene Allen, Deputy Director of Maternity and Childrens Commissioning / Deputy Chief Nurse - ICB Director of Children's Services, PCC and CCC Steve Bush, and John Webster, Managing Directors for Partnerships	Children and Young People's Mental Health Board Children and Young People's Partnership Board MHLDA Partnership Board
'Risk support' offer • Thriving Partners 'Getting Risk Support' programme: More CYP will be able to continue working with the same helping person when risk changes in their lives rather than being referred on to someone else. • Ensure processes for oversight of high needs children including those eligible for S117 Mental Health Aftercare needs. • Scope need and impacts (outcomes, financial, system impacts) • Develop action plan to support CYP/F and ICS partners. • Review crises support and adapt delivery model based on guidance and population needs. • Collaborate with system partners to ensure effective delivery of CYPMH needs within wider Crisis, UEC, Acute inpatient, Tier 4 pathways. • Development of the CPICS Health & Social Care Protocol for the Support of Children and Young People in Crisis. • Whole system approach to meeting the needs of CYP requiring support with high risk and complex behaviours	• Y 1-5 • Y 1 • Y 2-3 • Y3-4 • Y 2 – 3 • Y 1- 5 • Y 1-3	Steve Bush, Managing Director for Partnership Karlene Allen, Deputy Director of Maternity and Childrens Commissioning / Deputy Chief Nurse - ICB Director of Children's Services, PCC and CCC Steve Bush and John Webster, Managing Directors for Partnerships	C&M Partnership C&M Partnership Executive Group Children and Young People's Mental Health Board MHLDA Partnership Board

CYP social communication, neurodevelopmental and Special Educational Needs and Disabilities

Where we want to be by 2028 compared to where we are now and how we will measure success:

- Improved understanding and support for children and young people who are neurodiverse or differently abled.

- Redesigning the help and support available to families when social communication or neurodevelopmental needs are identified because the current model is unsustainable and not tailored sufficiently to meeting the needs of children, young people, parents, and carers.
- Transformation of how acute hospital-based services are accessed for annual medical reviews by children with complex needs, building on existing pilot work to host these reviews within special schools.
- Integration with the LD MH Partnership/ABU for all age LD&A programme, including systemwide use of the "reasonable adjustment" flag as an early alert, implementation of Quality standards for Dynamic Support Register and all age S117 pathway.
- All young people who have ongoing healthcare needs to benefit from a good and safe transition into adult healthcare services.

Deliverable / Milestones	**Timeline**	**SRO**	**Oversight group/s**
Co-develop the next CPICS SEND Strategy to include requirements in line with the forthcoming SEND and Alternative Review National Standards and SEND workforce planning.	24-27	Carol Anderson, Chief Nurse, ICB ICB Designated Clinical Officer DCS for PCC and CC	SEND Exec Boards Children and Maternity Partnership MHLDA Partnership
Expand the implementation of Cambridgeshire and Peterborough Co-production in Commissioning principles by introducing the 'Are you Coproducing?' toolkit to ensure inclusion, participation and collaboration in design and quality improvements of services.	23 - 25	Carol Anderson, Chief Nurse, ICB ICB Designated Clinical Officer DCS for PCC and CCC Director of Education from PCC and CCC	SEND Exec Boards
Redesign the local offer to meet social communication and neurodevelopmental needs – a needs led model		Director of Childrens Services Director of Education	C&M Partnership Executive Group MHLDA Partnership
Review the Neurodevelopmental Diagnostic Pathway and introduce a range of evidence based diagnostic models to meet the diverse needs of children for early identification, diagnosis, and post diagnostic support.	23-25	Carol Anderson, Chief Nurse, ICB ICB Designated Clinical Officer DCS for PCC and CCC Director of Education from PCC and CCC	C&M Partnership Executive Group/LD&A Board
Expand the Keyworker Collaborative to offer a Keyworker to all 0–25-year-olds with LD and/or Autism who are at risk of admission or out of area residential placement.	24-26	Karlene Allen, Deputy Director of Maternity and Childrens Commissioning / Deputy Chief Nurse - ICB	LD&A Board Children and Maternity Partnership MHLDA Partnership

Deliverable / Milestones	**Timeline**	**SRO**	**Oversight group/s**
Develop an All -Age NHS Continuing Care Pathway	24/25	Carol Anderson, Chief Nurse, ICB	QPF
Develop an All-Age S117 mental health aftercare pathway	24-26	Carol Anderson, Chief Nurse, ICB	QPF
Ensure quality and compliance with statutory timeframes for health services by implementing the SEND EHC Needs Assessment Improvement Plans.	23-25	Carol Anderson, Chief Nurse, ICB ICB Designated Clinical Officer DCS for PCC and CCC Director of Education from PCC and CCC	SEND Exec Boards
Develop a Learning from SEND Extended Appeal Tribunals and complaints programme to support continuous quality improvements and better communication for families.	24/25	Carol Anderson, Chief Nurse, ICB ICB Designated Clinical Officer DCS for PCC and CCC Director of Education from PCC and CCC	SEND Exec Boards
Preparation for Adulthood Programme: Create and adopt a systemwide communication tool for good and safe transitions so that young people with complex health needs feel safe, included, informed and in control of their transition. Implement systemwide Health Education England Transitions in Healthcare training quickly and effectively to ensure ICS workforce competency for improving good and safe transitions. Extend the Peterborough County Council Post-16 Education Offer Strategy to include the health and social care local offer for 16- to 25-year-olds with SEND.	23-25 23-25 24/25	Carol Anderson, Chief Nurse, ICB ICB Designated Clinical Officer DCS for PCC and CCC Director of Education from PCC and CCC	QPF SEND Exec Boards
Promote the 'SEND Pledge' by introducing a consistent set of self-evaluation measures to evidence commitment to improving the experience of children and young people with SEND	23 - 25	Carol Anderson, Chief Nurse, ICB ICB Designated Clinical Officer DCS for PCC and CCC Director of Education from PCC and CCC	SEND Exec Boards

Deliverable / Milestones	Timeline	SRO	Oversight group/s
Integrate SEND and CAMHs Quality Assurance measures into the ICB provider quality assurance visits.	23 - 24	Designated Clinical Officer, ICB	QPF SQG
Co-develop the next CPICS SEND Strategy to include requirements in line with the forthcoming SEND and Alternative Review National Standards and SEND workforce planning.	2024-2027	Carol Anderson, Chief Nurse, ICB ICB Designated Clinical Officer DCS for PCC and CCC Director of Education from PCC and CCC	SEND EXEC Board
Expand the implementation of Cambridgeshire and Peterborough Co-production in Commissioning principles by introducing the 'Are you Coproducing?' toolkit to ensure inclusion, participation and collaboration in design and quality improvements of services.	2023-2025	Carol Anderson, Chief Nurse, ICB ICB Designated Clinical Officer DCS for PCC and CCC Director of Education from PCC and CCC	Children and Maternity Partnership MHLDA Partnership
Health reviews in special schools: CYP enrolled in a special school will be able to access routine health review appointments at school rather than in hospital if appropriate.	23/24	Steve Bush, Director of CYP services, CCS	C&M Partnership

CYP physical health

Where we want to be by 2028 compared to where we are now and how we will measure success:

- CYP Asthma:
  - Reduce reliance on reliever medications
  - Reduce avoidable asthma admissions
- CYP Respiratory:
  - Reduce avoidable hospital admissions due to respiratory exacerbations.
- CYP Epilepsy:
  - Increase access to epilepsy specialist nurses as recommended by NICE.
- CYP Mental Health Epilepsy:
  - Increase identification and support to CYP with epilepsy and mental health difficulties.
- CYP Obesity:
  - Reduce childhood obesity to pre-pandemic levels by 2026.
  - increase the number of children in school meeting physical activity recommendations.
  - Reduce inequalities correlated with childhood obesity.

- Increase the number of holistic individualised plans and person–centred care packages for CYP with obesity.

- CYP Diabetes:
  - Increase access to real-time continuous glucose monitors and insulin pumps across the most deprived quintiles and from ethnic minority backgrounds.
  - Increase proportion of those with Type 2 diabetes receiving recommended NICE care processes.
- CYP Continence: Pilot to reduce demand on hospital-based services for continence advice, guidance, and support by developing a community-based service.

Deliverable / Milestones	**Timelines**	**SRO**	**Oversight group/s**
CYP Asthma programmes • Respiratory forum established. • In line with the CORE20PLUS5 aims, reducing respiratory exacerbations and emergency hospital admissions due to those exacerbations. Joined up approach across primary care /schools /community and acutes. • Asthma management in schools – training package • Wider determinants of health addressed re environment / pollution.	• 2022-2025 • 2023-2025 • 2023-2025 • 2022-2025	Karlene Allen, Deputy Director of Maternity and Childrens Commissioning / Deputy Chief Nurse ICB Jyoti Atri, Director of Public Health Director of Education at PCC and CCC Kirstie Lynn, Service Manager Children's Community Specialist Nursing Service CCS/CPFT	C&M Partnership Executive Group
CYP Diabetes programmes In line with Core20plus5 aims –reducing impact of diabetes in CYP. • Diabetes management pathways in place • Psychological support in place with long-term conditions management • Transitions planning for CYP with diabetes robustly managed. • Joined up approach across primary care /school s/community and acute care. • Use of digital technology to support ongoing monitoring	• 2023-2025 • 2023-2025 • 2023-2025 • 2023-2025 • 2023-2025	Karlene Allen, Deputy Director of Maternity and Childrens Commissioning / Deputy Chief Nurse - ICB Jyoti Atri, Director of Public Health Director of Education at PCC and CCC Kirstie Lynn, Service Manager Children's Community Specialist Nursing Service CCS/CPFT	C&M Partnership Executive group Provider Trusts
CYP Epilepsy programme • Reduction in health inequalities for CYP with long term conditions	• 2023 - 2025	Karlene Allen, Deputy Director of Maternity and Childrens	C&M Partnership

Deliverable / Milestones	Timelines	SRO	Oversight group/s
• In line with Core20plus5 aims –reducing impact of epilepsy in CYP (ensuring epilepsy management pathways in place) • Psychological support in place with long term conditions management • Transitions planning for CYP with epilepsy robustly managed. • Joined up approach across primary care /school s/community and acute care. • Use of digital technology to support ongoing monitoring.	• 2023-2025 • 2023 - 2025 • 2023 - 2025 • 2023-2025 • 2023 - 2025 • 2023-2025	Commissioning / Deputy Chief Nurse ICB Jyoti Atri, Director of Public Health Director of Education at PCC and CCC Kirstie Lynn, Service Manager Children's Community Specialist Nursing Service CCS/CPFT	Executive group Provider Trusts

Mental Health, Learning Disabilities and Autism

Overview

Within our system there is a strong history of partnership working across health, local authority, and voluntary and community sector to plan, deliver and improve services for people with mental health needs, people with learning disabilities and autistic people. This has led to collaborative models of delivery and service improvements to help improve access and outcomes, for example the YOUnited collaboration with the voluntary sector for Children and Young People's emotional and mental health and the implementation of a new community mental health model in Peterborough.

The Mental Health, Learning Disabilities and Autism (MHLDA) Partnership has been set up to drive the development and the delivery of improved care and outcomes for the Cambridgeshire and Peterborough population who receive mental health, learning disability and autism services.

Our vision is to embed collective responsibility for mental health, learning disabilities and autism across our ICS, and together with system partners improve the lives of our local population through driving the transformation of health and care services.

The aims of the collaborative are:

- To develop strong collaborative leadership where MH, LD & A features throughout the ICS to support holistic population health management by making mental health everyone's business.
- To drive the transformation of the design and delivery of care to improve service provision and population health.
- To support reductions in health inequalities which are caused by a complex mix of societal factors through advancing place-based approaches which address the wider determinants of health.
- To support improvements of service users' and carer's experience and recovery through evidence-based interventions, outcome measures, promoting shared decision making and personalised care.

Our delivery programmes for 23-28 are focused on the improvement areas set out in the Long-Term Plan and the NHS Mental Health Improvement Plan, as well as local transformation priorities. The partnership will develop and deliver:

- Community-based models to enable support and care to be provided closer to home, which will help address the demand and capacity pressures on inpatient care.
- A focus on reducing health inequalities, improving outcomes and access to health and care services for people with LD & ASD
- Strong and strategic partnerships with the voluntary sector reducing the burden on secondary and primary services.
- A focus on partnership working and integration.

Delivery plans

Improving access to Mental Health Community Support

Objectives:

- Develop models of care to increase access and experience of mental health support across the spectrum of need.

- Address the demand and capacity pressures in primary and secondary care through redesign and transformation.
- Reduce Health Inequalities through targeted interventions.

Measured by:

- Increase in the number of adults and older adults accessing community mental health services.
- Increase in Dementia Diagnosis rates.
- Reduced waiting times for community mental health services.
- Service satisfaction rates.
- Monitoring of access by hard-to-reach communities.
- Defined outcome measures.

Initiative:

Building integrated community mental health through roll out of stepped care model, which will increase access to mental health services by 5%, improve treatment options, and seek to address wider determinants of health.

Progress to Date:

- Exemplar Pilot delivered in Peterborough and evaluation complete
- Interventions for rollout identified.

Impact:

People with mental health issues will be able to access a wider range of treatment and support options to meet their needs.

Y1-2	**Y3-5**	**SRO**	**Oversight Group**
• Rollout of stepped care model in Cambridgeshire • Delivery of pilot community rehab model • Implementation of Move Away from CPA/Outcomes measurement	• Embed sustainable Community Rehab Model • Embedding Stepped Care model and ensuring interventions support access for younger adults and older adults	John Webster Managing Director, MHLDA Partnership	Community Strategic Partnership

Initiative:

Collaborating with the voluntary sector to strengthen engagement and involvement in the MHLDA Partnership and system structures, ensuring the voice of the VCS supporting mental health and people with a learning disability and autism is represented across all programmes and projects to shape mental health support for our communities.

Progress to date:

- Model agreed
- Partner to support strategic development of the sector identified

Impact:

The MHLDA VCSE sector will have the capacity to meaningfully engage in system structures and are represented across all programmes and projects to shape mental health support for our communities.

Y1-2	Y3-5	SRO	Oversight Group
• Implement model • Launch event and embed sector engagement • Build influence of the sector to support Mental Health, Learning Disability and Autism delivery priorities	• Evaluate success of model • Development of sustainable model led by VCSE	John Webster Managing Director, MHLDA Partnership	MHLDA Partnership Board

Initiative:

Targeted mental health programme for rough sleepers to improve access to treatment and ongoing support.

Progress to date:

• Funding approved for Peterborough service to be implemented
• Provider identified and mobilisation underway

Impact:

People experiencing homelessness will receive specific mental health treatment to support better life outcomes.

Y1-2	Y3-5	SRO	Oversight Group
• Implement Peterborough model Embed in local homelessness pathways and align with Homelessness Hub for Peterborough • Contribute to wider system plan for healthcare for homelessness population	• Evaluate success of programme • Review expansion in line with homelessness access for the system	ICB SRO TBC	Community Strategic Partnership

Initiative:

- Improving pathways for older people with focus on 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.

Progress to date:

Project yet to be initiated.

Impact:

Older People's mental health will be a priority with more opportunities to access a wide range of support and treatment options for individuals and their families and carers.

Y1-2	Y3-5	SRO	Oversight group
• Map system projects with alignment to older people mental health (i.e. frail elderly, loneliness) and link activity to MHLDAP • Refresh Dementia Strategy with system partners • Define programme required to address current waiting times and future delivery options and workforce requirements	• Carry out pilots with VCS partners to support individuals and families/carers • Review and amend treatment pathways	John Webster Managing Director, MHLDA Partnership	Community Strategic Partnership

Initiative:

Lead the implementation of specific areas of the 2022-25 priorities of the C&P children and young people's mental health strategy; including improving transition pathways between Children and Young People's and Adult MH services and ensuring access to services for 18–24-year-olds is developmentally appropriate.

Progress to date:

- CYPMH Strategy developed
- NHSE Toolkit for transitions
- Transitions working group established with representation from Adult and CYP Stakeholders

Impact:

Services will be flexible and developmentally appropriate to meet needs and not determined by rigid age boundaries.

Y1-2	Y3-5	SRO	Oversight group
• Hold system event to identify workstreams and activities required to support transfer/transitions programme • Resource work streams • Carry out engagement activity	• Deliver work programmes • Review changes required to commissioning and contracting • Implement new models and pathways	Karlene Allen Deputy Director of Maternity and Childrens Commissioning / Deputy Chief Nurse - ICB John Webster Managing Director, MHLDA Partnership	Children and Young People Mental Health Delivery Board MHLDA Partnership Board

Developing crisis care and reducing inequalities.

Objectives:

- Build resilience through alternative crisis solutions.
- Improve in-patient discharge pathways building on sustainable interventions to deliver care and support closer to home.
- Ensure system effectiveness in the delivery of statutory responsibilities.

Measured by:

- Adherence to statutory responsibilities
- Reduction in out of area placements and length of stay in an inpatient setting.

- Usage of s136 suite and places of safety

Initiative:

Pathways are improved to ensure patients experience discharge from inpatient settings with treatment and support which meets their needs and reduces out of area placements.

Progress to date:

- System assessment against 10 key initiative supporting effective discharge for Adults and Older People
- NHSE Mental Health and Community Discharge Challenge undertaken to establish action plan
- NHSE national requirements defined under Mental Health, Learning Disability and Autism Quality Transformation Programme to deliver a reimagined model of care.

Impact:

Patients receive quality care when requiring an inpatient admission and when ready to be discharged experience a joined-up process ensuring they are supported in more appropriate settings with the range of specialist support and accommodation to meet their needs.

Yr 1-2	**Yr 3 - 5**	**SRO**	**Oversight Group**
• Implementation of short- and medium-term actions required for pathway improvements aligned to NHSE Roadmap for Quality Transformation • Review of resources and models to improve Adult inpatient discharge process for all service user groups • Accommodation needs assessment complete, and recommendations enacted	• Implementation of long-term actions to improve discharge pathways for Mental Health and Learning Disability • Delivery and assessment of improvements to availability of specialist accommodation and support	Holly Sutherland, Deputy Chief Operating Officer CPFT	Crisis Strategic Partnership

Initiative:

Delivery of the system responsibilities under the Mental Health Act are reviewed to ensure resources are effectively deployed.

Progress to date:

- Scoping the range of interdependent system challenges through system events
- Planning for legislative changes

Impact:

When the Mental Health Act is required, there is a joined-up system response with the appropriate resources, training and awareness across all relevant system partners.

Yr 1-2	**Yr 3 - 5**	**SRO**	**Oversight group**
• Workstream established with system partners to define target operating model	• Implementation of identified changes to deliver MHA responsibilities with identified system	John Webster Managing Director, MHLDA Partnership	Crisis Strategic Partnership

• Review of the AMPH service • Development of case for change • Ensure legislative changes are enacted in the system pathway	resources, appropriate escalation and adherence to legislation	Donna Glover, Assistant Director Safeguarding Cambridgeshire County Council	

Developing learning disabilities and ASD care

Objectives:

- Improve access and experience of services for Autistic people.
- Reduce health inequalities for LD & ASD populations.
- Reduce premature mortality for LD & ASD populations.
- Deliver Autism in schools programme.

Measured by:

- Service satisfaction rates for Autism services
- Reduction in waiting times for Autism services.
- Number of Annual Physical Health Checks carried out.
- Improvement in health interventions for people with a Learning Disability.
- Care and Treatment reviews carried out as per Care, Education and Treatment Reviews guidance.
- Delivery of learning from Lives and Deaths of people with a learning disability and autistic people (LeDeR) in local areas.

Initiative:

Prioritising and enacting the recommendations from the All-Age Autism Strategy to transform adult autism services and improve access and treatment options.

Progress to date:

All Age Strategy 2021-26 in place following engagement with system stakeholders

Yr1-2	**Yr 3-5**	**SRO**	**Oversight Group**
• Review of 8 recommendations to determine priority areas and system partner responsibilities • Additional focus on specific recommendation to improve diagnostic pathways, improve waiting lists and pre and post diagnostic support	• Project delivery against key areas by system partners • Embed pathway and service solutions • Conduct review against strategic recommendations	Karlene Allen Deputy Director of Maternity and Childrens Commissioning / Deputy Chief Nurse - ICB Oliver Hayward Assistant Director – Adult Social Care Commissioning	LD&A Strategic Partnership

Initiative:

Reduce health inequalities for people with a Learning Disability through improved quality and delivery of health interventions such as vaccination programmes, and completion of annual physical health checks.

Progress to date:

- Focus on improving Annual Health Checks via LD register
- LD Needs Assessment commissioned

Impact:

People with a Learning Disability will receive proactive health interventions to improve their health outcomes.

Yr1-2	**Yr 3-5**	**SRO**	**Oversight group**
• Improve quality of Health Action Plan • Continue improvement plan for Annual Health Checks • Needs Assessment to inform scope of further Health Inequalities focus	• Health Inequality programme for LD established • Delivery and impact of health and interventions monitored	Karlene Allen Deputy Director of Maternity and Childrens Commissioning / Deputy Chief Nurse - ICB	LD&A Strategic Partnership

Community Diagnostic Centres

Overview

Working to our shared vision of 'All Together for Healthier Futures', the 2023/24 operational planning guidance, the NHS Long term plan, the Richards report on diagnostics (Diagnostics: Recovery and Renewal. Oct 2020) and the NHSEI CDC National Guidance – June 2022, our Community Diagnostic Centre (CDC) plan aims to deliver flexible and resilient diagnostic capacity for our population.

In the first instance, the current acute capacity will be supplemented by establishing and operating three Community Diagnostic Centres at the North Cambridgeshire hospital (Wisbech), the Princess of Wales Hospital (Ely) and Unex House (Peterborough). This will provide community access to core diagnostic tests while working towards meeting the six primary aims of the CDC programme:

- Improved population health outcomes.
- Increased diagnostic capacity.
- Improved productivity and efficiency.
- Reduced health inequalities.
- Improved patient experience.
- Support for the integration of primary, community, and secondary care.

By ensuring that our population has timely access to diagnostic test we will be able to better identify and provide appropriate treatments at an earlier stage in any disease progression. This will be particularly important in improving outcomes for cancer patients.

Our key targets are to reduce waiting times for diagnostic tests, support faster cancer diagnosis and improve access to screening in the community, including for rural and remote communities.

Oversight for delivery is through the System Diagnostic Board, with clinical and operational representation from all providers.

Delivery plans:

Increase diagnostic capacity

In order to deliver faster diagnostics for cancer services and to meet the 6-week standard for other conditions, we recognise that we need to increase our diagnostic capacity. This will be achieved by improving efficiency and productivity of existing services, but by also increasing the capacity of the services we can offer. CDCs will offer these services closer to the persons home.

Delivery of additional diagnostic capacity through the CDC Programme will occur over several phases:

- **Early Adopter** Additional capacity funded by the NHSE/I CDC Programme (including CT and MRI mobiles on acute sites) in advance of new CDC facilities. CDC funding of mobiles on non-CDC locations will end 31 March 2023.
- **Phase I** Delivery of both CT and MRI mobile capacity in Wisbech (North Cambs Hospital) in April 2023
- **Phase II** Delivery of the new Wisbech CDC facility (providing other diagnostics including NOUS, Echocardiography, ECG, and spirometry) in September 2023

- **Phase III** Delivery of the new Ely CDC facility (based on Princess of Wales Community Hospital) in October 2023
- **Phase IV** Delivery of the Peterborough CDC in 2024/25
- **Later Phases** Explore Southwest CDC

Deliverable/ milestone	Timeline	SRO/Lead Org.	Oversight group/s
Phase I			
CT and MRI Mobiles			
Complete Estates works	Apr 2023	CCS	SDB
Begin: CT	Apr 2023	CUH	SDB
MRI	Apr 2023	CUH	SDB
Phase II			
Wisbech CDC Build			
Complete Estates works	August 2023	CCS	SDB
Begin: NOUS	Sept 2023	CUH	SDB
Cardiology diagnostics	Sept 2023	CUH	SDB
Respiratory diagnostics	Sept 2023	CUH	SDB
Skin	Sept 2023	CUH	SDB
Urology/Gynae diagnostics	TBC	CUH	SDB
Other modalities TBC	TBC	CUH	SDB
Phase III			
Ely CDC Build			
Complete Estates works	Aug 2023	CCS	SDB
Begin: NOUS Service	Oct 2023	CUH	SDB
Respiratory diagnostics	Oct 2023	CUH	SDB
Cardiology diagnostics	Oct 2023	CUH	SDB
CT	Oct 2023	CUH	SDB
MRI	Oct 2023	CUH	SDB
X-Ray	Oct 2023	CUH	SDB
Phlebotomy	Oct 2023	CUH	SDB
Fibroscan	Oct 2023	CUH	SDB

Deliverable/ milestone	Timeline	SRO/Lead Org.	Oversight group/s
Skin	Oct 2023	CUH	SDB
Urology/Gynae Diagnostics	TBC	CUH	SDB
Mammography	TBC	CUH	SDB
Other modalities TBC	TBC	CUH	SDB
Phase IV			
Open Peterborough CDC	Mar 25	NWAFT	SDB
Later Phases			
Explore South West CDC	Mar 24	ICB	IRC

Improve productivity and efficiency through continuous improvement

Our System wide continuous improvement approach will support the work to increase productivity and efficiency. During 2023/24 the ICB will identify opportunities for increased productivity and new ways of working through a capacity and demand review of current diagnostic services across the system. Utilising the outcomes of the review, best practice guidance and engaging system wide clinical and operational stakeholders' improvement plans to maximise productivity and efficiency across diagnostic services will be developed. Utilising continuous improvement methodology and tools the plans will be delivered starting in early 2024. Ongoing review of opportunities, best practice and innovation will continue through maximising expertise within the system Diagnostic board and wider stakeholders.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Adopt a continuous improvement approach	Apr 24	DCI	SDB/QITG
Capacity and Demand Review	Sept 23	DPD	SDB
Development and roll out of productivity improvement plans	March 24	DPD	SDB

Reduce health inequalities and improve patient experience

The locations of the Cambridgeshire and Peterborough CDC were chosen as much as possible to provide easier access to the areas of the country where we see the greatest inequalities. By establishing facilities closer to these communities, we can help address inequality of access. Local efficient services that limit the need for our population to have to always the travel to an acute hospital site will improve their experience of being on a diagnostic pathway. Coupled with a reduced waiting time, this will deliver an overall improved population experience.

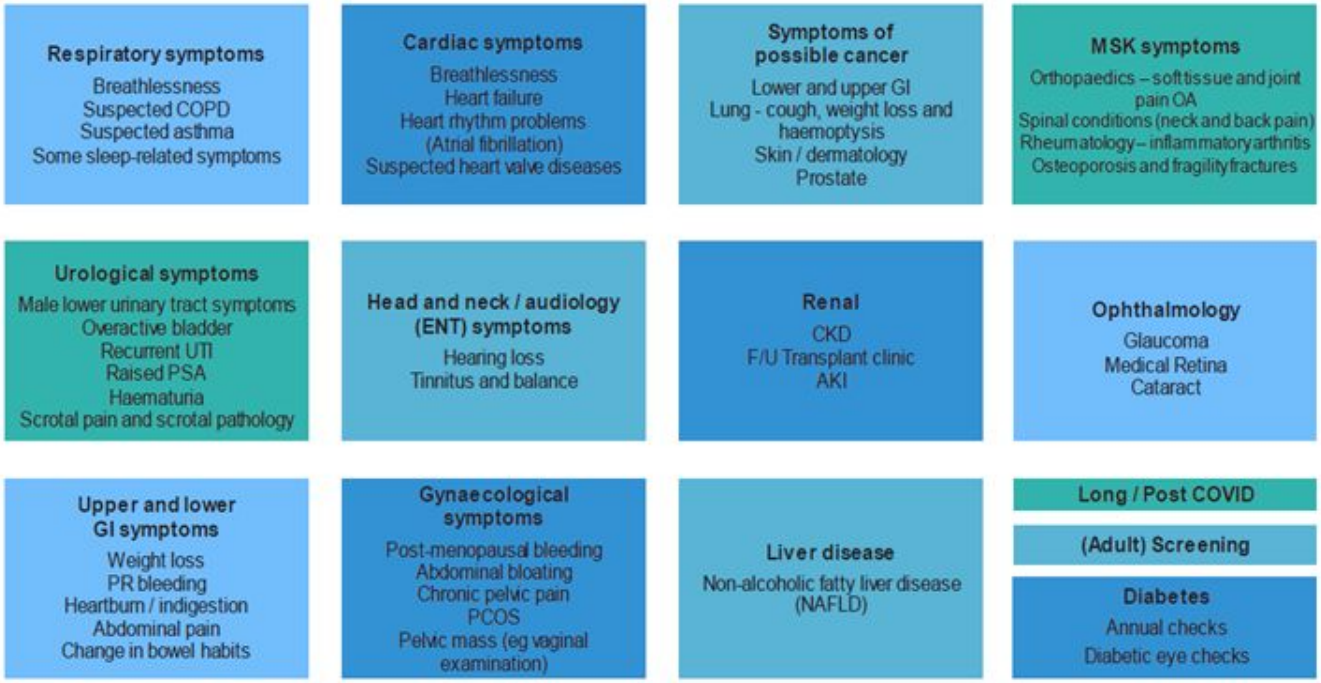
Deliverable/ milestone	Timeline	SRO	Oversight group/s
Improve access for rural/remote communities	Apr 24	DCI	ICB
Improve access for screening	Apr 24	DCI	SDB
Care closer to home	Apr 24	DCI	ICB
Fast access via GP	Apr 24	DCI	ICB

Support for the integration of primary, community, and secondary care

Key to the impact of CDCs will be the ability to design and implement new integrated pathways that will cut across traditional boundaries of primary, community and secondary care. Having a local CDC will encourage the development of shared care and shared pathways, improving our population's experience of health care.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Direct GP access to diagnostics	Apr 24	DCI	SDB
Single results sharing system	Apr 25	ICB CFO	DEG
Integrated diagnostic pathways (See fig. 1 below)	Apr 24	DCI	SDB

Figure 1



(Taken from: Community Diagnostic Centres Guidance for planning, design and implementation. NHSE June 2022, page 20)

Abbreviations

CDC – Community Diagnostic Centre
SDB – System Diagnostic Board
IRC – Improvement and Reform Committee
ICB – Integrated Carer Board
QITG – Quality Improvement and Transformation Group
DEG – Digital Enabling Group
CUH – Cambridge University Hospital – CDC Implementation lead for POW/NCH
CCS – Cambridgeshire Community Services – Estates lead organisation for CDCs at NCH and POW
DCI – ICB Director of Clinical Improvement
CFO – Chief Financial Officer – the CFO is the Exec lead for Digital.
DPD – ICB Director of Performance and Delivery

Primary Care Transformation

Overview

Through embracing the opportunities and delivering the recommendations outlined within the 'Next Steps for integrating primary care: Fuller Stocktake report' (commissioned by NHSE, published May 2022), our aim is to improve primary care services for our population by facilitating the collaborative working required at neighbourhood level to ensure services are as accessible and easy to navigate as possible. Our Primary Care Transformation strategy has three key objectives:

- Support the evolution of more sustainable General Practice clinical and business models.
- Co-design, develop and support delivery of scalable primary care transformation solutions.
- Embed change through service collaboration and integration at neighbourhood level.

We aim to improve access to services for our population whilst driving down health inequalities, supporting General Practice and wider primary care teams to better manage demands on their services and ensuring better patient, carer and clinician experience and outcomes. Integrated working involving health, care, local council, voluntary sector, and community assets at neighbourhood level is key to these changes.

What needs to happen to drive this change?

The Fuller Stocktake Report, and the associated Kings Fund paper 'Levers for Change in Primary care; a review of the literature' (April 2022) highlighted several areas of focus for 2023-25 to support systems in achieving their key objectives. This action framework is detailed below:

Action	Timeline	Oversight Group/s	SRO
Develop a single system-wide approach to managing integrated urgent care to guarantee same-day care for patients and a more sustainable model for practices	March 2025	PCCC, PCOG, Place and Collaborative Partnerships	Gary Howsam
Assist systems with integration of primary and urgent care access	March 2025	Regional PC Strategy & Recovery Groups	N/A
Enable all PCNs to evolve into integrated neighbourhood teams	March 2025	PCCC, PCOG, Place and Collaborative Partnerships	Gary Howsam
Co-design and put in place the appropriate infrastructure and support for all neighbourhood teams	March 2025	PCCC, PCOG, Place and Collaborative Partnerships	Gary Howsam
Develop a primary care forum or network at system level	March 2025	PCCC, PCOG, Place and Collaborative Partnerships	Gary Howsam
Embed primary care workforce as an integral part of system thinking, planning and delivery	March 2025	PCCC, PCOG, Place and Collaborative Partnerships	Gary Howsam
Include primary care as a focus in the forthcoming national workforce strategy to support ICSs to deliver	March 2025	Regional PC Strategy & Recovery Groups	N/A
Pivot to system leadership as the primary driver of primary care improvement and development of neighbourhood teams in the years ahead	March 2025	Regional PC Strategy & Recovery Groups	N/A

Action	Timeline	Oversight Group/s	SRO
Improve data flows	March 2025	Regional PC Strategy & Recovery Groups	N/A
Develop a system-wide estates plan to support fit-for-purpose buildings for neighbourhood and place teams delivering integrated primary care	March 2025	PCCC, PCOG, Place and Collaborative Partnerships	Gary Howsam
DHSC and NHSE should provide additional, expert capacity and capability to help offer solutions to the most intractable estates issues	March 2025	Regional PC Strategy & Recovery Groups	N/A
Create a clear development plan to support the sustainability of primary care and translate the framework provided by Next steps for integrated primary care into reality, across all neighbourhoods	March 2025	PCCC, PCOG, Place and Collaborative Partnerships	Gary Howsam
Work alongside local people and communities	March 2025	PCCC, PCOG, Place and Collaborative Partnerships	Gary Howsam
Embed primary care workforce as an integral part of system thinking, planning and delivery	March 2025	PCCC, PCOG, Place and Collaborative Partnerships	Gary Howsam
Include primary care as a focus in the forthcoming national workforce strategy to support ICSs to deliver	March 2025	Regional PC Strategy & Recovery Groups	N/A
Pivot to system leadership as the primary driver of primary care improvement and development of neighbourhood teams in the years ahead	March 2025	Regional PC Strategy & Recovery Groups	N/A

Where actions are aligned to the ICS, the ICB will convene, engage, facilitate, and assure transformational change acknowledging system partners are critical to delivery. System providers (including all Primary Care providers; General Practice, Dentistry, Optometry and Community Pharmacy teams) will develop and own the plans to drive system change. The ICB will also work very closely with the Place and Collaborative Partnerships and Integrated Neighbourhood Teams to support ownership and delivery where required.

Key to abbreviations:

ICS – Integrated Care System

ICB – NHS Cambridgeshire and Peterborough Integrated Care Board

PCCC – ICB Primary Care Commissioning committee

PCOG – ICB Primary care Operational Group

North/South Boards – Boards of the North/South Integrated Care Partnerships

DHSC – Department of Health and Social Care

HEE – Health Education England

Estates

Overview

Our joint health and wellbeing and integrated care strategy recognises that our estate is a key enabler for the delivery of our vision and for the provision of accessible, safe, integrated and cost-effective health and care services.

NHSPS have worked closely with system partners on a strategic review of estates which has identified priority areas to focus on. Our 3 key objectives were agreed by the ICB Board on 10th March 2023 as part of the ICS Estates strategy 2023 – 2033:

- Transform Places and Spaces
- Create a smarter and greener estate
- Achieve excellence in data and insights

These three key objectives do not sit as isolated headings but are intrinsically woven together and need to reflect wider socio, economic and environmental health factors to enable successful delivery of the system priorities.

As a mechanism to support transformation, the estates element of the JFP is cognisant of the multi-strands required to support living well and reduce health inequalities which includes travel and transport, digital and technology, access to green spaces to name a few. This wider holistic approach which will flow through each priority area and support the wider System Estate Strategy

The success of this workstream is dependent on collaboration with operational, clinical and professional colleagues, with direction on how and where services should be delivered. We have set out the deliverables with ambitious timescales that we will achieve by working across all partners within the ICS. There is further work required on some of the longer-term detailed deliverables.

Delivery plans:

Transform Places and Spaces

Objectives:

- Development of integrated hubs
- Integrated solutions for areas of highest population growth
- Increased access to community diagnostics
- Utilise wider public sector estate

The North and South Partnership delivery plans have identified priorities that support the delivery of care much closer to home. To support this, they each aspire to align the clinical and operational workforce from community health providers to neighbourhood footprints. Additionally, they aim to bring more local people into the workforce so that it reflects the diversity of local communities and proactively helps marginalised people access healthcare closer to home. This ambition will see focus on, but not limited to:

- Discharge to assess
- Virtual wards
- Mental health crises response
- Enhanced health in care homes and
- Urgent community response to support people who are unwell to be cared for safely at home.

- Access to diagnostics from phlebotomy, electrocardiogram and spirometry to more complex diagnostics like MRI and endoscopy without having to bring patients into hospitals.

To enable this both North and South Partnerships seek to develop a shared neighbourhood approach to estate bringing NHS trusts, local authorities and third sector partners together to facilitate the optimum colocation of local services. An overarching aim of this strategic approach is to reduce the need for continual growth of beds in the acute sector. Notwithstanding this objective both North and South Partnerships acknowledge the need for investment in new infrastructure at both Hinchingbrooke and Addenbrookes Hospital sites given the ageing condition of much of the estate at those locations.

Development of the estate is dependant on understanding of the local population needs and how the Partnerships intend to provide care to that population. It is important that the development of the estate is led by these ambitions.

Deliverable/ milestone	**Timeline**	**SRO**	**Oversight group/s**
Develop integrated hub policy and assess site options	March 2025	Kit Connick, Chief Officer, Partnerships and Strategy, supported by David Parke (S) and Lucy MacLeod (N) and linking with North & South Place Partnerships Managing Directors	System Estates Group
Agree physical estate required in areas of highest population growth	March 2024	Kit Connick, Chief Officer, Partnerships and Strategy, supported by David Parke (S) and Lucy MacLeod (N) and linking with North & South Place Partnerships Managing Directors	System Estates Group
Community diagnostic centres established in Ely, Peterborough and Wisbech	March 2024	Robert Freake, Assistant Director of Estates and Facilities, CCS & Gary Howsam, CCIO ICB	System Estates Group
Work with partner organisations to assess options for optimising public sector estate and creating collaborative solutions	March 2025	Kit Connick, Chief Officer, Partnerships and Strategy/ Alison Manton, Associate Director of Estates, CPFT	System Estate Group
All RAAC constructed health buildings have been identified and have remediation plans in place	March 2024	Kit Connick, Chief Officer, Partnerships and Strategy & David Parke, Assistant Director of Sustainability and Infrastructure	System Estates Group
Strategic growth sites have System approved business cases in place for delivery of healthcare	March 2025	Kit Connick, Chief Officer, Partnerships and Strategy, supported by David Parke (S) and Lucy MacLeod (N) and linking with North & South Place Partnerships Managing Directors	System Estates Group
Full Business Case Approval for new Cancer Hospital and Children's Hospital and Hinchingbrooke Hospital	March 2025	Trust Project Directors	System Estates Group
Long term plans for CUH, Fulbourn, Princess of Wales and Brookfields supported by System	March 2025	Trust Project Directors	System Estates Group

A smarter and greener NHS estate

Objectives:

- Improve estate flexibility and utilisation.
- Reduce office accommodation.
- Optimise assets and remove unwarranted variation.
- Achieve net zero by 2040 for the emissions we control directly (and by 2045 for our entire emissions profile).

As a costly asset, it is critical that the full capacity of our estate is utilised. In many cases our estate is only utilised during peak day times with significant capacity out of hours. There are various reasons for this but in the main is because of traditional working patterns rather than patient preference. We need to understand whether changes can be made that would result in our space being used for longer periods of time before we make decisions to invest in additional space, that also brings additional costs. We must also ensure that we consider carefully whether investment in more space and in particular new build is the most sustainable option available.

The recently published NHS Net Zero Building Standards provides tools to consider the whole life environmental cost of new build versus refurbishment. We should also be considering whether investment in more digital infrastructure can provide more sustainable solutions to delivering healthcare before increasing our estate footprint. These key questions should be resolved in all business cases for new estate.

The pandemic has change how many of us work and we recognise that there may be an opportunity to reduce the amount of office space that we have across the system. This may be made more possible by our partner organisations sharing access to locality office hubs that could offer opportunities for improved collaboration spaces.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Achieve an overall reduction in office accommodation across the System through use of digital transformation, sharing of work hubs across organisations and creation of the most suitable spaces.	March 2026	Lucy MacLeod Assistant Director of Infrastructure & Sustainability (North) & David Parke Assistant Director of Infrastructure & Sustainability (South)	System Estates Strategy
Ensure care is being delivered in the right place and our estate in turn is being utilised as efficiently as possible	March 2025	As above	System Estates Strategy
Apply the NHS Net Zero Building Standards to all proposals for refurbishment and new build	March 2024	Fiona O'Mahony, Programme Manager, ICS Sustainability, David Parke, Assistant Director of Infrastructure & Sustainability (South) & Lucy MacLeod Assistant Director of Infrastructure & Sustainability (North)	System Estates Strategy

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Develop decarbonisation plans for all our buildings that will support a road map to the net carbon zero target for the NHS	March 2024	As above	System Estates Strategy
Deliver care as close as possible to home with the support of digital technology where possible to reduce unnecessary journeys	March 2026	Nicci Briggs, Chief Finance Officer & John Clayton	System Estates Strategy

Excellence in delivery and insights

Objectives:

- Improve estate data and insights.
- Develop a long term System owned capital plan.
- Resource and PMO to drive delivery.

Our health and care estate must be safe and compliant with regulations and provide welcoming and accessible spaces for both our patients and staff. Adequate and sustained levels of investment will be continually required to achieve this. Given the challenging capacity and financial pressures of the system this will continue to be difficult, but it must be a core part of the Estate Strategy.

The partners across the System should have a shared understanding of priorities to support informed decisions on investment and a longer-term capital investment plan is required to support a roadmap to improving our estate. Access to a comprehensive data providing insight into how our estate performs is vital to enable the right investment decisions to be made. This data has not been available in one place and so we have ambition to facilitate access to this data from a shared planning tool.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Estate financial and condition data from System partners to be accessed from a shared planning tool	March 2025	All respective System CFOs	System Estates Group
Develop ICS capital investment prioritisation framework	March 2024	Nicci Briggs, Chief Finance Officer, ICB	Capital and Investment Committee
Long term System capital prioritisation to be agreed and understood by all partners	March 2025	Nicci Briggs, Chief Finance Officer, ICB	Capital and Investment Committee
Update governance for managing the System estate and provide dedicated PMO support	September 2023	Kit Connick, Chief Officer Partnerships & Strategy, ICB	System Estates Group

Digital

Overview

Our digital vision is to use technology to improve outcomes for residents by empowering them to control 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 and developed collaboratively over a 12-month period with our health and care partners across the region. 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 residents.

Our digital vision enables delivery of our ICS system-wide vision and goals and allows us to achieve the digital aspirations of NHS England.

All the programmes support us to achieve this vision and to develop a world-class digital infrastructure and information systems. Our strategy builds on what already is working well across our system. 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 digital programmes are:

- Shared care record
- Electronic patient record
- Digital social care records
- Secure data environment
- Transforming primary care
- Digital innovation and transformation
- Robotic process automation
- Virtual wards
- Diagnostics and digital image sharing

To get the best value for our residents, 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.

Delivery plans:

Shared Care Record - connect

The SCR gives visibility of GP, community, social care, mental health and acute patient records. This supports safer and better joined-up care as residents move between different parts of the health and social care system.

What we want to achieve by when:

- Appropriate access to a complete view of a person's health and social care record for all clinical teams by March 2025.
- Non-clinical staff in social care settings able to access appropriate information and input data into digital records in real time.

Milestone	Timeline	SRO	Oversight group/s
Phase 1 Go Live (Primary Care, Community and Mental Health Data)	Q1 FY23/24	Scott Haldane, Director of Finance, CPFT	DEG
Phase 2 Go Live (Acute and social care data)	Q4 FY23/24	Scott Haldane, Director of Finance, CPFT	DEG
Onboarding of other care settings (Care homes, hospices etc)	Q4 FY24/25	Scott Haldane, Director of Finance, CPFT	DEG

Electronic patient record (EPR) - connect

Our EPRs/ EPR will provide clinicians with more information at their fingertips to make better, more effective decisions, where we don't already have this. They give automatic access to decision support tools to ensure that clinical decisions are based on the best available information.

What we want to achieve by when:

- Interoperable systems across hospital settings, giving one view of a residents' care, rather than having to access several systems.

Milestone	Timeline	SRO	Oversight group/s
Options assessed and system approach agreed	Q1 FY23/24	Nicci Briggs, Chief Finance Officer, ICB	Management Exec / ICB
Board approvals	Q2/Q3 23/24	Nicci Briggs, Chief Finance Officer, ICB	Management Exec / ICB
Joint Contract Procurement (RPH/NWAFT)	Q1 24/25	Nicci Briggs, Chief Finance Officer, ICB	Management Exec / ICB
RPH EPR Go Live	Q3 26/27	Nicci Briggs, Chief Finance Officer, ICB	Management Exec / ICB
NWAFT EPR Go Live	Q1 28/29	Nicci Briggs, Chief Finance Officer, ICB	Management Exec / ICB

Secure Data Environment (SDE) - transform

SDEs will provide approved users with timely and secure access to health and care data. These users can be researchers, analysts and planners across the health and care ecosystem. The SDE was previously called a Trusted Research Environment and it is used for research across care settings.

SDE service Users are given access to the data approved under data sharing agreements. The secure platform puts virtual walls around data under each agreement to ensure that users can only access data for which they have been approved. All data is de-identified so does not contain personal information such as names, addresses or NHS numbers.

SDEs will become key platforms to access NHS health and social care data for research into diseases and conditions affecting the population. They will support the development of new treatments and the analysis of how health and care is delivered to continually improve it.

What we want to achieve by when:

- Support of the OBC by agreeing the statement of support [attached] for inclusion in our updated OBC to be submitted to NHS England.
- Subject to confirmation of funding, engage with the development of pilot use-cases in 2023-24.

- Mobilise and deliver momentum around this vision, and ensure we have access to a range of stakeholders to provide support, feedback, and challenge.

Milestone	Timeline	SRO	Oversight group/s
OBC agreement and letters of support	Q1 23/24	Mark Avery, Director of Informatics, CUP and EAHSN	DEG
Engage with the development of pilot use-cases (subject to confirmation of funding	Q4 23/24	Mark Avery, Director of Informatics, CUP and EAHSN	DEG

Transforming primary care – digitise and transform

The programme will delivery digital improvements to support primary care transformation.

What we want to achieve by when:

- Development of PCN and Practice staff, to ensure collaboration and consistency of digital offering, through an ICS-wide training approach.
- Employment of Training Team Coordinators to support and spread the learning to all PCNs and ensure consistency of services.
- Continuation of existing PCN Digital Champions roles and delivery of a coordinated digital development programme

Milestone	Timeline	SRO	Oversight group/s
Development of PCN and Practice staff	Q3 23/24	Greg Lane, Director of Clinical Improvement, ICB	Management Exec / ICB
Employment of Training Team Coordinators	Q3 23/24	Greg Lane, Director of Clinical Improvement, ICB	Management Exec / ICB

Digital innovation and transformation – digitise and transform

Digital Innovation and transformation support implementation of innovative technologies and new processes to improve health and care interventions.

What we want to achieve by when:

- Plan and hold an engagement event in C&P to address the innovation strategic priority and to ensure that we adapt the right technologies and also support our own innovations to scale.
- Plan and monitor benefits that will be gained from applying new innovations.
- Amend rollout plans if needed to ensure innovation is adopted and spread.
- Evaluate the short, medium, and long-term impact of innovation.

Milestone	Timeline	SRO	Oversight group/s
C&P Supplier Innovation Engagement event	Q3 23/24	Nicci Briggs, Chief Finance Officer, ICB	Management Exec / ICB
Agree and adopt digital innovation strategy and plan	Q4 23/34	Nicci Briggs, Chief Finance Officer, ICB	Management Exec / ICB

Digitising social care records (DSCR) – digitise and connect

The DSCR allows the digital recording of care information and care retrieved by an individual in a social care setting, replacing traditional paper records. The outcomes are person centred records, which enable information to be shared securely and in real time, with authorised individuals across the health and care sector. These records will play an important part in joining up care across social care and the NHS, freeing up time spent by care workers and managers and administrative tasks, whilst equipping them with the information they need to deliver care.

What we want to achieve by when:

- 80% of CQC registered Adult Social Care Providers have a digital social care record solution in place that can interoperate with a local Shared Care Record by March 2024

Milestone	Timeline	SRO	Oversight group/s
Year 1 Target Completion (30 Care home settings)	Q1 23/24	Rob Nimmo, ICS Head of Digital Transformation	DEG
Year 2 Plan Sign off	Q1 23/24	Rob Nimmo, ICS Head of Digital Transformation	DEG
Completion of Year 2 Target (80% of CQC registered Adult Social Care Providers)	Q4 23/24	Rob Nimmo, ICS Head of Digital Transformation	DEG
Year 3 Plan Sign off	Q1 24/25	Rob Nimmo, ICS Head of Digital Transformation	DEG

Virtual wards - transform

Digital support for implementation of virtual wards.

What we want to achieve by when:

- Continue the roll out and safe expansion of the programme. This should include a strategy for wider integration with UCR and other 'front door' services.
- Consistent clinical pathway design
- Safe and cost-effective utilisation of digital monitoring across C&P.

Milestone	Timeline	SRO	Oversight group/s
Agree programme funding for FY23/24	Q2 23/24	Kim Ashall, Head of Virtual Wards Programme, NWAFT and system	DEG
Develop digital workstream including agreement on resourcing and governance	Q2 23/24	Kim Ashall, Head of Virtual Wards Programme, NWAFT and system	DEG
Agree workforce and digital delivery plans (subject to funding confirmation)	Q3 23/24	Kim Ashall, Head of Virtual Wards Programme, NWAFT and system	DEG

Robot process automation (RPA) – digitise and transform

RPA can support our staff in patient administration, appointment scheduling, report generation and distribution, and in back-office processes in corporate functions like HR, finance, claims and administration.

What we want to achieve by when:

- Review and consolidate a Robotic Process Automations across the system.
- Build on existing capabilities within the system and share best practice for automations.

Milestone	Timeline	SRO	Oversight group/s
System wide review and strategy and benefits case for board approval	Q1 23/24	Keith Donovan PMO - Cambridgeshire & Peterborough ICS – Regional Productivity Group	DEG
Implement existing automations in 4 providers that currently have no RPA	Q3 23/24	Keith Donovan PMO - Cambridgeshire & Peterborough ICS – Regional Productivity Group	DEG
Establish regional RPA community of practice group	Q3 23/24	Keith Donovan PMO - Cambridgeshire & Peterborough ICS – Regional Productivity Group	DEG

Digital diagnostics capability - digitise

Development of new diagnostics capacity to enable image sharing and clinical decision support, linked to the development of Community Diagnostic Hubs and imaging and pathology network improvements.

What we want to achieve by when:

- Improved diagnostic waiting times, with more accurate image interpretation, leading to earlier treatment, improved outcomes, and reduction in care needs.

Milestone	Timeline	SRO	Oversight group/s
Scope diagnostic & imaging clinical requirements across C&P ICS	Q1 23/24	Savi Cartwright, Strategic Clinical Services IM&T Consultant	DEG / System Diagnostics Board
Gather & document business requirements from multiple stakeholders and translating the requirements into diagnostic digital programme requirements.	Q2 23/24	Savi Cartwright, Strategic Clinical Services IM&T Consultant	DEG / System Diagnostics Board
Production of C&P Diagnostic & Imaging Plan/OBC for Year 1/2/3 of the diagnostic's digital capability programme, with implementation plans in short and long-term savings	Q2 23/24	Savi Cartwright, Strategic Clinical Services IM&T Consultant	DEG / System Diagnostics Board

Enabling themes

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.
- Providing the best security for our IT systems and data.
- Optimizing our Electronic Patient Record Systems, creating a safe, robust, and fast network.
- Enhancing our Electronic Prescriptions and Medicines Administration systems (EPMA).
- Continuing to improve our digital maturity as a system.

Improved models of care:

- Co-designing services and innovation with our residents to provide the best possible health and care.
- Embedding robotic processes where they bring benefits.

Bringing our people with us (digital upskilling):

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

Supporting our residents:

- Personalisation of services so that our residents are in control of their health and care.
- Implementing our shared care record, patient portal, population health management system and digitising social care record programmes.

Population health management and research:

- Providing digital services that support and improve our delivery of care and reduce health inequalities.
- Developing 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 resident outcomes, working within the national What Good Looks Like Framework.
    - Well led – We will 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 ensure that we are delivering the best possible digital outcomes.
    - Ensure smart foundations – We will 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 – We will continue to work will all organisations to ensure that our digital services meet the standards required for safe care.
    - Support people – We will work across the system to develop a workforce that is able to 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 within our system to access and share information across care settings is recognised as a key enabler for truly transformational change.

- Empower residents - We will provide access to our digital services to allow residents to collaborate with health and care professionals. We will enable citizen access to their integrated care record and care plans to empower then to manage their own health and care needs and will provide digital services to support residents to stay healthy or to manage monitoring and treatment at home. We want to enable our residents 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.
- Improve care – We will develop new ways of working and models of care through the introduction of innovative digital tools and services, 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 - We will 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 our operational analytics capability allowing us to improve system wide resource utilisation, flow, and the identification of system pressures.

Cambridgeshire South Care Partnership

Overview

Locally, the organisations that provide support, care and healthcare are working together as the Cambridgeshire South Care Partnership (CSCP) to better understand and address the needs and ambitions of people in our communities. We are developing new ways of collaborating and using our combined resources (staff, estates and funding) to deliver more joined up care, so that people living and working in our neighbourhoods experience the health and wellbeing outcomes that matter to them.

Our partnership is committed to transforming the ways we organise and deliver care so that our local people can enjoy healthy lives in strong, connected communities. We will do this by co-developing person-centred care models, informed by our people, data, and best practice evidence. We will collaborate with the Integrated Care Board teams, and our colleagues in the other partnerships and collaboratives to ensure alignment, avoid duplication of focus or effort, and minimise unwarranted variation.

The Cambridgeshire South Joint Strategic Board was established in August 2022 and is co-chaired by representatives from the local authorities, primary care and the hospitals.

Our Programme Boards will support the Cambridgeshire South Joint Strategic Board to lead the strategic co-development and delivery of new models.

We have agreed hosting arrangements for Cambridgeshire South Care Partnership with Cambridge University Hospitals NHS Foundation Trust and continue to build the team and structures to support future delivery.

South Place Partnership delivery priorities for the next two to five years:

- Build community-based infrastructure to enable support and care to be provided at home or in a neighbourhood setting, including Integrated Neighbourhood partnerships and care teams, care coordination hub, capacity and resilience, community diagnostics infrastructure.
- Embed an integrated proactive and personalised care approach to reduce inequalities and increase years people enjoy good health.
- Enable ‘home first’ through optimising and integrating urgent community/intermediate care to maximise care at/close to home and reduce attendance or admission to acute services.
- Enable ‘home first’ through improved discharge coordination, pathway optimisation and new virtual care models to ensure right care in the right setting.
- Collaboratively develop partnership working and integration enablers.

Through these delivery priorities we will focus on individual schemes which contribute to the achievement of the ICS priorities. In year one we will focus on cardiovascular disease, high intensity users, the urgent community response, hospital discharge and virtual wards.

In addition, we will work to support the delivery priorities led by other parts of the system including primary care resilience, community diagnostics and digital transformation.

Delivery plans

PRIORITY 1: Building community-based infrastructure to enable support and care to be provided at home or in a neighbourhood setting

OBJECTIVE 1.1

Build integrated neighbourhoods (INs) - In collaboration with local partners, lead the development of resilient Integrated Neighbourhood partnerships that can hold responsibility for design and delivery of support and care to meet the needs and ambitions of their population.

Progress to date:

- Neighbourhood Programme team in place, and linking with partner teams to support development of neighbourhood partnerships
- Co-developed and agreed 'working draft' Operating Framework for Integrated Neighbourhoods
- Hosted workshop for key partners across Cambridgeshire South to co-develop implementation plans for next 1-2 years
- Four Integrated Neighbourhood Boards established, building on existing governance and partnership working
- All Neighbourhood teams worked with new partners to deliver support and care through team-based arrangements

Milestones Y1	Milestones Y2	Milestones Y3-5	SRO	Oversight Group
• Each Neighbourhood has agreed its priorities based on PHM approach, staff insight and lived experience, and develop Annual Plans for delivery • All Neighbourhoods will engage with their communities about the experience and outcomes that matter to them • Neighbourhood budgets agreed for Integrated Neighbourhood Teams (INTs) with health, social care and VCS staff co-locating by the end of 23/24 (as physical estate permits) • Co-develop a plan for 'hubs' for communities to access services in their Neighbourhood	• Integrated Neighbourhood Operating Framework finalised, building in learning from 23/24, which ensures each neighbourhood has an agreed delivery plan, including shadow responsibility for relevant population outcomes. • Agree/delegate Neighbourhood budgets to fund transformation and service delivery • Co-design Neighbourhood workforce and organisational development, estates and digital infrastructure plans to deliver new way of working in neighbourhoods • Lead the development of, and embed core training and induction for Neighbourhoods, working for all partners	• Visible shift to all partners (patients, staff, providers) in how we plan and deliver care locally • Evaluate impact of Neighbourhood partnership based model – experience and outcomes that matter to citizens, e.g. increased years of healthy life expectancy	Erin Lilley, Director, Partnership Development & Transformation, CSCP	Proactive and Personalised Care Programme Board

OBJECTIVE 1.2:

Build integrated neighbourhood teams - In collaboration with system partners, lead the development and testing of a Neighbourhood-based personalised team care model to deliver proactive care, improve continuity of care and reduce health inequalities.

Progress to date:

- Improved recruitment of Additional Roles Reimbursement Scheme (ARRS) roles in PCNs.
- Implemented Winter Personalised Care initiatives across all PCNs and their partners.
- Tested patient experience and outcomes measurement tool.
- Developed and recruited to Personalised Care lead role, hosted within a VCS partner.
- Worked with partners to start planning for alignment of community staff within Integrated Neighbourhood Teams

Milestones Y1	Milestones Y2	Y3-5	SRO	Oversight group
• Clinical and professional staff aligned to IN teams based on priority needs of local population, to build Neighbourhood Personalised Care Teams, supported by appropriate governance arrangements. • Embed Personalised Care lead role, provide training and support to workforce undertaking these roles within INs, and develop plan to optimise personalised care models. • Optimise planning for and recruitment of Additional Roles Reimbursement Scheme (ARRS) roles in PCNs. • Co-design and test primary care mental health model	• Further scale models to support larger populations and delivering more complex care • Review other workforce groups identify opportunities for support and alignment e.g. teams delivering health and social care to people at home • Co-design plan for scaling, transferring and embedding outpatient / specialty services within neighbourhood models and settings • Individuals identified with long term conditions who are likely to experience worse outcomes, and personalised shared care plans put in place	• Accessing care feels seamless across services and people receive early support to prevent crisis, with care delivered close to home • Fully integrated Neighbourhood Personalised Care Teams working as one with single leadership • Full time jointly funded and appointed operational managers and support to deliver this model • Single care record for each patient/citizen, and digitally enabled shared care plans (in real time)	Erin Lilley, Director, Partnership Development & Transformation, CSCP	Proactive and Personalised Care Programme Board

PRIORITY 2: Embedding integrated proactive and personalised care to reduce inequalities and increase years people enjoy good health

OBJECTIVE 2.1:

Addressing wider determinants of health - Coordinate partner activities to deliver prevention and community engagement initiatives that tackle inequalities.

Progress to date:

- Collaborated across partners and communities to co-design and deliver Heat for Health programme, including warm hubs and increased options to access support funds.
- Worked with partners to deliver electric blankets to vulnerable individuals
- Pilot approach to addressing digital inequalities within IN initiatives

Milestones Y1	Milestones Y2	Y3-5	SRO	Oversight group
• Multiagency coordination of Cost of Living Support by joining up governance/ projects • Establish/embed sustainable Community Hubs, building on Warm Hubs, vaccination hubs and other existing/planned Hubs • Align and agree how available inequalities and prevention funding will be used at Neighbourhood and District Level	• Support focused approach using access to local and hyper-local knowledge	• Evaluate impact of proactive support and use learnings to inform co-development of future plans	Erin Lilley, Director, Partnership Development & Transformation, CSCP	Proactive and Personalised Care Programme Board

OBJECTIVE 2.2:

Addressing wider determinants of health – in collaboration with partners, codesign and deliver personalised care approaches to meet the reduce high impact service use reduce health inequalities

Progress to date:

- Jointly-funded and piloted new models of care including: a Drug and Alcohol Recovery Worker, the Moon Project for children affected by Domestic Violence and a Carers Care Coordinator in East Cambs
- Winter Wellbeing projects identifying cohorts at risk of worse outcomes and providing proactive and personalised care and support

Milestones Y1	Milestones Y2	Y3-5	SRO	Oversight Group
• Co-design approaches to identify and address needs of people with high intensity service use within Neighbourhoods • Appreciative Inquiry and co-design/co-production approach in place to understand root causes of high impact service use and co design changes • Pilot AI-based tool to predict people likely to be admitted to hospital in 6-18 months and offer tele-coaching and personalised care plans to reduce acute attendances	• Scale use of personalised care planning and measurement of patient/citizen reported experience and outcome measures • Routine use of population health management and appreciative inquiry approaches to identify service users, understand their needs and personalise their care • Use of iterative learning to improve pathway and service redesign (including future resource alignment)	• Evaluation of predictive hospital avoidance and use this to co-develop future plans	Erin Lilley, Director, Partnership Development & Transformation, CSCP	Proactive and Personalised Care Programme Board, CSCP

OBJECTIVE 2.3

Preventing and managing long term conditions – in collaboration with partners, co-develop and implement integrated and proactive models of the care to prevent and manage long term conditions with a particular focus on cardiovascular disease (hypertension & heart failure), diabetes, frailty, respiratory conditions and mental health.

Progress to date:

- Commenced the co-development & piloting of potential elements of an integrated population health model for hypertension
- Commenced the co-development and piloting of potential elements of an integrated population health model for diabetes
- Monthly Health Hub offering health checks and advice in Cambridge City
- Healthier Weight Project including Menopause Event, awareness raising tools, health checks, healthy walks, housebound insulin dependency reviews, group consultations and peer support in East Cambs
- Agreement to collaborate with the Children's & Maternity Partnership to improve management of asthma in children
- Piloted single-sessions of support with a therapist, by phone/video call within two weeks for CYP and families with mild to moderate mental health challenges
- Winter project supported men struggling with poor mental health or cost of living that are unlikely to engage with early support
- Cambridge Central Mosque hosted day of wellness related workshops, information stalls & activities for local community
- Collaborated on system Falls Prevention Strategy, completing a comprehensive service mapping for falls prevention and management services
- Collaborated on expansion of Care Together programme across Cambridgeshire South, including pathway redesign for care closer to home

Milestones Y1	Milestones Y2	Y3-5	SRO	Oversight Group
• Continue to co-develop & pilot an integrated population health model for hypertension prevention, detection and management across primary and community care at Neighbourhood level • Innovation funding to Neighbourhoods to support identification and management of local patients • Work with partners to review and understand existing diabetes support, services, and pathways	• Evaluate pilots and co-develop integrated hypertension model for scaling, linked with Neighbourhoods (including resource alignment) • Co-develop and pilot an integrated Heart Failure model, linked with Neighbourhoods (including resource alignment) • Diabetes pathway and service redesign based on learning (Funding required) • Collaborate with Mental Health team and citizens to iteratively improve service	• Evaluate the impact on population health outcomes from earlier identification and management of cardiovascular disease, and iteratively improve care models. • Demonstrable improvement in management of Diabetes 3 Treatment Targets (3TT) and 8 Care Processes (8CP)	Erin Lilley, Director, Partnership Development & Transformation, CSCP	Proactive and Personalised Care Programme Board, CSCP

Milestones Y1	Milestones Y2	Y3-5	SRO	Oversight Group
• Continue to co-develop and pilot an integrated population health model for diabetes prevention, detection and management across primary and community care at IN level • Support PCNs through Neighbourhood working to improve Diabetes related outcomes against 3 Treatment Targets (3TT) and 8 Care Processes (8CP) • Co-design and pilot intervention for PHM Target cohort 1 in Cambridge City IN • Working with the MH ABU to co-develop MH Community Connector posts and how they are embedded in Neighbourhood Teams • Collaborate on expansion of CPFT led MH Community Transformation across Cambridgeshire South, including pathway redesign for care closer to home • Lead the co-design and pilot for an integrated multi-disciplinary team model for assessment and secondary prevention of falls, with IN component • Lead the co-design and implement the interventions for PHM Target cohort 2, starting in Ely North & Ely South IN: People at risk of developing moderate to severe frailty (aged 45+, with Heart Failure, pre-diabetes, no falls history) • Collaborate on expansion of Care Together across South Place, including pathway redesign for care closer to home	integration and embed within Neighbourhoods • Evaluate and iteratively improve mode/s for supporting people at risk of developing moderate to severe frailty • Alignment of mild-moderate falls approach with the Urgent Community Response and Step Up/ Intermediate Care models	• Reduction in unplanned care attendances and days of school missed for children with asthma • In collaboration with the MH Team, evaluate impact on population health outcomes, with a focus on reducing health inequalities • Ongoing cycle of valuation of population outcomes related to mild-moderate frailty, with a focus on prevention and early intervention		

PRIORITY 3: Enable 'home first' through optimising and integrating urgent community/intermediate care to maximise care at/close to home and reduce attendance or admission to acute services

OBJECTIVE 3.1:

Optimising and integrating step up/ intermediate care services – in collaboration with partners, develop, implement and integrate 'Call Before You Convey' model

Progress to date:

- Developed model for access to Call Before You Convey (CB4UC), a clinician led service with option for paramedics to refer direct to step up/intermediate care services.
- Implemented CB4UC clinician cover Mon - Fri 10-18hrs (Sat/ Sun from end Feb)
- Ambulance service contact CB4UC to discuss options to admission avoidance, including being routed directly to assessment units/ ambulatory care or ED as appropriate

Milestones Y1	Milestones Y2	Y3-5	SRO	Oversight Group
• Embed 7-day service provision, extending service provision until 10pm • Triangulate data with EEAST and Acute providers to enable evaluation of data/ service demand profiles; to inform UCR capacity planning and commissioning requirements to meet population needs • Start to co-design proactive urgent care pathways with Neighbourhood teams	• Iteratively improve the CB4UC IVR model based on evidence and partner feedback	• Evaluate the impact of UCR admission avoidance delivery models, based on experience and outcomes that matter to service users, the wider population and the providers, aligned with best practice models and national requirements, utilising peer reviews and clinical audit.	Yvonne Beaumont-Hill and Sabina Fitton, Director, Operations & Delivery, CSCP	Home First Programme Board, CSCP Unplanned Care Board, ICS

OBJECTIVE 3.2:

Optimising and integrating step up/ intermediate care services - in collaboration with partners, develop, implement and integrate step-up/ step down care (ICT & RBT)

Progress to date:

- Not in scope for current year.

Milestones Y1	Milestones Y2	Y3-5	SRO	Oversight group
• Systemwide evaluation of Pathway 1 provision, building on outputs from ICB commissioned review • Evaluate utilisation of commissioned resource to ensure capacity optimisation and inform C&D modelling	• With partners, co-design system wide integrated delivery model to meet the needs of the population based on C&D modelling undertaken by ICB	• Evaluate the impact of UCR admission avoidance delivery models, based on experience and outcomes that matter to service users, the wider population and the providers, aligned	Director, Operations & Delivery, CSCP	Home First Programme Board, CSCP Unplanned Care Board, ICS

Milestones Y1	Milestones Y2	Y3-5	SRO	Oversight group
• Scope current VCSE service provision in admission avoidance and evaluate opportunity to utilise VCSE resource to enhance step up provision within CSCP system		with best practice models and national requirements, utilising peer reviews and clinical audit.		

OBJECTIVE 3.3:

Optimising and integrating step up/ intermediate care services - in collaboration with partners, review and integrate Urgent Community Response model (JET, ERS, Granta, etc)

Progress to date:

- Granta provision of UCR model went live in January 23, with ongoing collaboration with EEAST to identify patients who could potentially be managed without conveyance to hospital.
- React Cars – rapid response with Advanced Nurse Practitioners to assess and identify people who could remain at home with support.

Milestones Y1	Milestones Y2	Y3-5	SRO	Oversight group
• Undertake a service benefits realisation evaluation of the Granta UCR service to inform impact of extending the service to support delivery of a 7-day service 8am – 10pm • Develop UCR pathways to support virtual ward, early facilitated discharge and admission avoidance • Utilise ICB C&D data to inform the rightsizing the UCR services, ensuring maximum utilisation of current resources, developing business cases if increased provision is required. • Review current delivery model and co-design/ implement system response to meet demand, incorporating VCSE	• Iteratively improve integrated UCR evidence-based models of care/ service delivery	• Visible shift to all partners (patients, staff, providers) in how care and services are planned and care delivered • Ongoing evaluation of the impact of place-based model for delivery of UCR provision, based on the experience and outcomes that matter to the population e.g. feedback from care receivers/ carers and service providers	Director, Operations & Delivery, CSCP	Home First Programme Board, CSCP Unplanned Care Board, ICS

OBJECTIVE 3.4:

Optimising and integrating step up/ intermediate care services - in collaboration with partners, review and integrate rapid stabilisation services/G&A for ‘planned’ step up care.

Progress to date:

- Not in scope for current year.

Milestones Y1	Milestones Y2	Y3-5	SRO	Oversight Group
• Scope opportunity for delivering urgent outpatient activity at place, i.e. frailty, osteoporosis, falls clinics, working closely with system partners to identify an integrated model of care • Pilot principles and evaluate outcomes	• Co-develop the service model for specialist support based on the 23/24 scoping work	• Ongoing evaluation of relevant population health outcomes, user experience, and impact on acute care capacity	Director, Operations & Delivery, CSCP	Home First Programme Board, CSCP Unplanned Care Board, ICS

OBJECTIVE 3.5:

Optimising and integrating pathways for specialist support - in collaboration with partners, review and integrate alternative pathways to unplanned emergency department care (Same Day Emergency Care / Minor Injury Units / Urgent Treatment Centres)

Progress to date:

- Not in scope for current year.

Milestones Y1	Milestones Y2	Y3-5	SRO	Oversight Group
• Identify current SDEC/ MIU/ UTC provision support interfaces • Partnership working to inform gaps in support and identify pathway requirements	• Work collaboratively with all partners to bolster current established access routes	• Ongoing evaluation of relevant population health outcomes, user experience, and impact on acute care capacity	Director, Operations & Delivery, CSCP	Home First Programme Board, CSCP Unplanned Care Board, ICS

OBJECTIVE 3.6:

Develop support model for care/nursing homes - in collaboration with partners, co-develop support and care model to reduce use of unplanned care services by people living in care or nursing homes

Progress to date:

- Not in scope for current year.

Milestones Y1	Milestones Y2	Y3-5	SRO	Oversight Group
• Review the current support provision for Care/Nursing homes • Triangulate CUH ED attendance and admission data with care home provision to identify high service users, identifying top 5 users for focussed support	• Continue to iteratively improve service model	• Ongoing evaluation of relevant population health outcomes, user	Director, Operations & Delivery, CSCP	Home First Programme Board, CSCP Unplanned Care Board, ICS

• Using PDSA approach, identify and implement a support model, to reduce demand and enable place-based care delivery, based on top five care home high users of ED data		experience, and impact on acute care capacity		

PRIORITY 4: Enable 'home first' through improved discharge coordination, pathway optimisation and virtual care to ensure right care in the right setting

OBJECTIVE 4.1:

Optimising coordination of discharge planning and transfers of care - in collaboration with partners, review and integrate discharge planning and transfer of care pathways to ensure the right care is delivered in the right setting

Progress to date:

- Co-developed a virtual Transfer of Care Hub (TOCH) to facilitate timely decision making on pathways 1-3 discharge with system-wide partnership working.
- Additional funding secured to enable resourcing of the TOCH –backfilling current commitments and commissioning additional resource to enable pathway review and development.
- Additional funding secured to enable a system- wide digital solution to support the visibility of system capacity and pressure points.

Milestones Y1	Milestones Y2	Y3-5	SRO	Oversight Group
• Utilise the system-wide workforce backfill resource from the additional funding to support the development of TOCH pathways and procedures • Develop operational processes to support effective management of TOCH caseload • Further development of the digital solutions to support co-ordination of system capacity and enable data visibility. • Utilise ICB C&D analysis outcomes to inform capacity requirements for winter resilience. • Embed the Harm review processes for TOCH patients, engaging with Healthwatch • Agree workforce and funding requirements to continue TOCH processes into 24/25 • Review the TOCH functionality in line with updated national guidance in Q4 23/24	• Continue to refine processes to improve patient outcomes and experience for complex discharges, through improved pathway reviews and co-design. • Agree long term workforce model to sustain and grow the TOCH functionality based on 23/34 learnings and outcomes	• Ongoing review and evaluation of the effectiveness of the TOCH functionality in line with best practice models and national requirements utilising peer reviews and clinical audit	Director, Operations & Delivery, CSCP	Home First Programme Board, CSCP Unplanned Care Board, ICS

OBJECTIVE 4.2:

Implement virtual ward model - in collaboration with partners, further develop Virtual Ward (VW) capacity to 80% utilisation of 70 bed equivalent.

Progress to date:

- South Cambridgeshire delivering VW capacity equivalent to 30 beds (acute), with occupancy rates currently 55-65%

Milestones Y1	Milestones Y2	Y3-5	SRO	Oversight Group
• Collaborate with partners to support the expansion of the current VW model to increase care at home • Develop pre-hospital VW approach in conjunction with Primary Care UCR for the South to increase VW utilisation and reduce acute hospital occupancy, to include direct referrals from GP services • Achieve the occupancy target 80% - 85% • Evaluate patient outcomes and experience of VW care provision.	• Continue to refine VW processes to improve patient outcomes and experience to improve care models • Evaluate VW model and expand to other specialties / service providers aligned to demand and needs assessments	• Evaluate relevant population health outcomes, user experience, and impact on acute and social care capacity	Director, Operations & Delivery, CSCP	Home First Programme Board, CSCP Unplanned Care Board, ICS

OBJECTIVE 4.3:

Optimise discharge pathways 1 to 3 - in collaboration with partners, embed John Bolton model across pathways 1 to 3 to ensure the right care is delivered in the right setting

Progress to date:

- Pathway 1 Trusted Assessor (TA) model introduced in Cambridgeshire South, with the continuation of principles to include admission avoidance/ early facilitated discharge TA model by EIT
- Trial commenced for Pilot P2 D2A model for patients with ongoing assessment of care needs
- Evaluation of compliance with John Bolton model of care and identification of scope for improvement.
- Identification of gaps in pathway models and specifications and associated governance processes including reporting

Milestones Y1	Milestones Y2	Y3-5	SRO	Oversight Group
• Embed TA principles across Pathway 2 health beds • Embed John Bolton principles across the system, and align the related coding and reporting requirements • Co-review and co-design the discharge pathways identified as not meeting the population needs. • Develop robust collaborative processes to support co-designed pathway delivery and evaluation • Evaluate user experience, and the impact on health and social care capacity	• Working in collaboration with partners to deliver continuous improvement and integrate service models • Ongoing review and evaluation of the relevant population health outcomes, user experience, and the impact on health and social care capacity	• Evaluate relevant population health outcomes and the impact on health and social care capacity	Director, Operations & Delivery, CSCP	Home First Programme Board, CSCP Unplanned Care Board, ICS

North Cambridgeshire and Peterborough Partnership

Overview

We have established a key vision for North Care Partnership: To support people to stay well, be independent and live happier and healthier lives, ensuring every person matters and every contact counts.

Across North Cambridgeshire and Peterborough, we aim to work in partnership with our population and local partner stakeholder organisations to provide an integrated health and care system fit for the future.

This means people receiving and having access to seamless holistic services that meet their physical, social and mental health needs at the earliest possible opportunity.

Through a focus on the individual, and communities, as opposed to structure, we place an increased priority on prevention and pro-active care rather than reactive treatment. We expect to increasingly deliver most of an individual's care needs in their local community and to reduce the need for hospital-based care.

Improving equity, through an integrated approach to:

- Prevention of ill health, early intervention, health improvement and creating environments that support and enable people to live healthily.
- Ensuring our actions are centred on the individual, their goals, and the communities in which they live and supporting people to help themselves.
- Having shared planning and decision making with our residents.

Our strategic priorities:

- Striving to achieve better health outcomes for everyone in the North Care Partnership
    - Care closer to home.
    - Prevention and early intervention – wrapping our Neighbourhood Teams working alongside our communities to keep them well for longer.
    - Standardise and improve outcomes for everyone, prioritising those of greatest need.
    - Utilising data insights and evaluation to enable better outcomes
- To develop and deliver a sustainable, integrated health and care system across the North Care Partnership
    - Integrating through delivery, wrapping services around our communities, developing shared protocols/policies enabled by shared data and technology.
    - New models of care, building steppingstones within the community reversing the reliance on secondary care and bed based social care.
    - Coproduction with our communities – listening to our communities and modifying our delivery dependent on age/race/disability/needs.
- To create a sustainable workforce
    - Getting the best from our collective workforce.
    - Seizing opportunities from shared health and care workforce.
    - Creation of new integrated provider roles, providing joint continuous professional development across Health and Social care.
- To create a financially balanced system

- ‘One and done’ ethos - driving efficiencies for the Place and value to our communities to create a financially balanced system.
- Improve sharing of best practice regarding pooled or aligned budgets, aligned to resources and shared outcomes.

Based upon our ICS Health and Wellbeing strategy, our North Partnership has developed its plans and priorities, ready for delivery in 2023/24 and beyond.

These balances delivering on population health and care outcomes, performance improvement and improving equity of access and outcomes.

It also requires us to building more integrated models of delivery to meet future demand and longer-term resilience for our care staff, residents, and carers.

Delivery plans

Growing Well

Initiative:

Optimise and improve equity of uptake of childhood immunisations.

Progress to date:

Childhood immunisation programme led by public health team.

Impact:

Improve uptake and equity of uptake of childhood immunisations.

Year 1-2	Year 3-5	SRO	Oversight Group
Pilot a service in each locality combining health and local authority data to support case finding. Provide call and recall, targeted conversations and to provide specific outreach sites to provide local access to services Evaluate impact and uptake and adapt delivery model	Establish and expand to multiple public health programmes. Develop case finding analytical capabilities. Develop a multi-channel public information campaign with tailoring to specific communities/languages.	Emmeline Watkins, Deputy Director of Public Health	North Care Partnership Board

Initiative:

Support the development of family hubs with accessible services for communities.

Progress to date:

- Published Start for Life Offer
- Parent Care Panel in place
- Initial Family Hub Buildings identified
- Digital platform in place

Impact:

- Improved physical health and mental health and emotional wellbeing.
- Families able to make positive choices/ improved family awareness of where to get help and confidence to ask for help.
- Improved readiness for next stage of life/school.
- Improved social networks / reduced isolation.

Year 1-2	Year 3-5	SRO	Oversight Group
Family hubs open their doors. Define a parenting programme plan, including an online offer. Define Home Learning Offer. Workforce planning commences	Expansion of the programme through available services including perinatal and infant/parent relationship support, speech and language support for home learning Longer term workforce planning	Kat Band, Assistant Director Children's Services, Barnados	North Care Partnership Board

Initiative:

Develop a model of virtual wards/hospital at home for children and young people

Progress to date:

- Project initiation
- Analysis of best practice models

Impact:

- Provide safe and effective alternatives to hospital-based care which has the potential to improve recovery and outcomes for children and young people
- Reduce pressure on hospital paediatric inpatient facilities

Year 1-2	Year 3-5	SRO	Oversight group
Scope and develop the model based upon best practice Workforce and financial planning Pilot and test the model through our acute hospital and community services for children and young people	Establish and baseline the model of care Scale the model to meet the demand in North Cambridgeshire and Peterborough	Arshiya Khan, Deputy Chief Executive, North West Anglia NHS Foundation Trust and Director of Strategy & Planning	Virtual Ward Programme Board

Living Well

Initiative:

Optimise and improve equity of uptake of screening, health checks and immunisations (all ages) providing support to stay active and healthy

Progress to date:

- Service planning and cohort identification (Core 20+5 and those with inequity of access and outcomes).
- Request for health inequalities funding.
- Assessment of data requirements

Impact:

Improve outcomes and effectively address and reduce unequal health outcomes for residents and variation in uptake. Focusing on: heating and eating; safe housing; immunisations; high blood pressure; early cancer diagnosis; and long-term condition optimisation.

Year 1-2	Year 3-5	SRO	Oversight Group
Pilot a service in each locality combining health and local authority data to support case finding Provide call and recall, targeted conversations and to provide specific outreach sites to provide local access to services Evaluate impact and uptake and adapt delivery model	Establish and expand to multiple public health programmes Develop case finding analytical capabilities Develop a multi-channel public information campaign with tailoring to specific communities/languages	Emmeline Watkins, Deputy Director of Public Health	North Care Partnership Board

Initiative:

Support the design and roll-out of community mental health teams aligned to our integrated neighbourhoods.

Progress to date:

- Exemplar Pilot delivered in Peterborough and evaluation complete.
- Interventions for rollout identified.

Impact:

People with mental health issues will be able to access a wider range of treatment and support options to meet their needs.

Year 1-2	Year 3-5	SRO	Oversight Group
Rollout of stepped care model in Cambridgeshire	Delivery of Community Rehabilitation Model	Debbie Smith, Chief Operating Officer, CPFT	Community Strategic Partnership (led by MHLDA Pshp)

Year 1-2	Year 3-5	SRO	Oversight Group
Scoping of community rehabilitation model Implementation of Move Away from CPA/Outcomes measurement	Embedding Stepped Care model and ensuring interventions support access for younger adults and older adults		

Initiative:

Develop and support multi-partner initiatives (in each locality) to support those challenged by cost of living (all ages) including through community hubs.

Progress to date:

- Cost of living programme with and through Peterborough, Fenland and Hunts Councils.
- Warm spaces implemented.

Impact:

Improving outcomes for people most impacted by cost-of-living challenges and in deprived communities.

Year 1-2	Year 3-5	SRO	Oversight group
Baseline mapping of existing hubs and access points Targeting specific individuals and households at greater risk through cost-of-living challenges. Pilot an 'access and information' community hub in at least each locality	Consider developing access and information hubs in each neighbourhood Develop analytical systems with precision for identifying those at risk of poorer outcomes due to life circumstances	Paul Medd, CEO Fenland District Council	North Care Partnership Board

Initiative:

Identify and support high intensity users (HIU) and those at risk of cardiovascular disease (CVD) through population health analysis and targeted interventions.

Progress to date:

- Winter initiative.
- Service model development
- Business case development
- Cohort identification
- Development of CVD local

Impact:

- CVD: 5% reduction in deaths; 5% reduction in acute admissions with heart failure; 10% reduction in death within the poorest quintile
- HIU: reduction in A&E attendances, admissions, and ambulance conveyance

Year 1-2	Year 3-5	SRO	Oversight Group
Implement a targeted multidisciplinary model for those who make most high intensity use of urgent care services. Implement a model for supporting those people in each neighbourhood at risk of hospitalisation. Evaluation and quality improvement.	Adaption and scaling to cover a greater number of residents who are high-impact users and are at risk from cardiovascular disease.	Abby Richardson, Clinical Lead for Integrated Neighbourhoods	North Care Partnership Board.

Ageing Well

Initiative:

Deliver improvements in our urgent care system and hospital flow including the implementation of our transfer of care hub and virtual wards.

Progress to date:

- Co-development of a virtual Transfer of Care Hub (TOCH)
- Secured £530k to enable resourcing of the TOCH and £650k to enable a system- wide digital solution
- Implementation of virtual wards
- Identification of priority initiatives

Impact:

- Reduction in length of stay (acute and community) and improved waiting times in A&E
- Increase in home-based care solutions (versus bed-based care)
- Occupancy of greater than 80% in virtual wards
- Reduction in emergency admissions and ambulance conveyance
- Improved experience and outcomes for residents

Year 1-2	Year 3-5	SRO	Oversight group
Implement models and improvement in: • Same day emergency care • High-intensity users • Transfer of care hub • Integrated discharge • Virtual wards	Embed and develop scope and scale of models	Arshiya Khan, Deputy Chief Executive at North West Anglia NHS Foundation Trust and Director of Strategy & Planning	North System Resilience Group

Initiative:

Develop a model of multidisciplinary support for prevention and support for those who at risk of becoming frail and who are frail.

Progress to date:

- Initial project scoping
- Determination of Huntingdonshire as the pilot site
- Identification of SRO and key stakeholders

Impact:

- Number and rate of unplanned (or avoidable) in people age 65 years or more
- Proportion of people who were still at home 91 days after discharge
- Permanent admissions to residential and nursing care homes, per 100,000 population

Year 1-2	Year 3-5	SRO	Oversight Group
Design and implement a model of multidisciplinary support for frail residents in Huntingdonshire. Develop case finding techniques with council, VCFS for those who are at risk of isolation/frailty. Evaluate the model.	Embed and develop scope and scale of model with roll-out across localities in Fenland and Peterborough.	Oliver Morley, Interim CEO, Huntingdon District Council	North Care Partnership Board.

Initiative:

Develop (in partnership with our South Care Partnership) and deliver upon a long-term strategy for integrated and resilient intermediate care.

Progress to date:

- Analysis of best practice models
- Analysis of demand and capacity requirements

Impact:

Ensuring individuals receive care at the right time in the right place, reducing acute hospital admission.

Year 1-2	Year 3-5	SRO	Oversight group
Scope and develop the model based upon best practice Service mapping across health, care and voluntary services Population analysis (including demographic change), capacity, workforce and financial planning To implement a proactive multidisciplinary and integrated discharge function in our hospitals to improve the discharge support to our residents and to improve our a 'home first' approach	Implement a future-proofed and integrated model of intermediate care, with a focus on: Home-based intermediate care Reablement Bed-based intermediate care Crisis response	Debbie McQuade, Service Director, Adults & safeguarding, CCC and PCC	Cambridgeshire and Peterborough Unplanned Care Board

Neighbourhoods

Initiative:

Implement and develop our integrated neighbourhood teams as our model of improving equity, prevention and integrated care.

Progress to date:

- Built Neighbourhood Programme team, linking with partner teams to support development of neighbourhood partnerships.
- Developed Maturity Framework for Integrated Neighbourhoods.
- Eight Neighbourhood Boards established building on existing governance and partnership working.
- All Neighbourhoods worked with new partners to deliver through team-based arrangements.

Impact:

- Visible shift to all partners (residents, staff, providers) in how we plan and deliver care
- Evaluate impact of Neighbourhood partnership-based model – experience and outcomes that matter to citizens, e.g., increased years of healthy life expectancy.

Year 1	Year 2	Year 3-5	SRO	Oversight Group
Each Neighbourhood agrees priorities based upon staff insight and lived experience, and develop annual plans for delivery. All Neighbourhoods engage with their communities about the experience and outcomes that matter to them Agree Neighbourhood budgets to fund project and transformation work Integrated Neighbourhood Teams (INTs) with health, social care and VCS staff co-locating (as physical estate permits) Each neighbourhood has identified workforce and organisational development support requirements Events to share learning about neighbourhood	Finalise Integrated Neighbourhood Operating Framework, building in learning from 23/24 Each neighbourhood has an agreed delivery plan, including shadow responsibility for relevant population outcomes. Agree/delegate Neighbourhood budgets to fund transformation and service delivery Co-design Neighbourhood workforce and organisational development plans Co-design plan for meeting estates and digital infrastructure needs to deliver new way of working in neighbourhoods	Visible shift to all partners (residents, staff, providers) in how we plan and deliver care Evaluate impact of Neighbourhood partnership-based model – experience and outcomes that matter to citizens, e.g., increased years of healthy life expectancy	Abby Richardson, Clinical Lead for Integrated Neighbourhoods	Integrated neighbourhood programme board

Year 1	Year 2	Year 3-5	SRO	Oversight Group
based care from others in our system, and in other systems. Co-ordinate/establish 'hubs' for communities to access services in their Neighbourhood Test models for proactive identification of individuals with long term conditions who are likely to experience worse outcomes	Develop and embed core training and induction on Neighbourhood working for all partners Scale successful models for proactive identification of individuals with long term conditions who are likely to experience worse outcomes, and ensure personalised shared care plan in place			

Health and Wellbeing

Overview

Across Cambridgeshire and Peterborough, we face many challenges in improving the health and wellbeing of our local people and communities. The impact of COVID-19, combined with rising living costs, is continuing to impact on people's lives. More than ever, we need to find new, effective, and sustainable ways to work together to improve health and wellbeing and to prevent ill health. The pandemic also highlighted and exacerbated health inequalities, this strategy aims to tackle some of these inequalities.

Our strategy is a truly integrated piece of work, developed by working closely with local partners from health, social care, local authorities and the voluntary, community sector along with feedback from local people across Cambridgeshire and Peterborough.

Our Vision: All Together for Healthier Futures

The Overarching Ambitions:

- Have better outcomes for our children
- Reduce inequalities in deaths under 75 years
- Increase the number of years that people live in good health

The four priorities which we believe, through working in partnership, will make a difference to people's lives:

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

Our collective aim is simple – to work together to enable local people across Cambridgeshire and Peterborough to live happier and healthier lives."

Delivery plans (in development):

PRIORITY 1: Our children are ready to enter and exit education prepared for the next phases of their lives

Overview

Education, employment, socioeconomic background, and health are all complexly interlinked. Whilst our socioeconomic background and many other factors influence our readiness to enter formal education, our attainment once we are at school is affected by our background also.

'School readiness' is the preparedness of children to enter the formal education system at 4-5 years old. Influences on school readiness start before birth, with the socio-economic circumstances, mental and physical health of mothers affecting the outcomes of their children.

High-quality early years education also improves readiness to enter formal education. It is associated with improved cognition, sociability and concentration when starting school, and the investment is recouped by better attainment, future productivity, and employment, (as well as a reduced attainment gap for children in low income families). Good parenting can have an impact on life chances, just as much as income, education and socioeconomic class which are all interlinked, and parenting support groups therefore can improve language, emotional and social development before school education begins.

The Education system teaches and promotes healthy choices, the ability to advocate for better environment and neighbourhoods for our communities, and to avoid risk behaviours. It further provides a structured social environment for development of interpersonal skills for the future, and to allow both broad and targeted interventions from public health to be delivered to young people. These measures can solidify habits and practices to create healthy and resilient adults.

School attendance has many positive impacts on health and wellbeing and once we leave school, our level of education is closely associated with our long-term health. Adults with a tertiary education were found to have lower rates of smoking and obesity after accounting for differences in age, gender, and income and were more likely to take up healthcare such as vaccines, and screening programmes. These factors directly contribute to improved health in those with higher levels of education.

Long-term outcomes

- Increase the number of children who show a good level of development (GLD/school readiness) when they enter education
- Reduce the number of young people aged 16-17 who are Not in Education Employment or Training (NEET)
- Reduce inequalities in both these outcomes

Delivery plans: Our children already to enter and exit education prepared for the next phase of their lives			
Deliverable	Timeline	SRO	Oversight
Increase uptake up of the Healthy Start Scheme	2023/25		CPH Team
Promote the Start for Life offer through health and community settings	2023/25		CPH Team
Ensure local service providers including midwifery, health visiting, and community partners have an aligned approach to support new families with their mental health during the perinatal period and to develop good parent/infant relationships	2023/25		CPH Team Children and Maternity Partnership
Deliverable 4: Ensure all new parents & parents-to-be receive good infant feeding support	2023/25		CPH Team Children and Maternity Partnership
Deliverable 5: Provide families with the support and advice they need to access Early Years and Childcare opportunities	2023/25		Heads of Early Years CCC & PCC Children and Maternity Partnership
Deliverable 6: Ensure damp free accommodation for children with a respiratory condition	2023/25		Lead P3

Deliverable 7: Increase apprenticeships through Anchor institutions (Councils, Combined Authority, NHS, commissioned services)	2023/25		Lead P3
Deliverable 8: Improve Mental Health, Emotional Wellbeing and Resilience among the school aged population	2023/25		CPH Team
Deliverable 9: Improve immunisation rates at entry into school and exit from school	2023/25		Imms Board
Deliverable 10: Establish a mechanism to improve health outcomes for our school-aged population	2023/25		CPH Team
2.1 NEET Engagement programmes - multicomponent (classroom and work-based)			
2.2 Interventions with commissioned services contracted to offer a number of apprenticeship opportunities.			
2.3 Activity Agreements - between NEET and advisor, Career awareness leading to apprenticeships and other career-based learning opportunities supported by local employers			
Improve outcomes for vulnerable groups- Children in Care, Care leavers, Young carers, Young offenders, Young parents, Children with SEND, Children in alternative education provision, LGBTQ+, certain Ethnicities, Socio-economic deprivation, Traveller communities			

PRIORITY 2: Create an environment to give people the opportunity to be as healthy as can be. Reduce childhood and adult obesity.

Overview

Obesity is the most pressing public health challenge with national and global increases for several decades. There is evidence that there have been further increases in both childhood and adult obesity, post pandemic. Obesity is a complex issue and requires the whole system to work together if we are to be successful in halting and reversing the rise.

Policymakers however still tend to focus on single initiatives, but our ambition is to use the opportunity afforded by the Joint Health and Well Being/Integrated Care System Strategy of incorporating 'systems thinking' into our effort to tackling obesity. This approach requires transformational evidence-based change that requires interventions to promote change across areas that we know have the greatest impact upon obesity.

Nationally we have around two thirds of the adult population either overweight or obese. This requires a broad response, although we know there are higher rates amongst children and adults amongst certain groups and in deprived areas. Our interventions will be at a population level, they must affect everyone. Consequently, there is a focus upon creating environmental changes which affect everyone and address multiple settings, family, school, workplace, community, and the media.

However, we know people and communities respond differently to environmental and service level interventions which can exacerbate any inequalities. Our efforts therefore will reflect a "proportionate universalism" approach which will seek to understand the different needs and motivations that drive people and communities. This understanding will need to be embedded into how we plan and implement policy and other interventions.

Historically, locally and nationally there has been a plethora of interventions reflecting the complexity of obesity, but they have had varying levels of impact. It is important as we move

forwards that we have a clear evidence-based approach that will lower rates and decease any inequalities.

This clearly identifies synergies and areas of mutual benefit with the other three priorities being pursued in the Joint Health and Well Being Strategy Integrated Care Strategy. For example, the school environment can influence the diet and physical activity levels of children or the negative effects of easy access to fast food.

Although it is complex and challenging, we have set ourselves stretching ambitions for improving outcomes that will require ongoing development of interventions that will move us consistently along the path to achieving them.

Long term outcomes

- Reduce childhood and adult obesity
- Reduce inequalities in overweight / obesity

Delivery plans: Create an environment to give people the opportunity to be as healthy as can be. Reduce childhood and adult obesity.			
Deliverable	Timeline	SRO	Oversight
Deliverable 1: Establish a delivery vehicle/group for years 2023/25	2023/24		Public Health
Deliverable 2: Develop and implement Behavioural Insights research-based interventions that have impact and traction on health behaviours	2024/25		Public Health
Deliverable 3: Identify and develop improvements in the internal and external food environment-based school food survey and behavioural insights research	2023/24		Education/Schools/Public Health/Environmental Health/LA Planning
Deliverable 4: Increase physical activity in schools e.g. active travel programmes, daily mile	2023/24		Education/Public Health/Place & Sustainability (Active Travel)
Deliverable 5: Develop integrated evidence based interventions for the behavioural and clinical treatment / management of obesity and associate clinical risk factors	2023/24		ICS

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

Overview

Poverty limits life chances, health and wellbeing, and has a much wider societal impact beyond the individuals who are personally affected. This priority focuses on reducing poverty through improving skills, better employment and better housing, though reducing poverty is much broader than just these aspects.

Paid work is the main route out of poverty for working-age adults. Sometimes paid work is not feasible for some people due to disabilities, caring responsibilities, or other life circumstances, though there is still a large opportunity for employers to show greater creativity and flexibility in their approach.

Employment is not a guarantee of escaping poverty; there are growing issues of in-work poverty and insecure employment which affect many of our residents and we also need to consider how to improve the opportunities for our residents to secure 'good' employment (stable, well-paid, and safe). A good job should also be one that does not pose a threat to physical or mental health.

The interaction between housing and poverty is two-way; poverty limits people's housing choices, often resulting in living in poor quality housing as that is all that is affordable or available. However, housing also affects the risk or severity of poverty; expensive housing reduces the financial resource for other life essentials, poor quality housing is likely to require considerably greater spend of limited incomes on heating, and poor quality or insecure housing also affects wellbeing and physical health which in turn can limit educational or employment outcomes. Stable, secure, and good housing can have huge benefits not just to health but to the wider life chances. For example, housing with adequate space not only improves personal privacy, reducing depression, anxiety and stress but also gives children room to play, a good night's sleep and provides sufficient study space, enabling better achievement.

The issue of poverty is being exacerbated by the cost-of-living crisis. The 'Let's Talk - your health and care' campaign that ran to inform the Health and Wellbeing Integrated Care Strategy has identified that 45.8% of the respondents (1051/2292) felt that the cost-of-living crisis was impacting their health and wellbeing; key themes were the cost of heating and not having the heating on, having to cut down or purchase cheaper versions of food, the costs of transport to key services such as hospital appointments, reducing activities and increasing feelings of isolation.

Long term poverty outcomes

- Reduce the proportion of children living in relative poverty
- Reduce the proportion of working age population claiming out of work benefits
- Reduce the proportion of working age population claiming in-work Universal Credit
- Deliver improved quality and availability of housing that meets health and wellbeing needs

Delivery plans: HOUSING Reduce poverty through better housing, employment, and skills			
Deliverable	Timeline	SRO	Oversight
Establish a delivery vehicle/group for years 2023/25	2023/24		Public Health Emmeline Watkins
DELIVER NEW HOMES TO MEET HEALTH& WELLBEING NEED			
• Increase the supply of more affordable housing including addressing needs of key workers across Cambridgeshire and Peterborough.			
• Ensure the design and layout of new homes enable people, especially children, to live with personal privacy and be able to play, learn and rest.			
• Increase the number of homes which provide for specialist housing need.			
• Increase the availability of assistive technology in new homes & communities.			
IMPROVING QUALITY OF HOUSING TO ENABLE HEALTH & WELLBEING RESILIENCE.			
• Increase the identification and improvement of homes in poor condition across all tenures, especially for vulnerable groups such as children with asthma			
• Reduce housing related delayed transfers of care			
• Increase thermal comfort in homes, reducing excess winter and summer deaths			
• Improve quality of houses of multiple occupation			
INCREASING THE PROPORTION OF RESIDENTS IN SAFE AND SECURE HOUSING.			
• Increase prevention of homelessness by increasing early referrals by all partners into homelessness prevention teams			
• Improve access to health and wider services for those that are homeless, especially rough sleepers			
SUPPORTING MENTAL HEALTH AT HOME (FOR NEW AND EXISTING HOMES).			
• Increase the supply of homes suitable for the ageing population including dementia-friendly homes			
• Support people out of hoarding, improving their life chances and reducing risk of death due to fire and other risks for them, their neighbours and their visitors			

Delivery plans: EMPLOYMENT and SKILLS Reduce poverty through better housing, employment, and skills			
Deliverable	Timeline	SRO	Oversight
Deliverable 1: Secure information to re-design the pathway to employment through health and social care services care. (Information to include the barriers to using the fit note to support patients to consider their ability to work? How the recording of the functional effects of the patient's condition and fitness for work currently look, how the ideal referral	2023/24		ICB, Public Health

pathway/health journey would look, how to challenge the patient perceptions about their ability to work			
Deliverable 2: Secure information to identify how the system can work collaboratively to support people into employment. To include following how Primary Care/Health/Social Care Professionals can be supported, how the new Integrated Neighbourhood structure can support, existing resources within the system	2023/24		ICB, Public Health
Deliverable 3: Identification of contact points/service provision/locations with which the work and health agenda could be integrated	2023/24		South Cambs District Council and other C&P LAs Public Health Cambridgeshire Insights
Deliverable 4: Establish a collaborative system wide approach to employment services delivery that is integrated into skills/health/social care services and improves access.	2023/24		Cambridgeshire and Peterborough Combined Authority (CPCA) DWP, Public Health Cambridgeshire Insights, Work, HWB Oversight Group
Deliverable 5: Employer and employee hub to provide information and advice.	2023/24		System wide Health Safety and Wellbeing Group
Deliverable 6: Public sector / Anchor institution role modelling in relation to access to skills and employment.	2023/24		ICS/LAs/Combined Authority
Deliverable 7: Improved training / support for leaders / managers to support employees in poor health.	2023/24		ICB & Combined Authority

PRIORITY 4: Promoting early intervention and prevention measures to improve mental health and well-being.

Overview

Good mental health and well-being are essential factors in a thriving community. The impacts of poor mental health are significant and far reaching and can have a dramatic effect on whole life satisfaction and achievement. Our vision is that everyone in our communities across Cambridgeshire and Peterborough has opportunities for good mental health & wellbeing, and access to resources and information to prevent the onset of mental health problems, especially for those facing the greatest adversity and barriers. This includes those living with and recovering from mental illness.

Mental well-being promotion involves encouraging good mental health, positive feelings such as life satisfaction and happiness, reducing inequalities, building social capital, enhancing the quality of life, and enabling optimal psychological and psychophysiological development throughout the life course.

Mental illness prevention involves reducing the incidence, prevalence, and recurrence of mental health problems, as well as reducing the risk factors and the impact of mental illness on the affected person.

The pandemic has changed and disrupted the way many of us live, work, form relationships, participate in activities and enjoy ourselves; furthermore, inequalities have been exacerbated by the COVID-19 pandemic. Coupled with its wider impact on employment, economics, and education it has taken a toll on the populations' mental wellbeing and therefore timely to focus our efforts on addressing this.

In the years following there is more economic uncertainty, bringing greater stresses on individuals and families to cope with challenges such as the cost of living in a changing world. These factors all impact on our mental wellbeing.

By 2030, we want our population to have measurably better mental wellbeing than in 2022.

Long term outcomes

- Reduce the proportion of children and young people who need to be referred to mental health services
- Improve access to help and information to prevent mental health problems escalating
- Increase awareness about what choices can be made to best support people's well-being and the well-being of those they care about
- Implement understanding and awareness of Mental Health and Wellbeing programmes.

Delivery plans: Promoting early intervention and prevention measures to improve mental health and well-being			
Deliverable	Timeline	SRO	Oversight
Theme 1 – Communications, information, and resources Deliverable: Increase people's understanding of what they can do and their choices to best support their wellbeing and those they care about	2024/25		Mental Health Collaborative
Theme 2 – Motivation Deliverable: Increase engagement of people in activities that will encourage, motivate, and support them to improve their mental wellbeing.	2024/25		Mental Health Collaborative
Theme 3 – Relationships Deliverable: Support and foster positive relationships across the life-course for better mental wellbeing and prevention of loneliness	2024/25		Mental Health Collaborative
Theme 4- Wider determinants and leadership			System wide Mental Health Collaborative
Theme 5 - System understanding of Pathways and Resources			System wide Mental Health Collaborative

Environmentally Sustainable Healthcare

Overview

Our overall carbon reduction targets are:

- An 80% reduction in the emissions we control directly (NHS Carbon Footprint) by 2028-2032, and net zero by 2040 (47% by 2028-2032 from 2020 baseline)
- An 80% reduction in our entire emissions profile (NHS Carbon Footprint Plus) by 2036-2039, and net zero by 2045 (73% by 2028-32 from 2020 baseline)

We will develop a programme of work to involve all our health and care partners and improve the understanding of the links between climate change and poor health outcomes.

What we want to achieve:

- Have a knowledgeable and motivated workforce that understands sustainability, can incorporate it into normal everyday business and feels empowered to act on the issue in the workplace and in their personal lives.
- Build sustainability considerations into all our strategies, policies, processes, and business models.
- Decarbonise our built environment and set the highest standards for new build and refurbishment, regarding use of materials and design of sustainable and flexible workplaces and be prepared for future extreme climatic events.
- Move to relying on energy from sustainable sources and reduce our overall energy use.
- Encourage the use of sustainable modes of transport for our suppliers, workforce, and patients, to improve air quality.
- Work with suppliers, purchasers, and consumers to procure more sustainably, with a circular economy approach.
- Purchase less, increase reuse/recycling/repurposing and increase separation of waste, to be disposed of in the most sustainable fashion.
- Reduce the use of high carbon footprint medication and medical gasses. Optimise use of medications and improve on waste and sustainable disposal of same.
- Support the adoption and development of new technologies and innovation to assist reduced carbon footprint.
- Maximise use of digital technologies and look at whole pathways to adopt the most sustainable healthcare practices.

Delivery plans:

Workforce and leadership

Objectives:

- Raise sustainability awareness across the ICS workforce, that builds confidence, understanding and motivation to ‘be’ the change.
- Embed sustainability into organisational values, policies, and operational processes.

By 2028 we want sustainability to be embedded in normal everyday business, considerations, and processes.

Deliverable	Milestone & timeline	Lead/SRO	Oversight group/s
Training & engagement programme for system leaders and staff	• ICB Board training delivered 2023 • GP & Trust staff programmes established 2023 • System champions in place 2023/24	Claudia Iton, Chief People Officer, ICB Fiona O'Mahony, Programme Manager ICS Sustainability, ICB	Green Plan Programme Board, ICB People Board
Sustainability embedded in all processes and policies	• Informed environmental considerations are an integral part of all policy, strategy, and business case development by 2024	Nicola Ward, Director of Strategy and Development, ICB Kit Connick, Chief Officer Partnerships & Strategy, ICB Claudia Iton, Chief People Officer ICB Louis Kamfer, Deputy Chief Executive Officer & Managing Director of Strategic Commissioning, ICB	Green Plan Programme Board
Adaptation plans	• Adaptation lead in place 2023 • Work with LAs on linking all Adaptation/Resilience and Climate Risk plans 2023/24	Kit Connick, Chief Officer Partnerships & Strategy, ICB	Green Plan Programme Board, ICB Audit & Risk Committee
Joint engagement and messaging across the system	• Shared system brand 2023 • Events programme 2024	Laura Halstead, Assistant Director of Communications & Engagement, ICB	LA and NHS Comms Group

Estates and facilities

Objectives:

- Reduce the reliance on fossil fuels for energy and heating
- Increase on site renewables
- Invest in energy saving measures
- Plan for a lower carbon footprint estate

By 2028 we aspire to a more flexible estate, that delivers services as locally as possible (considering both patient and staff demands), working with system partners to maximise space utilisation. An estate that has reduced its carbon footprint and with a worked plan for how it will manage its energy usage and demands for the next decade. Progress with our new build hospitals to be to the highest standards in terms of use of sustainable materials and design.

Deliverable	Milestone & timeline	Lead/SRO	Oversight group/s
Work towards decarbonisation of existing estate	• Identified timed and resourced plan for secondary care estate 2023 and primary care 2024	Kit Connick, Chief Officer Partnerships & Strategy, ICB Alison Manton, Associate Director of Estates, CPFT	System Estates Group

Deliverable	Milestone & timeline	Lead/SRO	Oversight group/s
		David Parke, Assistant Director Sustainability & Infrastructure, South, ICB Lucy Macleod, Assistant Director Sustainability & Infrastructure, North, ICB	
Align ICS Estates strategy with deliverables in the NHS Estates Net Zero Carbon Delivery Plan	• 2023	As above	System Estates Group
Embed circular economy and good design into all new capital developments	• Direct input into new build programmes 2023	As above	System Estates Group
Business case for local heat networks for key NHS service hubs	• Established if business case feasible by 2023. If so, developed approach by 2024.	Alison Manton, Associate Director of Estates, CPFT Eithne George, Head of Energy Services, CCC	System Estates Group

Research and innovation

Objectives:

- Support research and adoption of green technologies and innovations

By 2028 we will have built a strong and ongoing relationship with the local research community in support of the programmes we are working on. We will be in a strong position to trial and spread new innovations, when the opportunities arise, at a range of sites and organisations, across the system.

Deliverable	Milestone & timeline	Lead/SRO	Oversight group/s
Collaborative projects and academic partnerships	• Build connections 2023. • Identify and agree research areas ongoing	Fiona O'Mahony, Programme Manager ICS Sustainability, ICB Phillipa Brice, Head of R&D, ICB	Green Plan Programme Board
Initiatives and partnerships to embed new technologies and innovations	• Explore plastics project 2023-2026	Fiona O'Mahony, Programme Manager ICS Sustainability, ICB Stella Cockerill, Regional Net Zero Programme Lead	Green Plan Programme Board

Active and sustainable travel

Objectives:

- To reduce emissions and improve air quality

By 2028 we will have helped the workforce and patient community reduce reliance on single person fossil fuelled car journeys and consider alternatives as a default position. As a health service, we will have a predominantly electrified fleet supported by charging infrastructure across the system.

Deliverable	Milestone & timeline	Lead/SRO	Oversight group/s
Non fossil fuel fleet & EV infrastructure	• 50% fleet EV 2023 • Infrastructure plan 2023/24	Trust Sustainability Leads/Fiona O'Mahony, Programme Manager ICS Sustainability, ICB	Transport subgroup Green Plan Programme Board
Active travel policies and promotion	• Trusts and ICB 2024 • GP programme 2024/25 • Combined approach with LAs and public transport providers 2028	Trust Sustainability Leads/ Fiona O'Mahony, Programme Manager ICS Sustainability, ICB	Transport subgroup Green Plan Programme Board
Air quality improvement in targeted areas	• Pilot at one NHS site 2023 • Combined strategy with LA 2025 • Adopt Clean Air Hospital Framework at key hospital sites 2028	Trust Sustainability Leads/Fiona O'Mahony, Programme Manager ICS Sustainability, ICB	Transport subgroup Green Plan Programme Board

Supply Chain

Objectives:

- Drive emission reductions throughout the supply chain with a circular economy approach to procurement and waste

By 2028 we will have developed a robust method of evaluating the 10% social value in tenders and a system of monitoring its delivery, working with procurement and contract management staff and the supplier network. We will have a standardised approach to the market across local authority and NHS contractors giving a clear message to the market and suppliers what expectations are for delivery in this system with regards to carbon plans and reducing the impact on the environment. We will have reduced waste through a move to reusable products, better repurposing and recycling and improved waste separation.

Deliverable	Milestone & timeline	Lead/SRO	Oversight group/s
Develop the skills and guidance for procurement staff and contract managers to evaluate and monitor carbon reduction in all contracts	• 100% of Trusts/ICB 10% weighting in all new NHS contracts 2023 • Identify suppliers requiring a carbon reduction plan (contracts over £5m) 2024	Ian Hooper, Director of Procurement and Supply chain, ICB	C&P system Procurement group
Develop a sustainable procurement policy for the ICS and seek a joint approach with LAs in social value assessments	• policy statement 2023/24 • joint approach agreed 2024/25	Ian Hooper, Director of Procurement and Supply chain, ICB	C&P system Procurement group

Deliverable	Milestone & timeline	Lead/SRO	Oversight group/s
Reduced waste, working with partners to move to reusable products and separate waste more effectively improving recycling and repurposing.	• Identified system wide projects and processes as part of overall Waste Strategy by 2025	Trust Sustainability Leads	Green Plan Programme Board
Explore the potential for a plastics recycling plant locally	• By 2027	Stella Cockerill, Regional Net Zero Programme Lead/ Fiona O'Mahony, Programme Manager ICS Sustainability, ICB	Green Plan Programme Board, EoE NHS Regional Team, Combined Authority project group

Medicines, Digital and Sustainable Pathways

Objectives:

- Optimise the use of medicines to deliver health and environmental benefits.
- Integrate sustainability goals in care delivery through QI, pathway, and service redesign.

By 2028 we will have achieved:

A change in the management of asthmatic and COPD patients reducing SABA over-reliance and the prescribing of green inhalers as the default position.

Use of desflurane only in exceptional circumstances and leak-proof systems for administration of NO2 in hospital settings.

A project for waste reduction in medicines working with primary and secondary care prescribers and pharmacists.

A clinician led programme of pathway reviews, to reduce carbon footprint.

Deliverable	Milestone & timeline	Lead/SRO	Oversight group/s Chief Pharmacist Leadership Group
Reduce the use and waste of medical gases to as little as practically possible	• By 2025	Sati Ubhi, Chief Pharmacist, ICB	Chief Pharmacist Leadership Group
Maximise prescribing of low carbon inhalers and improve return of used units	• Reduction in use of high carbon inhalers to those with clinical need only by 2026 • Programme to collect and recycle used high carbon inhalers by 2024	Sati Ubhi, Chief Pharmacist, ICB	Chief Pharmacist Leadership Group
Optimise use of medicines: appropriate prescribing, regular	• Review process of providing green prescribing advice looking	Sati Ubhi, Chief Pharmacist, ICB	Chief Pharmacist Leadership Group

Deliverable	Milestone & timeline	Lead/SRO	Oversight group/s Chief Pharmacist Leadership Group
meds reviews; greener prescribing	at data and progress to date in 2024 • Consider including green prescribing indicators within 2024 prescribing incentive scheme		
Maximise digital care opportunities across all care settings	• Secondary care outpatients 25% target for phone or video 2023	Nicci Briggs, Chief Finance Officer, ICB Louis Kamfer, Deputy Chief Executive Officer & Managing Director of Strategic Commissioning,	Green Plan Programme Board
Specialty / pathway specific initiatives	• Draft project brief to consider best practice and scope for targeted intervention 2025/26 • Heart Failure Pathway reviewed by 2024	Fiona O'Mahony, Programme Manager ICS Sustainability, ICB Richard Hales, Energy and Sustainability Manager, CUH	Green Plan Programme Board

Procurement & Supply Chain

Overview

The procurement & supply chain function is a key enabler in delivery of our system's health and well-being and integrated care strategy (HWICS) and the shared vision around the four priorities:

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

The NHS procurement & supply chain functions within the system have an established collaborative workstream in operation, which will be expanded to include ICB and local authority as appropriate in 2023. The NHS functions currently operate as separate entities, with CUH and NWAFT being in-house, and RPH/CCS/CPFT being outsourced to NHS Shared Business Services.

The ICS' Procurement & Supply Chain Workstream (P&SCW) is working together in collaboration with focus on the following three priorities:

1. To develop and deliver best practice procurement & supply chain services to the partners within the ICS.
2. To develop and deliver collaborative approaches to the procurement of common goods and services where of added benefit (financially/operationally) to the system.
3. To support and enable the objectives of other workstreams within the system where procurement and supply requirements are a deliverable.

Our vision is to achieve best value in the goods and services we procure and enable in support of patient care delivery within the health economy. Whilst aiming to achieve all possible on an 'as-is' basis under a collaborative model, consideration will be given to added value that could be achieved with investment in a fully aligned shared service procurement and supply chain operation for the ICS in the future.

Delivery plans:

Best practice procurement & supply chain services

Objectives:

<u>PTOM 34 Steps</u>

We have adopted the model as developed and set by NHSE's Procurement Target Operating Model (PTOM) for ICS procurement & supply chain identified as the '34 Steps'.

The model includes three stages of maturity:

- Stage 1 – 'Get Informed'
- Stage 2 – 'Get Connected'
- Stage 3 – 'Get Optimised'
- Stage 4 – 'Get Scale'

The 34 activities (or steps) under each stage of maturity above are rated using the following classifications:

- 'Not Started'
- 'Some Progress'
- 'Great Progress'
- 'Complete'

During 23/24, we will continue to use this model to develop our functions in accordance with Stages 1 and 2 of maturity against the following categories:

- Data, Technology & Performance
    - Identify and agree key data sets.
    - Agree to systematic procurement & commercial information sharing
    - Contribute to and use spend analytic tools to gather information on spend opportunities.

- People & Skills –
    - Identify and allocate category leads where possible.
    - Perform a skills development analysis to allow appropriate sharing of collective resources to support ICS initiatives.

- Policies & Procedures
    - Convene a regular ICS Procurement forum including all Heads of Procurement across working within approved Terms of Reference.
    - Formalise the collaboration via the creation of an MOU, documenting an agreed common line of collaborative action.

- Strategic Procurement
    - Develop a shared ICS level procurement risk register.
    - Undertake a full review of ICS 3rd party spend at project level incorporate any relevant procurement risks and are escalated where appropriate. Continue to review ICS third party spend.
    - Identify "tier 1" shared suppliers and align on a common approach to their management.

- Strategy & Organisation
    - Gain ICS-level executive sponsorship for ICS based Procurement.
    - Nominate an ICS Procurement lead to drive change.
    - Develop a shared ICS procurement strategy

- Supply Chain Management
    - Nominate an ICS Supply Chain Lead to drive visibility.
    - Undertake analysis of supply chain management processes across the ICS.

- Sustainability
    - Nominate an ICS lead for sustainable supply chain and procurement to incorporate sustainability into foundations of ICS delivery.

- Adopt national approach for incorporating environmental and social value in procurements at ICS level.
- Directly address any nationally communicated Planning Guidance and National Commitments published in this space.
- Confirmed support to central government's approach on eliminating modern slavery in government supply chains.
- Mandatory Government training to be undertaken by all applicable staff.

CCIAF Standards

In accordance with the initiative being driven through NHSE's Central Commercial Function (CCF), we will continue our development by adopting the national Commercial Continuous Improvement Assessment Framework (CCIAF).

The CCIAF is designed to help drive continuous improvement in commercial practices across the Government Commercial Function (GCF) and wider public sector by enabling organisations to benchmark their commercial operations against good practice.

The maturity ratings for the standards are as follows:

- 'In-development'
- 'Good'
- 'Better'
- 'Best'

The list below sets out the structure of the framework with the eight themes (within which there are 27 practice areas):

- Theme 1. Commercial strategy, planning and governance.
- Theme 2. Commercial capability and resourcing.
- Theme 3. Commercial lifecycle define: pre-procurement.
- Theme 4. Commercial lifecycle procure: procurement and contracting
- Theme 5. Commercial lifecycle manage: contract management
- Theme 6. Managing categories, markets, supplier relationships, and working with partners
- Theme 7. Commercial systems, reporting and information
- Theme 8. Policy

Deliverable/Milestone	Timeline	SRO	Oversight group/s
PTOM 34 Steps: Stages 1 and 2 of maturity 'Complete'	Dec 24	Ian Hooper, Director of Procurement and Supply Chain	FPPG
CCIAF Standards: Achieve maturity rating of 'Good'	Apr 24	Ian Hooper, Director of Procurement and Supply Chain	FPPG

The NHS partners' procurement teams within the system will continue to operate on a collaborative basis in the short term as a minimum. An assessment will be conducted to establish the potential benefits (operational and financial) and added value that could be gained through investment in a formal shared procurement & supply chain function (to include requirements for the ICB).

Collaborative approaches to the procurement of common goods & services

Objectives:

We will continue to build on areas of success to date to identify and progress opportunities to drive efficiencies for the system through the collaborative procurement of common goods and services.

- Using the already implemented platforms (Adviseinc and NHS Digital's Spend Comparison Service) to load AP/PO data to compare costs and prices across categories and identify validated opportunities.
- Using the already implemented Atamis Procurement Pipeline Management platform to capture workplans and identify potential areas for collaboration.
- Identify and progress opportunities for the collaborative procurement of common clinical and non-clinical goods where of benefit operationally and/or financially. In 23/24, focus is on the portfolio of medical/surgical product categories procured via NHS Supply Chain. Scoping activity is on-going, with some examples of projects identified as follows:
    - Procedure packs
    - Orthopaedics
    - Ward based consumables
- Identify and progress opportunities for the collaborative procurement of common clinical and non-clinical services where of benefit operationally and/or financially. Scoping activity is on-going, with some examples of projects identified/progressed as follows:
    - Non-emergency patient transport
    - Laundry & linen
    - Electronic Patient Record (EPR)
    - Interpretation & translation

Deliverable/Milestone	Timeline	SRO	Oversight group/s
Implement and utilise spend data platforms	Complete	Ian Hooper, Director of Procurement and Supply Chain	FPPG
Implement and utilise procurement pipeline management platform	Complete	Ian Hooper, Director of Procurement and Supply Chain	FPPG
Progress opportunities for the collaborative procurement of common clinical and non-clinical goods	Ongoing	Ian Hooper, Director of Procurement and Supply Chain	FPPG
Progress opportunities for the collaborative procurement of common clinical and non-clinical services	Ongoing	Ian Hooper, Director of Procurement and Supply Chain	FPPG

Support and enable the objectives of other workstreams

Objectives:

- Provide professional advice, guidance and support to other workstreams where procurement and supply chain requirements are a deliverable, with active engagement on 'Digital' and 'Green' so far.

- In 23/24, much of the support available from the P&SC workstream will be focussed on Sustainability and the ICS' Green Plan; a key objective within the relevant workstream's delivery plan being to: "Drive emission reductions throughout the supply chain with a circular economy approach to procurement and waste"

  Extract from the Green JFP Delivery Plan: "By 2028 we will have developed a robust method of evaluating the 10% social value in tenders and a system of monitoring its delivery; working with procurement and contract management staff and the supplier network. We will have a standardised approach to the market across local authority and NHS contractors giving a clear message to the market and suppliers what expectations are for delivery in this system with regards to carbon plans and reducing the impact on the environment. We will have reduced waste through a move to reusable products, better repurposing and recycling and improved waste separation."

Deliverable/Milestone	Timeline	Lead/SRO	Oversight group/s
Develop the skills and guidance for procurement staff and contract managers to evaluate and monitor carbon reduction in all contracts	• 100% of Trusts/ICB 10% weighting in all new NHS contracts 2023 • Identify suppliers requiring a carbon reduction plan (contracts over £5m) 2024	Ian Hooper, Director of Procurement and Supply Chain	C&P system Procurement group
Develop a sustainable procurement policy for the ICS and seek a joint approach with LAs in social value assessments	• policy statement 2023/24 • joint approach agreed 2024/25	Ian Hooper, Director of Procurement and Supply Chain	C&P system Procurement group
Reduce waste, working with partners to move to reusable products and separate waste more effectively improving recycling and repurposing.	• Identified system wide projects and processes as part of overall Waste Strategy by 2025	Trust Sustainability Leads	Green Plan Programme Board
Explore the potential for plastics recycling plant locally	• By 2027	Fiona O'Mahony, Programme Manager ICS Sustainability	Green Plan Programme Board, EOE NHS Regional Team, Combined Authority Project Group

Organisational Development, Culture and Leadership

Overview

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 residents.

Organisational Development (OD) will be an important enabler to achieve this. As the 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, Partnerships, 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.

Objectives: Our OD priorities

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

Measuring the impact of OD interventions

The overarching measure of success for OD interventions is that we are working differently together and are delivering this Joint Forward Plan.

For each of the interventions/deliverables that we have identified, we have identified a number of outcomes we anticipate they will help achieve. To help us evaluate impact, we will use a range of measures that will draw on the Kirkpatrick model of evaluation (reaction, learning, behaviour and results).

Delivery Plans

The design and delivery of some of the priority OD interventions will be supported by the Leadership and Culture subgroup of the People Board. The work plans for the other subgroups of the People Board will also play a significant part in helping us achieve the culture shift we require (see workforce section).

The ICB is also leading on the design and delivery of several system wide programmes including a Just and Learning Culture, Continuous Quality Improvement, Civility and Respect, Above Difference and Delivering Environmentally Sustainable Healthcare. These programmes have been noted in here because they are key to the culture shift that we need and are therefore important OD interventions in themselves. Detail of delivery will be managed through other parts of the JFP delivery plan.

Given the complexity, uncertainty, and ambiguity that we are operating in, it is important that our delivery of OD is dynamic and is both proactive and responsive. A range of key OD interventions have been identified but these may evolve over time as the needs of the ICS and its constituent parts develop. We will also embed an ethos of continuous improvement in how we identify, design and deliver our OD interventions.

System Relationships and Collaborative Working

OD interventions will support the achievement of the following outcomes:

- The ICB and the 4 Partnerships have high-performing and effective Boards/Executive Groups, so that they are effectively undertaking their strategic role in the ICS and delivering the Health and Wellbeing/integrated care strategy and priorities, with:
  - Clarity about vision, scope, objectives, and TOR
  - Clarity about roles, responsibilities, and accountability
  - Collective decision-making
  - Collaborative working values, culture, and behaviours
  - System leadership and working across organisational boundaries.
- Boards are operating effectively as a partnership/collaborative and are delivering its priorities and delegated functions.
- There is a strong working relationship between the ICB, and the Partnership Boards and they are working as equal partners in the ICS; there is a culture of mutual support and accountability.
- Executive Groups are working effectively leading the delivery of the ICB/Partnership delivery plans to achieve the ICS priorities.
- ICB and Partnership Board Members, ICB and Partnership Executives and Senior Leaders are operating as compassionate and inclusive, system leaders, operating as representatives of the ICB/Partnership and their communities and not the needs of their own organisations.

- There is a strong cross-working and collaborative relationship between all Partnership Boards and the MOU that sets out roles, priorities and expectations between the Partnerships is working effectively; there is a culture of mutual support and accountability.
- There is a strong cross-working and collaborative relationship between the ICB teams and the Partnerships teams and the MOU that sets out roles and expectations between the Partnerships and the ICB teams is working effectively.
- The Care Professional and Clinical Assembly is operating effectively and the ICB and Partnerships are informed by strong and representative care and clinical advice and decision-making; Care Professionals and Clinical leaders are operating as representatives of their professions and not only their organisation.

Deliverable/Intervention/Milestones	**Timeline**	**SRO**	**Oversight Group**
ICB Board Development **Partnership Board Development** **ICB Management Executive Development** **Partnership Management Executive Development** For all the above, key milestones will be: • Initiate suite of activities/interventions • Review and evaluate impact of interventions. • Refine and deliver interventions. • Embed changes. • Ongoing development as required.	2023-2024 and ongoing	Jan Thomas, CEO, ICB Partnership Managing Directors	System Development Forum
Partnership collaborative working programme. Key milestones will be: • Initiate suite of activities/interventions • Review and evaluate impact of interventions. • Refine and deliver interventions. • Embed changes. • Ongoing development as required.	2023-2024 and ongoing	Partnership Managing Directors	System Development Forum
ICB teams and Partnership teams collaborative working programme Key milestones will be: • Initiate suite of activities/interventions • Review and evaluate impact of interventions. • Refine and deliver interventions. • Embed changes. • Ongoing development as required.	2023-2024 focus and ongoing as required	Claudia Iton, Chief People Officer, ICB Partnership Managing Directors	System Development Forum

Leadership Development

OD interventions will support the achievement of the following outcomes:

- Leaders are demonstrating the ICS leadership behaviours and values in all their interactions.
- Leaders are demonstrating system leadership behaviours.
- ICB and Partnerships are informed by strong and representative care and clinical advice and decision-making.
- Groups of leaders from different organisations are working collaboratively on specific transformation projects – working as system leaders and not as individuals representing their own organisational needs.
- Managers of integrated teams – whether these are cross-organisational or cross-professional – have the skills to lead and manage teams with different organisational and professional cultures that are focused on providing care for specific patient populations.
- Members of the integrated teams are working together as "one team," and feel empowered by their leaders to identify improvements and make changes needed.
- Differences are valued and diversity is embraced. Senior Leaders are:
  - Culturally intelligent
  - Value driven leaders who transform cultures
  - Intentionally inclusive leaders
  - EDI change catalysts
- There is a developing culture of inclusivity across the ICS where behaviours and attitudes embrace and enhance diversity.
- Leaders from different organisations can collaborate effectively as they have an understanding and appreciation of other professions, roles, services, and organisations.
- Multi-professional working is effective.

Deliverable/Intervention/Milestones	**Timeline**	**SRO**	**Oversight Group**
Embed **Leadership Compact and System Leadership Behaviour Framework** and Self-assessment and **Environmental sustainability** in all organisational and system leadership programmes	2023-2024 and then ongoing	Claudia Iton, Chief People Officer, ICB	Leadership and Culture subgroup
Bespoke Leading Beyond Boundaries Leadership Programme Key milestones: • Commission programme • Identify teams to participate and deliver. • Evaluate • Embed	2023-2024 and then ongoing	Chair, Leadership and Culture Subgroup	Leadership and Culture subgroup
Bespoke leadership programme for leaders of integrated teams Key milestones:	2024-2025 and then ongoing	Chair, Leadership and Culture Subgroup	Leadership and Culture subgroup

Deliverable/Intervention/Milestones	Timeline	SRO	Oversight Group
• Design and Commission programme • Deliver • Evaluate • Embed			
Care Professional and Clinical Leadership Programme(s) Key milestones: • Design and Commission programme • Deliver • Evaluate • Embed	2023-2024 and then ongoing	Carol Anderson, Chief Nurse, ICB Other SROs to be confirmed	Leadership and Culture subgroup
Above Difference Programme Key milestones: • Deliver • Evaluate • Embed	2023-2024	Chair EDI subgroup	EDI subgroup
Stepping in your shoes - programme	2023-2025	Chair, Leadership and Culture Subgroup	Leadership and Culture subgroup

Culture of Integrated Team Working

OD interventions will support the achievement of the following outcomes:

- Service transformations and improvement priorities identified in this JFP are successful as teams involved are working in a collaborative and integrated way, working across organisational and professional boundaries.
- Members of the integrated teams are working effectively together as “one team.”
- People can demonstrate that they are empowered to do the right thing for residents, are able to say yes, feel included in decisions and are thriving in their roles.
- There is a culture that enables residents to contribute to and coproduce the development of services.
- People have the skills to support:
  - Collaborative working
  - Working across organisational boundaries
  - Managing both technical and adaptive challenges that complex, system working involves.
- There is a culture of compassion and inclusivity, and people are treating each other with compassion, civility, and respect.
- There is a developing culture of continuous improvement where people feel empowered to identify and make improvements to meet the care and health needs of residents.

Deliverable/Intervention/Milestones	Timeline	SRO	Oversight Group
Tailored interventions to support cross organisational teams who are working on transformation projects. Key milestone: • Partnerships identify cross organisational teams. • Undertake diagnostic. • Design interventions. • Deliver interventions. • Evaluate impact of interventions	2023-2024 and ongoing	Partnership Managing Directors	System Development Forum
Civility and Respect (and embedding Leadership Compact) Key milestones: • Design and deliver Conference (week) • Evaluate and capture any key actions for follow up	2023-2024	Carol Anderson, Chief Nurse, ICB	Leadership and Culture Subgroup
Culture review Key milestones: • Commission and undertake culture survey. • Identify key actions for improvement (Partnership, Organisational and team level) • Undertake follow up survey, 1 year later.	2023-2024	Carol Anderson, Chief Nurse, ICB	Leadership and Culture Subgroup
Just and Learning Culture Programme Key milestones: • Deliver Human Factor Training • Deliver Just Culture Training • Patient Safety Framework	2023-2024	Carol Anderson, Chief Nurse, ICB	TBC
Continuous quality improvement programme Cross-reference to CQI delivery section and Environmentally Sustainable Healthcare			

Continuous Quality Improvement Strategy

Overview

Cambridgeshire and Peterborough has developed its first system-wide Continuous Quality Improvement 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 QI/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, share and celebrate learning.

Our CQI Strategy

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

- Strategic intent for CQI: Supporting leaders to explore and identify CQI opportunities linked to strategic and annual planning.
- 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.
- Leadership for CQI: To provide clear leadership for delivering quality improvements. Senior leaders, who model appropriate improvement focussed leadership behaviours and visible hands-on-approach.
- Building CQI skills at all levels: To demonstrate an accessible approach to providing CQI to every level of the System.
- Building CQI engagement all levels: We want to be more inclusive in our approaches, ensuring everyone has a voice in making improvements.
- System view for CQI: Working 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 the System's vision, ambitions, improvement programmes, strategic and tactical priorities.

Action	Timeline	SRO	Oversight Group/s
Agree all provider and wider system CQI projects against each of the 6 elements	June 2023	Gary Howsam, CCIO	QITG
23/24 CQI Project progress and outcomes delivery report	April 2024	Gary Howsam, CCIO	QITG
CQI Strategy Review 24/25	Sept 2024	Gary Howsam, CCIO	QITG

Measuring Success

Success factors for the System and our Partners organisations will 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 and key stakeholders in driving 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.

Our success will be measured by all the improvements we make. We will ensure that we can collate the benefits from everyone who undertakes an improvement activity, to include it in our CQI Knowledge Hub and play back 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.

Agenda Item No:

Report title: Better Care Fund Plan 2023-25 and End of Year 2022/23 Returns

6

To: Cambridgeshire and Peterborough Health & Wellbeing Board / Integrated Care Partnership

Meeting Date: 21st July 2023

From: Caroline Townsend, Head of Commissioning Partnerships and Programmes Cambridgeshire County Council and Peterborough City Council

Outcome: The approval of end of year returns and plans enables us to comply with the national conditions associated with the release of Better Care Fund monies.

Recommendation: The Cambridgeshire and Peterborough Health & Wellbeing Board / Integrated Care Partnership What is recommended to:

a) Approve the 2023-25 Better Care Fund Plans for Cambridgeshire and Peterborough.
b) Approve the 2022/23 Better Care Fund year end report for Cambridgeshire and Peterborough.

You should not repeat the recommendations at the end of the report.

Officer contact:
Name: Caroline Townsend
Post: Head of Commissioning Partnerships and Programmes
Email: caroline.townsend@cambridgeshire.gov.uk
Tel:

Member contacts:
Names: John O'Brien (ICP), Councillors Wayne Fitzgerald (PCC) & Susan van de Ven (CCC)
Post: Lead Members for Health and Wellbeing
Email: john.obrien5@nhs.net;wayne.fitzgerald@peterborough.gov.uk; susanvandeven@cambridgeshire.gov.uk
Tel: 07592 594776 and 01223 706398 (office)

1. Background

1.1 The Better Care Fund was originally launched in 2015 to join up the NHS, social care and housing services that older people, and those with complex needs, can manage their own health and wellbeing and live independently in their communities for as long as possible. The Better Care Fund requires local authorities and the NHS to establish a pooled budget in relation to the Better Care Fund funding to support health and social care services to work more closely together in local areas.

1.2 Under the terms of the Better Care Fund, jointly invested by the NHS (ICB) and Local Authorities, health and wellbeing boards have a statutory duty to submit agreed plans for Cambridgeshire and Peterborough.

1.3 Due to the tight timelines for submission of local plans and year end reports, these were submitted to the NHS England on the 30th May 2023 (year end reports) and 28th June 2023 (2023-25 Plans) without full Cambridgeshire and Peterborough Health & Wellbeing Board / Integrated Care Partnership approval prior to submission. It was noted on submitted plans, that they were pending this approval. Year end reports and plans were approved by both local authorities and the ICB prior to submission.

1.4 To ensure formal compliance with national conditions, it is requested that the Cambridgeshire and Peterborough Health & Wellbeing Board / Integrated Care Partnership approves both the 2022/23 year end reports and the 2023-25 plans.

1.5 This report is for the Cambridgeshire and Peterborough Health & Wellbeing Board / Integrated Care Partnership to consider under its Terms of Reference.

2. Main Issues

2.1 NHS England Better Care Fund Policy Framework and Planning Requirements for 2023-25 were released in early April 2023.

2.2 The guidelines clarified that this was to be a two-year planning cycle.

2.3 The aim of the BCF is to support people to live healthy independent and dignified lives, through joined up health, social care and housing services seamlessly around the person. This vision is underpinned by two objectives:

- Enabling people to stay well, safe and independent at home longer
- Provide people with the right care, at the right place, at the right time

2.4 Performance in 2022/23 against national metrics has been positive, as outlined below and reported in the final year end position.

	Cambidgeshire								Peterborough							
Metric	2022-23 Plan				2022-23 Actual				2022-23 Plan				2022-23 Actual			
Avoidable Admissions*	765				749.75				835				797.79			
	196 (Q1)	193 (Q2)	191 (Q3)	185 (Q4)	192.54 (Q1)	182.75 (Q2)	201.24 (Q3)	172.23 (Q4)	217 (Q1)	209 (Q2)	206 (Q3)	203 (Q4)	200.24 (Q1)	176.98 (Q2)	218.95 (Q3)	185.07 (Q4)
Discharge to usual place of residence	90.90%				91% (Q1)	91.3% (Q2)	91.4% (Q3)	91.2% (Q3)	92.10%				92.2% (Q1)	92.8% (Q2)	92.3% (Q3)	91.2% (Q4)
Residential Admissions*	603				602.6 (Forecast)				465				651.4			
Reablement (at home 91 days after discharge)	72.20%				72.7% (Forecast)				74%				90.90%			

2.5 For 2023-25, there are two key priorities which align with the above objectives:

1. Improving overall quality of life for people, and reducing pressure on Urgent Emergency Care, acute and social care services through investing in preventative services. To include:

    - collaborative working with the voluntary, housing and independent provider sectors
    - investment in a range of preventative, community health and housing services
    - supporting unpaid carers

2. Tackling delayed discharges and bringing about sustainable improvements in discharge outcomes and wider system flow. To be achieved through strong joint working between the NHS, Local Authorities and the voluntary, housing and independent provider sectors.

2.6 There has been a slight upturn in the level of investment, all of which aims to join-up health and care services, so that people can manage their own health and wellbeing and live independently in their communities for as long as possible. The NHS minimum contribution will increase by 5.66% each year and the minimum contribution to social care will also increase by 5.66% each year.

2.7 In December 2022, the additional ring-fenced Adult Social care Discharge fund was released, to support discharges and reduce the number of patients remaining in hospital with no criteria to reside. This fund will continue for the next two years and this has been incorporated in BCF plans for 2023-25.

2.8 The full allocations to be included in the BCF pooled budget in 2023-25 are outlined in table below.

	PETERBOROUGH			CAMBRIDGESHIRE		
	2022/23	2023/24	2024/25	2022/23	2023/24	2024/25
NHS Minimum Contribution	£14,507,310	£15,328,096	£16,196,013	£45,441,112	£48,013,079	£50,730,620
NHS Additional Contribution	£1,125,014	£1,077,287	£1,077,287	£3,512,222	£3,360,606	£3,360,606
Disabled Facilities Grant	£2,236,384	£2,236,384	£2,236,384	£5,069,550	£5,069,550	£5,069,550
Improved Better Care Fund	£7,479,861	£7,479,861	£7,479,861	£15,171,304	£15,171,304	£15,171,304
ICB Discharge Funding	£991,392	£1,146,287	£1,891,239	£2,512,475	£2,461,969	£5,253,567
LA Discharge Funding	£661,384	£1,048,665	£1,747,076	1,936,714	£2,126,993	£3,543,570
Total BCF Allocation	**£27,001,345**	**£28,316,580**	**£30,627,860**	**£73,643,377**	**£76,203,501**	**£83,129,217**

2.9 Whilst the narrative plan was joint across the footprint, separate Cambridgeshire and Peterborough submissions were required in relation to the planning template and demand and capacity modelling templates.

2.10 Our BCF plan continues to build on progress of 2022/23 plans, but has been refreshed to ensure alignment with wider system plans, including the local Joint Health and Wellbeing / Integrated Care Strategy, NHS operating plans and North and South Place Partnership priorities.

This is against the continued backdrop of significant challenge in a number of areas, including:

- **Market sustainability:** the ongoing impact of inflation, workforce and cost of living pressures continues to be significant for providers, impacting on the costs of providing care and capacity within the market.
- **Workforce recruitment and retention:** despite ongoing local and regional focused workforce programmes, the labour market remains constrained. We continue to have high levels of turnover and vacancy rates across the sector, with particular local challenges due to the cost of living and affordable accommodation.

Our local priorities for 2023-25 continue to reflect our key strategic themes as outlined in previous plans and ***place-based delivery is at the absolute heart of our integration vision*** with Integrated Neighbourhoods the cornerstone to delivering this vision. Supporting people at place, means supporting people at all stages of their life journey, and thus we have reshaped our strategic themes to reflect this, as outlined below:

1. **Focus on Prevention and Early Intervention** – we want to support people in their local communities to remain independent at home for as long as possible.
2. **Integrating services and budgets at a place-based level -** When people need support, we want this to be personalised and joined up, with people having choice and control. We need local areas to have the flexibility to shape and respond to needs on the ground, commissioning and delivering services based on what local communities are telling us they need.
3. **Patient Flow –** sometimes people will have crisis situations, when this happens, we want to prevent them from going into hospital unnecessarily and support them to go home safely and quickly after a stay in hospital.
4. **System enablers –** we want to join up systems and data in ways that help us to deliver integration in a seamless way and deliver the best health outcomes for our local populations, e.g. shared care record implementation, population health management, workforce development and health inequalities.

Locally we have committed to undertake a local systematic review of the BCF to ensure we are delivering the best outcomes for people. To deliver on our future place-based vision for integration, we are committed to transforming services to support delivery of

this model, recognising the need to shift to a more preventative focus, supporting people and communities to improve local health outcomes. This will lead to identification of a number of system priorities that we want to review in a phased manner over the next 12-24 months. In reality, this does not necessarily mean a 'lift and shift' of funding (i.e. stopping core statutory services and investing in something else) but about transforming the way we shape, structure and deliver services to deliver the best outcomes for people. We will continue to work together as a system around developing local action plans to evolve and shape these opportunities further, but initial identified opportunities for focus include:

- Ensuring we are investing in voluntary sector and community capacity in a sustainable way to support place-based delivery.
- Developing our local offer to carers
- Discharge flow
- Progressing the roll out of Integrated Neighbourhoods at pace, including joint commissioning and devolving budgets
- Embedding health in all policies approach to address health inequalities
- Workforce recruitment and retention – ensuring we are delivering sustainable improvements, including maximising opportunities like funding and contractual levers to deliver priorities around workforce and social value.

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

3.1 This recommendation is relevant to priorities 2 and 4 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 Resources
There are no direct resource implications as a result of this report.

4.2 Statutory, Legal and Risk Implications
Assurance of local Better Care Fund plans will enable the local authorities and the Integrated Care System to continue to meet NHS England's conditions for receiving Better Care Fund monies.

The BCF funding is in line with the Council's Medium Term Financial Strategy (MTFS).

4.3 Equality and Diversity Implications
There are no direct implications as a result of this report.

This report has been signed off by the Executive Director of Public Health.

5. Appendices

5.1 Appendix 1 – Cambridgeshire and Peterborough Better Care Fund 2022/23 Joint Narrative Plan.
Appendix 2 – Cambridgeshire Better Care Fund Planning Template 2022/23
Appendix 3 – Peterborough Better Care Fund Planning Template 2022/23
Appendix 4 – ICB Discharge Funding Template
Appendix 5 - Cambridgeshire 2022/23 Year end report
Appendix 6 – Peterborough 2022/23 Year end report

6. Source documents

6.1 Source documents

- Better Care Fund Planning Guidance 2022/23

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)

BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans. Although the template is optional, we ask that BCF planning leads ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 25 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Integration and Better Care Fund

Health and Wellbeing Board(s).

Cambridgeshire and Peterborough

Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils).

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

- Peterborough City Council
- Cambridgeshire County Council
- Cambridgeshire and Peterborough Integrated Care Board (ICB)
- North Place Integrated Care Partnership
- South Place Integrated Care Partnership
- Public Health
- Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
- North West Anglia Foundation Trust (NWAFT)
- Cambridgeshire University Hospital NHS Foundation Trust (CUHFT)
- Cambridgeshire and Peterborough Combined Authority
- Voluntary Sector
- District Councils
- Healthwatch

How have you gone about involving these stakeholders?

In developing and drafting of the BCF plans there were discussions with partners across the system, including the following formal meetings which have cross system health and social care representation:

- ICB Management Executive Board on the 18.5.23
- Unplanned Care Board on the 16.5.23 and 20.6.23
- Commissioning and Investment Committee on the 16.6.23
- Joint Health and Wellbeing Board / Integrated Care Partnership Board development session on 6.6.23

The local BCF plans have been approved by both Peterborough City Council (PCC) and Cambridgeshire County Council (CCC) and the ICB. Cambridgeshire and Peterborough Health and Wellbeing Board / Integrated Care Partnership (HWB/ICP) Board members have been involved in the

development of local plans, with the plans discussed at a development session on the 6th June 2023. Formal approval will be sought at the HWB/ICP Board on the 21st July 2023 for full retrospective approval, but this is not prior to the submission of the BCF plans to NHS England.

Governance

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

The existing oversight of the BCF continues to sit within the remit of the Health and Wellbeing Boards. There have been no changes to our governance arrangements since submission of our 2022/23 BCF plans.

Locally, as outlined in our 2022/23 plans, we have established a joint Cambridgeshire and Peterborough Health and Wellbeing Board (HWB), which operates as a committee in common with the Integrated Care Partnership (ICP) Board. This approach continues to work well for us due to the coterminous boundaries between the joint HWB and the ICB and reflects a genuine ambition across the local health and care system to develop innovative ways of working together.

Executive summary

This should include:

- Priorities for 2023-25
- Key changes since previous BCF plan.

This document forms part of Cambridgeshire and Peterborough's BCF plans for 2023-25, a joint narrative, highlighting the integrated approach across the two HWB footprints. Our strong leadership foundations and joint commitment to integration sets the tone locally and this is evident to the approach we have taken to the establishment of a local joint HWB Board, which operates as a committee in common with the ICP Board, underpinned by the development of a joint Health and Wellbeing and Integrated Care Strategy which set a clear set of integration ambitions for our local system.

Our BCF plan continues to build on progress of 2022/23 plans, but has been refreshed to ensure alignment with wider system plans, including the local Joint Health and Wellbeing / Integrated Care Strategy, NHS operating plans and North and South Place Partnership priorities.

This is against the continued backdrop of significant challenge in a number of areas, including:

- **Market sustainability:** the ongoing impact of inflation, workforce and cost of living pressures continues to be significant for providers, impacting on the costs of providing care and capacity within the market.
- **Workforce recruitment and retention:** despite ongoing local and regional focused workforce programmes, the labour market remains constrained. We continue to have high

levels of turnover and vacancy rates across the sector, with particular local challenges due to the cost of living and affordable accommodation.

Our local priorities for 2023-25 continue to reflect our key strategic themes as outlined in previous plans and ***place-based delivery is at the absolute heart of our integration vision*** with Integrated Neighbourhoods the cornerstone to delivering this vision. Supporting people at place, means supporting people at all stages of their life journey, and thus we have reshaped our strategic themes to reflect this, as outlined below:

1. **Focus on Prevention and Early Intervention** – we want to support people in their local communities to remain independent at home for as long as possible.
2. **Integrating services and budgets at a place-based level -** When people need support, we want this to be personalised and joined up, with people having choice and control. We need local areas to have the flexibility to shape and respond to needs on the ground, commissioning and delivering services based on what local communities are telling us they need.
3. **Patient Flow –** sometimes people will have crisis situations, when this happens, we want to prevent them from going into hospital unnecessarily and support them to go home safely and quickly after a stay in hospital.
4. **System enablers –** we want to join up systems and data in ways that help us to deliver integration in a seamless way and deliver the best health outcomes for our local populations, e.g. shared care record implementation, population health management, workforce development and health inequalities.

Locally we have committed to undertake a local systematic review of the BCF to ensure we are delivering the best outcomes for people. To deliver on our future place-based vision for integration, we are committed to transforming services to support delivery of this model, recognising the need to shift to a more preventative focus, supporting people and communities to improve local health outcomes. This will lead to identification of a number of system priorities that we want to review in a phased manner over the next 12-24 months. In reality, this does not necessarily mean a 'lift and shift' of funding (i.e. stopping core statutory services and investing in something else) but about transforming the way we shape, structure and deliver services to deliver the best outcomes for people. We will continue to work together as a system around developing local action plans to evolve and shape these opportunities further, but initial identified opportunities for focus include:

- Ensuring we are investing in voluntary sector and community capacity in a sustainable way to support place-based delivery.
- Developing our local offer to carers
- Discharge flow
- Progressing the roll out of Integrated Neighbourhoods at pace, including joint commissioning and devolving budgets
- Embedding health in all policies approach to address health inequalities
- Workforce recruitment and retention – ensuring we are delivering sustainable improvements, including maximising opportunities like funding and contractual levers to deliver priorities around workforce and social value.

National Condition 1: Overall BCF plan and approach to integration
Please outline your approach to embedding integrated, person-centred health, social care and housing services including:

- Joint priorities for 2023-25
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

Our vision for Cambridgeshire and Peterborough is:

"People are supported to enjoy healthy lives in strong, connected communities. Keeping people at the heart of everything we do, working with communities and partners to design and deliver health and care services that enable our changing population to fulfil their wish to remain independent at home for as long as possible."

Place-based delivery is at the absolute heart of our integration vision and Integrated Neighbourhoods are the cornerstone to delivering on this vision.

Our local vision is aligned to the four strategic priorities of the Joint HWB/ICP Board as outlined below.

Core to delivery of our integration vision is a move to delivering and commissioning at a local place-based level. As outlined in our 2022/23 Better Care Fund plan, we have commenced our journey to implement Integrated Neighbourhoods alongside integrating this with local authority led place-based working programmes (e.g. Care Together in Cambridgeshire) and Decentralisation. Our plans for 2023-25 continue to build on and accelerate this work to widen the learning out across the County. To deliver this vision, we aim to support people at all points in their journey, and this translates to the following key priorities for our BCF plan:

- Integrated person centred, place-based delivery and commissioning with prevention and early intervention at its core.
    - Patient flow: Providing services that prevent unnecessary hospital admissions and supporting people back home after a stay in hospital.
- Enablers for integration: joining up systems and data in ways that help us to deliver integration in a seamless way and deliver the best health outcomes for our local populations.

Our approach in 2023-25 is to continue to build on delivery in these key areas. The summaries below provide an overview of learning to date, key priorities for this planning cycle, examples of joint commissioning and information on where BCF funding is supporting these priorities.

<table>
<tr><th colspan="2">Integrated Person-centred place-based delivery and commissioning with prevention and early intervention at its core</th></tr>
<tr><td colspan="2">Key priorities:
Roll out at pace of Integrated Neighbourhoods and integration with local authority place-based programmes of work and Decentralisation.
Continued embedding of prevention and early intervention opportunities, e.g. Reablement, Technology Enabled Care (TEC).
Growing and expanding new models of personalised local care delivery through our Cambridgeshire Care Together Programme, e.g. care micro-enterprises.
Developing our support offer to carers and getting better at identifying and engaging with unpaid carers in the community, e.g. social prescribers for carers.
Continued embedding of personalisation in culture, behaviours and practice across health and social care.
Ageing well: a priority focus on implementing our falls prevention strategy to reduce the risk of hip fractures in older people and managing frailty.</td></tr>
<tr><td>Learning and Good practice to date:
Integrated Neighbourhoods are progressing.
First annual integrated neighbourhood report has been published for East Cambridgeshire
Voluntary sector investment and capacity through Care Together seed funding and ICS Healthier Futures Fund.
Individual service funds (ISFs) have been established, which give people more choice and control over the care and support they receive.
Continued joint commissioning arrangements for a number of services, e.g. section 75 mental health and occupational therapy services, learning disabilities partnership (LDP); Prevention and Early Intervention Framework and Integrated Community Equipment (ICES) and Technology Enabled Care (TEC).
Falls Prevention strategy has been developed.
Carers Strategy is being refreshed.</td><td>Areas funded by BCF that support this priority:
Neighbourhood Teams
Social Care Teams
Care placements to meet assessed eligible social care needs – e.g. residential/nursing care, homecare.
Carers support and respite
Voluntary sector provision
Prevention and Early Intervention: reablement, community equipment, Technology Enabled Care (TEC)
Care Navigation / Information and advice
Additional areas of investment from NHS Minimum contribution uplift:
Increased investment in residential and domiciliary care placements to address increasing demand and inflationary impact on care costs.
Investment in priorities identified through the planned review to meet BCF requirements and support performance metrics.</td></tr>
</table>

Patient Flow – preventing unnecessary hospital admissions; and supporting people home after a stay in hospital	
Key priorities: 1. Virtual wards, further expansion. 2. Development and embedding of the Transfer of Care Hub (TOCH). 3. Implementation of the voluntary sector alliance single point of access to support discharge. 4. Continued capacity to support discharge flow. 5. Opportunities for greater discharge to assess pathway integration, e.g. pathway 2 offer. 6. Admission avoidance – urgent community response, frailty, falls prevention and early intervention. 7. Personalised care offer to support high intensive users to stay safe, well and reduce visits/admissions	
Learning and Good Practice to date: 1. Integrated pathway approaches are in place and continue within operational teams. 2. Virtual wards have been established. 3. Additional discharge funding committed to support establishment of transfer of care hub (TOCH). 4. Voluntary sector alliance has been commissioned. 5. Discharge funding supported additional capacity across reablement, brokerage and social care. 6. Discharge funding supported new initiatives, e.g. rapid discharge incentive scheme, discretionary housing grants.	**Areas funded by BCF that support this priority:** 1. Pathway 0: VCS capacity to support hospital discharge 2. Pathway 1 Intermediate and reablement care at home 3. Pathway 2: Intermediate care bed provision 4. Pathway 3: long term care placement costs 5. Discharge support capacity: e.g. social worker discharge planning capacity 6. Care Home Trusted Assessor 7. Palliative Care Hub 8. Hospice at Home 9. Community IV antibiotic service 10. Enhanced Response Service 11. Additional discharge funding supporting additionality of capacity across a range of areas, including reablement, intermediate care, TEC, brokerage, social worker discharge capacity, workforce and market capacity. 12. Use of Population health management (PHM) data to support high intensive users through personalised care offer. ***Additional areas of investment from Discharge Funding uplift:*** 1. Intermediate care capacity. 2. Technology Enabled Care 3. Workforce recruitment and retention 4. Commissioning capacity to support strategic joint commissioning of discharge capacity and pathway development. 5. Investment in delirium pathway (2024/25).

Enablers
Key priorities: 1. Population Health Management (PHM) data set:

a. Develop our PHM capability by building on our local system wide Analytics Community to develop an Intelligence Function which also supports wider system aims.
b. Implementation of the Client Level Data Set, which will enable more granular adult social care activity data that can be linked to wider health data on a pseudonymised basis.

2. Health Inequalities: tackling digital exclusion, restoring services inclusively and accelerating preventative programmes.
3. Building on the development and commitment of our co-production strategy to embed co-production with local people across service design and development.
4. Shared Care Record – summary access to primary, community and mental health records will be rolled out across social care professionals during 2023/24. Phase 2 of the programme is currently being scoped, with timelines to be confirmed, this phase will include the introduction of social care and acute hospital records being added to the shared care record, with a configured tailored view for different professional groups.
5. Workforce recruitment and retention:
    a. Delivery of the workforce development programme focused on the social care provider market; including development of a comprehensive marketing plan, standardised delivery and assessment of the care certificate, development and promotion of realistic career pathways and competitive pay (Cambridgeshire County Council has committed to paying providers the Real Living Wage).
    b. Regionally, through an Integrated Care and Health Workforce Delivery Group, we aim to develop a "Centre of Excellence", to support recruitment of our International Workforce.
    c. Further develop our Health and Care Academy together with our Apprenticeship schemes, promoting social mobility, supporting clearer visibility of careers and future development opportunities in both Care and Health.
    d. 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.
    e. Developing a system focused Retention Action Plan.

Learning and Good Practice to date:

1. Co-production strategy developed and adopted by the ICS and training roll out has commenced. Appreciative enquiry approach has been rolled out in East Cambridgeshire.
2. Joy app Social Prescribing digital platform has been implemented to support social prescribing and more seamless referrals.
3. Shared Care Record phase 1 early adopters are due to go live in June 2023. This will mean health and social care practitioners working in learning disabilities services will have view access to the summary health record (containing primary, community and mental health records).
4. Local workforce programmes have been established and we are making progress:
    a. Strong international recruitment pipeline for nursing staff.
    b. Use of apprenticeships.
    c. Establishment of our ICS Recruitment and Retention Working Group

Areas funded by BCF that support this priority:

1. Voluntary sector representation at strategic system meetings and forums to support and enable engagement with the wider sector.

5. Health Inequalities Challenge Prize and District Challenge Fund. 6. Eclipse Vista PHM data tool rolled out.	

Whilst much of the content within this plan builds on 2022/23 plans, an overview of key changes from the 2022/23 plan are outlined below:

- Stronger embedding of integration vision within Integrated neighbourhoods and place-based models of delivery and commissioning and a realignment of priorities in line with this vision.
- Outlined commitment to undertake a planned review of BCF investment in a phased way throughout 2023/24.
- An update on progress made to date since 2022/23 plans across key priorities.
- Strong focus on refreshing carers strategy locally and implementing the new strategy locally to further improve and enhance our local offer to carers.
- Introduction of additional discharge funding and overview of how the funding is being utilised across the system to support discharge flow.
- Utilisation of NHS minimum uplift being utilised to support additional social care home care and care home placements, alongside being invested in areas identified as part of the planned review.

National Condition 2

Use this section to describe how your area will meet BCF objective 1: **Enabling people to stay well, safe and independent at home for longer.**

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- steps to personalise care and deliver asset-based approaches.
- implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches.
- multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake
- how work to support unpaid carers and deliver housing adaptations will support this objective.

As previously outlined, core to delivery of our vision is our move to delivering and commissioning at a local place-based level. Primary care and Integrated Neighbourhoods are the cornerstone of this model, very much in line with the vision outlined in the Fuller Stocktake report. As described in our

2022/23 Better Care Fund plan, we have commenced our journey to implement Integrated Neighbourhoods and our plans for 2023-25 continue to build on and accelerate this work.

To deliver this vision, we need to make sure we support people at all points in their journey and this includes people dealing with a range of different issues, whether that be physical disability, older age, mental health or learning disabilities. This ultimately aims to ensure people receive the right level of support at the right time, in the right place and by the right person.

Our Local Vision	Fuller Stocktake Vision
We want to support people to stay at home to remain independent for as long as possible. When someone needs support, their care will be personalised and joined up and they will have choice and control. When someone has a crisis situation, we will provide access to rapid support to prevent them having to go to hospital unnecessarily. But when they do have to go to hospital, we will support them home safely and quickly.	Neighbourhood teams aligned to local communities. Streamlined and flexible access to people who require same day urgent access. Proactive personal care with support from a multi-disciplinary team in neighbourhoods from people with more complex needs. More ambitious approach to prevention at all levels.

We aim to deliver a model supports people to remain as independent as possible within the community and also ensures that carers can be supported to look after their own health and wellbeing and to have a life of their own alongside their caring responsibilities. We have adopted a Prevent – Reduce – Delay approach to managing care; recognising that supporting people early with targeted information and advice and low level and community support is key to supporting the best outcomes for people. This includes:

1. Providing information and advice, signposting to voluntary and community sector organisations and/or onward referral to the wider Early Intervention and Prevention services. Examples of this include Adult Early Help services, social prescribers, community navigator services, online digital information and advice.
2. Early Intervention and Prevention services are designed to improve or maintain people's independence, to support people to recover from illness of injury and help people re-learn lost skills, abilities and confidence and is delivered through services such as:
    - Technology Enabled Care (TEC)
    - Reablement and Intermediate Care
    - Therapy, including Occupational Therapy and Sensory Rehabilitation
    - Housing Services including Care and Repair/Home Improvement Agencies (HIAs)

When people need more support, including long term care and support, we work to ensure it is personalised and keeps people connected to their local communities. In terms of both our mental health and learning disabilities support we already operate a very integrated model of care assessment and planning as we have an existing joint health and social care service which has been

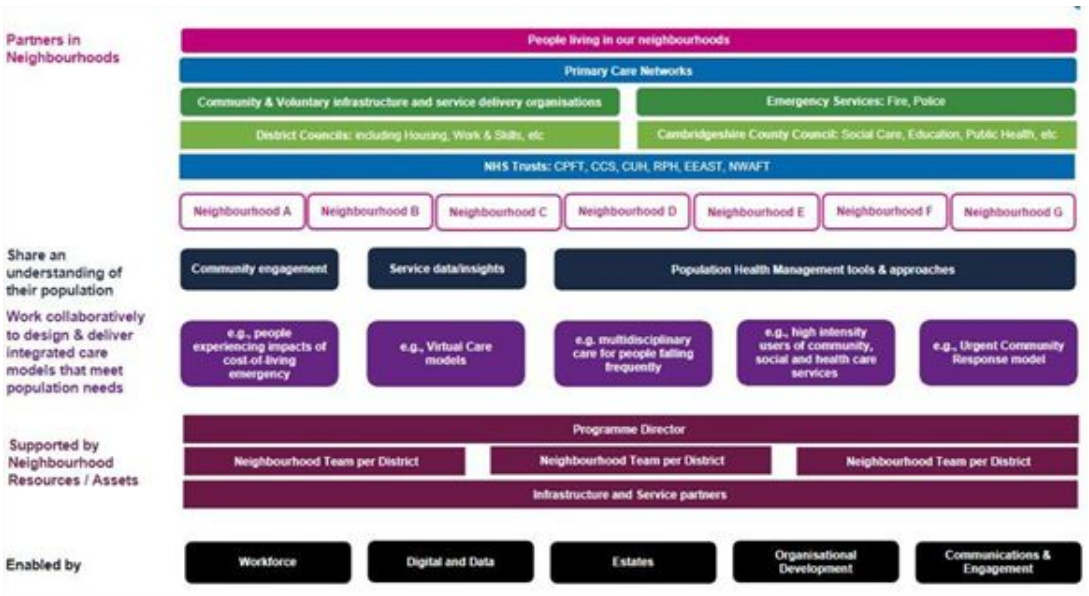
in operation for a number of years. This is delivered under a section 75 agreement by Cambridgeshire and Peterborough NHS Foundation Trust (CPFT). In Cambridgeshire the learning disability service is also supported by a fully pooled budget arrangement with health to offer a fully integrated model of delivery to people.

What does an Integrated Neighbourhood look like?

Our Integrated Neighbourhoods aim to result in:

- Partners working closely together to help people access the care and support they need and to coordinate this.
- Moving care closer to home.
- Focusing on inequalities and making sure care and support is more proactive and personalised.
- Making changes to how we work in partnership with communities (embedding co-design).
- Understanding our population and services, support and assets that exist in neighbourhoods.
- Reduce health inequalities and increase the years that people enjoy good health.
- Local businesses and communities benefit from social value by working together to deliver positive benefits to communities that extend beyond health and care services.
- People get discharged from hospital to their own home wherever appropriate and stays in hospital are no longer than necessary.

Our local operating framework for what an Integrated Neighbourhood looks like is outlined below.



Integration with local authority led place-based commissioning development work, for example our Care Together Programme in Cambridgeshire (see Appendix 1 for an overview), is key to our integration agenda.

A key element of this vision is supporting carers by identifying local activities and services that help prevent carer breakdown. For example, in East Cambridgeshire, a co-funding agreement is in place with Ely Primary Care network for a Neighbourhood Carers Social Prescriber post, serving the whole district for a 3-year period from 2023. In other localities, teams are working with local partners and engaging with older adults themselves, to identify other gaps and opportunities in support for carers.

Some examples of what some of our Integrated Neighbourhood Footprints look like in practice are outlined in Appendix 2.

The patient's perspective – Winter Wellness Project

In autumn 2022, East Cambridgeshire Integrated Neighbourhood received notification of incoming funds from NHS England and Improvement (NHS&I) that would be devolved directly to Integrated Neighbourhoods to support locally identified cohorts that were deemed most vulnerable and at-risk during winter.

Following collaborative discussions with local partners, project resources such as a Personalised Care and Support Plans (PCSP) were co-developed. There was agreement to commission partners (across the health, social, community and voluntary sector) to facilitate a 'What Matters to Me?' conversation and develop a PCSP (including the consideration of informal carers) with eligible individuals. Information gained from this personalised and holistic approach supported the coordination of any required planned care and support for the individual, including uptake of the PCN's offer of a health check, long term condition(s) and medication reviews.

Collection of MYCaW pre and post outcome measures were written into the commissioning arrangements to measure the impact of this approach as well as allocation of non-means tested personal budgets (coordinated by Care Network on behalf of the project). It was agreed that personal budgets would enable timely access to anything identified in the planned support that was legal and would support an individual to stay happier, healthier and safer at home this winter.

A fortnightly face-to-face Central Health and Wellbeing Hub was formed with representatives from each partner organisation including Adult Social Care, Age UK, Care Network, Caring Together, CPFT, Ely PCNs and Littleport Town Council. This enabled discussion and exchanging of referrals (in accordance with information governance conditions) as well as relaying PCSP outcomes to inform next steps and seek expertise from the group.

A 'Team Around Me' meeting model was developed to enable dedicated time for person centred discussions (with the individual present) if the person's needs were deemed complex with the requirement for multi-agency input.

Conversations with Cambridge University Hospitals NHS Foundation Trust resulted in their engagement in communicating whether any of the cohort had accessed unplanned health care to enable responsive follow up with the individual and re-review of their requirements.

Case Study

An 87 year old woman with multiple LTCs had recently moved house and when contacted as part of the Winter Pressures Project said she would like some support. The personalised conversation about what mattered to her flagged that:

- her new housing better met her physical needs but she was still very lonely and worried about the future
- she was sleeping in her chair at night which raised concerns around her COPD and respiratory compromise
- she had previously refused a wheelchair because she was scared of going out which also meant she had not received her COVID-19 vaccination.

Bringing together partners at the Central Health and Wellbeing Hub allowed a different conversation to take place, flagging that:

- while she did not meet the financial thresholds for social care there were other options to support her
- she had not had a COPD review in a while and needed one
- a COVID-19 vaccination was needed but it was recognised that the root cause was that she was fearful of going out and not easily able to access the community which needed to be addressed
- voluntary and community sector partners identified a range of support to help reduce her social isolation and focus on what mattered to her – i.e. mobile library, warden scheme, befriending, and how to support her with accessing the community and
- a personal budget can now be used to provide a wheelchair to help improve her access to the community and support/services.

What was different and how we want to work differently:

- Facilitating open conversations and focusing on what mattered to the person
- Health, social care and voluntary and community sector professionals came together having a different discussion and identified gaps and opportunities for support that no one organisation could have done alone
- Preventative support could be put in place around LTCs and vaccination and wider health and wellbeing support could be put in place before the point of crisis.

Personalisation Agenda

Personalised care, Our Personalised Care Strategy, which has been developed through engagement and co-production, sets out our vision for how we plan to implement the comprehensive model of personalised care and deliver our local priorities. We plan to deliver personalised care in the following ways.

- Shared Decision Making (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.
- A public awareness campaign will be delivered to ensure citizens are aware of their choice.
- Personalised Care Support Planning (PCSP) - We aim to put PCSPs in place 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. Social Prescribing Is available to the local population via primary care, local authority, and voluntary services. This model is being expanded with pilots due to commence in the acute setting. Community support groups and their capacity to take referrals is managed via JOY, this enables commissioners to assess the patterns and gaps in services, and to ensure support and funding is directed to build new groups in the areas of need. The public will also have access to the JOY app to self-refer into local support services.
- 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 and facilitated to people who have a legal right to have one.
- Coproduction and peer leadership Training is available, and it is our aim to have people with lived experience support board level delivery across the ICS. Leaders will have the knowledge and tools required to embed personalised care.

National Condition 2 (cont.)

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- learning from 2022-23 such as ○ where number of referrals did and did not meet expectations ○ unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - ○ patterns of referrals and impact of work to reduce demand on bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified ○ where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?
  how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

Community capacity and demand for 2022/23 forecasts undertaken as part of BCF plan submissions, were based on a number of assumptions, including:

- The Urgent Community Response demand and capacity figures included the Council Early Response Service (ERS) and CPFT's Joint Emergency Team data. The wider demand on other urgent community response services was not included in the analysis.
- The reablement figures used current community referral levels as a proxy for demand. Capacity and demand forecasts for reablement covered the PCC Reablement, CCC Reablement and CPFT ICT at home services.
- The number of VCS services and support (commissioned and non-commissioned) covers too many services and too wide a range of services without a central dataset to meaningfully estimate demand and capacity, so this was entered as a nil return.
- We have used the same rationale and parameters for the demand and capacity modelling for 2023/24 to ensure a level of consistency, and to enable alignment with local data capture and reporting capabilities.

We have reviewed actual demand and capacity across services during the 2022/23 against the capacity and demand returns for 2022/23, which identified the following key learning points for Cambridgeshire and Peterborough for community capacity and demand:

Demand/Capacity Pathway	Key points/learning
Voluntary Sector or community sector services	• As mentioned, the range of VCS commissioned services which support prevention and early intervention in the community are wide ranging and varied (commissioned and non-commissioned) without a central meaningful dataset to estimate capacity and demand. • We have adopted the same approach to capacity and demand modelling for 2023-25. • However, wider BCF plans have a strong focus on strengthening the voluntary, community and social enterprise support to support our community place-based model of delivery, that aims to prevent unnecessary hospital admissions.
Urgent community response	• Demand for UCR services in 2022/23 were very much in line with forecast demand (which covered the period Oct 22 – Mar 23), seeing on average 1,300 referrals per month into UCR services. • Across the course of 2022/23, we did see a significant 34% increase in numbers accessing UCR services, predominantly JET due to a strong focus on call before you convey locally. But this increase had been reflected in our BCF 2022/23 demand forecasts. • In 2022/23 capacity, we appear to have underforecasted on capacity, as in reality we responded well, meeting the demand locally and this has been captured in 2023/24 forecasting.
Reablement/support someone to remain at home	• Actual community demand was slightly lower than forecast in 2022/23 for reablement. (c. 35% versus c. 40%) and this has been reflected in the 2023/24 planning. • Overall, across both intermediate care and reablement, there have been ongoing challenges with recruitment and retention. Whilst there has been a strong focus on maintaining turnover and vacancy rates relatively low levels for the particular service area, alongside mitigating with alternative commissioned intermediate care car provision, services are not running at full capacity. • Intermediate care services recruitment and retention has been a particular challenge and capacity has been mitigated through

	commissioning additional intermediate care car provision. • Whilst reablement workforce recruitment and retention has been challenging, there has been a continued strong focus in this area and we are maintaining relatively low levels of vacancy rates and turnover for this particular service area. Overall we have responded to demand well and prioritise referrals based on need and risk. We intend to review our staffing model to establish levers for increased recruitment and retention as part of our Reablement workforce strategy. • Vacancy assumptions have been factored into capacity forecasts for 2023/24. • Workforce development is a key focus of wider BCF plans.
Bed based intermediate care (step up)	• Interim health beds were largely as forecast in terms of both demand and capacity.

National Condition 2 (cont)

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- unplanned admissions to hospital for chronic ambulatory care sensitive conditions
- emergency hospital admissions following a fall for people over the age of 65
- the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

BCF funding supports this objective through funding in a number of areas as outlined below.

Area of BCF Investment	**Metric Supported**
Significant investment in supporting the infrastructure to enable integrated neighbourhood teams delivering personalised care; including investment in Neighbourhood Teams community health and social care capacity.	This supports people receiving the right care, at the right time in the right setting in the community; preventing the unnecessary escalation of needs to crisis point. This therefore supports all of the below metrics: • unplanned admissions to hospital for chronic ambulatory care sensitive conditions • emergency hospital admissions following a fall for people over the age of 65

	• the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.
Funding of social care placements, to ensure sufficient capacity in the market to support community demand.	• Ensuring people have the right support to meet their care needs in the community, preventing the unnecessary escalation of crisis leading to hospital admissions, thus supporting the metric of unplanned admissions to hospital for chronic ambulatory care sensitive conditions. • Ensuring we have home care capacity to support people with their care needs in their own homes means that people can be supported to remain independent in their own home for as long as possible, supporting the metric of reducing the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.
Investment in community equipment and Technology Enabled Care (TEC)	• Community equipment and TEC supports people to remain independent in their own homes for as long as possible therefore supporting the metric of reducing the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population. • Community equipment and TEC includes monitoring equipment such as Lifelines, which provides alarm alerts where someone has a fall for instance. This means that issues can be responded to early on and ambulance conveyances can be prevented wherever possible, thus contributing to the metric of emergency hospital admissions following a fall for people over the age of 65.
Disabled Facilities Grant (DFG) funding to enable housing adaptations to support people to remain independent in their own homes for as long as possible.	• DFGs pay for people to have housing adaptations to their homes, enabling them to remain independent in their own homes for as long as possible. This therefore supports the metric of reducing the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

Funding for the enhanced response service (ERS) across Peterborough, offering a 2-hour social care crisis response service.	The rapid response service responds to calls from lifeline alarm centres, GPs, 111 and other professionals where someone has an urgent social care crisis. It offers a 2-hour emergency response and aims to provide immediate care and support to someone in their own home, with a view to preventing an unnecessary hospital admission. This may be due to someone having had a fall for instance. This supports the following metrics: • unplanned admissions to hospital for chronic ambulatory care sensitive conditions • emergency hospital admissions following a fall for people over the age of 65
Contribution to falls prevention programme in Peterborough.	This investment supports the public health falls prevention programme, which commissions the delivering of multi-factorial risk assessments embedding within community health provision, alongside the provision of strengths-based exercise classes. This contributes to delivery of our local falls prevention strategy and supports delivery of the metric of emergency hospital admissions following a fall for people over the age of 65.
Funding of voluntary sector support, e.g. day opportunities, sensory support, information and advice.	• This provides a range of prevention and early intervention support that supports people to remain independent within their own homes and communities for as long as possible. This therefore supports the metric of reducing the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population. • In addition, this supports people to self-manage their conditions and needs, preventing the unnecessary escalation of need to crisis point and contributing to the metric of unplanned admissions to hospital for chronic ambulatory care sensitive conditions.
Funding for unpaid carers, including information, advice, support and respite.	Supporting carers with the right support, when they need it, including respite, enables carers to manage their health and wellbeing and prevents carer breakdown. When there is a carer breakdown this inevitably leads to the cared for person tipping into needing higher levels of care provision, often residential or nursing. Supporting carers to deliver on their caring responsibilities, also means that people's chronic health conditions continue to be managed

	more effectively and unnecessary crisis situations are less likely to occur. As outlined later within this plan, we are finalising a refresh of our all-age carers strategy, which will lead to an action plan to improve our local offer to carers. This therefore supports the following metrics: • unplanned admissions to hospital for chronic ambulatory care sensitive conditions • the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

National Condition 3

Use this section to describe how your area will meet BCF objective 2: **Provide the right care in the right place at the right time.**

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and timely discharge, including:

- ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance.

- How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.

- Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

We continue to have a strong focus as a system on the integration of health and social care pathways to support hospital discharge flow, with a 'home first' approach embedded as core to our model of delivery. As a system we have identified a core set of priorities to improve the coordination of discharge pathways to reduce length of stay for inpatient settings for patients who no longer meet the criteria to reside by reducing discharge delays, alongside optimising the use of step-down care options to deliver care at home. This will ensure that people are discharged to their usual place

of residence wherever possible, and that we have the right capacity in the right place at the right time to respond to demand and address peoples' needs upon discharge.

A stock take of progress completed in June 2023, has shown a number of achievements to date, including:

- Introduction of the Virtual Transfer of Care Hub and new Patient Tracking and Escalation processes
- Completed diagnostic work to evaluate gaps in discharge pathways and processes
- Successful introduction and embedding of a Trusted Assessor model for Pathway 1
- Increased programme resources to secure dedicated operational support of the Transfer of Care Hub and deliver a digital platform for a single Patient tracker list that is accessible to all partners.
- Piloted discharge to assess beds for patients with ongoing assessment of care needs, which proved to be very successful and a proposal to sustain this approach long term is currently being developed for approval by the system in advance of winter 23/24.
- Developed patient harm review processes to learn from suboptimal patient journeys and introduced patient tracker list RAG rating to support clinical and operational prioritisation
- We have seen a 22% reduction in numbers of patients with LoS >14 days post clinically fit date between January and May 2023, as well as a 21% reduction in stranded patients during the same period.

Alongside this, we have also reviewed capacity and demand for 2023/23, with key learning feeding into our local priorities and BCF plan. The detail of this can be found in the next section of this plan, however in summary, the key themes that have informed planning include:

- An opportunity to increase capacity for low level pathway 0 voluntary sector support to meet demand in this area, which we are addressing through the commissioning of the voluntary sector alliance to provide a single access point for discharge.
- The need to ensure capacity with pathway 1 reablement and intermediate care and the need to improve recruitment and retention in this area, reducing reliance on alternative provision (e.g. intermediate care discharge cars), which we are addressing through investment in workforce.
- Issues over visibility of data to inform capacity and demand modelling in some instances, which we are addressing through the implementation of the TOCH and digital solution to support the TOCH.
- Capacity and demand review also highlighted that in many areas, our actual demand was closely aligned to forecast activity, indicating that improvements in patient flow/speed of processing discharges needed to be an area of priority, this is being addressed through increased capacity to support flow in areas such as brokerage, social worker discharge capacity and TOCH.

Locally, we have identified the following key priorities to continue to build on progress to date and to support delivery of this objective:

- Virtual wards: we have made good progress implementing 140 virtual ward beds locally. Our continued focus is the ongoing embedding of the use of virtual wards to maximise acute bed capacity, with plans to increase virtual ward capacity to 240 beds in 2023/24.
- Transfer of care hub (TOCH) - implementation of a multi-disciplinary TOCH to manage and coordinate patient flow onto the discharge to assess pathways. The TOCH is a fundamental element of the Cambridgeshire and Peterborough Home First Programme designed to expedite the safe discharge from hospital of medically fit patients, prioritising the patient's own home as the preferred discharge destination whenever clinically safe to do so.
- Integrated Patient Tracker List (PTL): daily afternoon multi-disciplinary huddles have been launched, allowing a focus on the most complex and unresolved cases. Huddles are embedding well and there are further changes to the process being discussed with partners to ensure continuous improvement.
- High level discharge pathways review is being undertaken and this is feeding into further system wide priorities and objectives.
- Trusted assessor pilot: rolled out to 12 wards in Cambridgeshire University NHS Foundation Trust (CUHFT). Additional pilot has commenced for pathway 1 admission avoidance / early facilitated discharge from front door services in the acute. This involves collaborative working between intermediate care, reablement and CUHFT, building on the virtual ward principles. Further training is being rolled out to staff to support the roll out of the model to pathway 1 in the north.
- Discharge to assess pathway 2 pilot: commenced roll out in south, with 7 beds commissioned.
- Voluntary Sector alliance: commissioned single point of discharge access to the voluntary sector and the focus is now on implementing the model of delivery.
- Digital enablers: commissioning the TOCH digital solution and beginning recruitment process for Digital Lead.
- Intermediate Care Pathway 1: ongoing recruitment, efficiencies and improvement.

The additional discharge funding is being used to deliver investment in a range of additional social care and community capacity to support discharge flow. As a system we agreed a set of principles for use of the funding, and worked collectively to identify areas of spend that supported delivery of these principles:

- **Additionality:** Delivers capacity over and above what is already commissioned across the system.
- **Feasibility: F**easible and deliverable short term Underpinned by data and evidence of need.
- **Sustainability:** Delivers a sustainable impact, beyond the initial investment and supports system priorities.

This led to investment in 2022/23 being focused primarily in the following areas.

ICB Allocation	**Local Authorities Allocation**
Voluntary, community and social enterprise sector: • Intensive dementia support • High Intensive Users	Voluntary, community and social enterprise sector: • Voluntary sector single point of access • Investment in our people

• Voluntary sector single point of access Transfer of Care Hub (TOCH) • Additional capacity: • Patient transport • Support out of county discharges	• Winter retention bonus for reablement staff Additional capacity: • Reablement, brokerage and social worker capacity • Discretionary housing grants • Care home and home care rapid discharge incentive payments for providers

Whilst funding became available late in the year, and implementation timelines, meant impacts only started to be seen in the latter part of the year, we held performance at a stable level last winter, despite it being one of the most challenging winters on record. We also started to see some early impacts in a number of specific funded areas as reported at year end, including increased capacity in a number of areas, including a 5-6% increase in reablement capacity, 99% of same day community equipment orders being fulfilled and over 339 patient transport discharges.

In 2023-25, we propose to continue to maintain capacity across a number of areas, including:

- Discretionary housing grants to support discharge
- Social worker discharge capacity
- Reablement capacity
- Brokerage capacity
- Community equipment
- Rapid discharge incentive payments for care homes and home care providers

There are also a number of additional areas of investment we are planning, including:

- Intermediate care capacity
- Additional Technology Enabled Care investment
- Workforce development initiatives to aid recruitment and retention for targeted roles
- Commissioning capacity to support strategic joint commissioning of discharge capacity and pathway development.

National Condition 3 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- learning from 2022-23 such as ○ where number of referrals did and did not meet expectations ○f unmet demand, i.e., where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - ○ patterns of referrals and impact of work to reduce demand on bedded services – e.g., improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services);

- approach to estimating demand, assumptions made and gaps in provision identified
- planned changes to your BCF plan as a result of this work.
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand? ○ how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

Hospital capacity and demand for 2022/23 forecasts undertaken as part of BCF plan submissions, were based on a number of assumptions, including:

- As all service data is not broken down on HWB footprints, a system total has been taken and divided across Peterborough and Cambridgeshire (based on population and historic service use)
- We have used the same rationale and parameters for the demand and capacity modelling for 2023/24 to ensure a level of consistency, and to enable alignment with local data capture and reporting capabilities.

We have reviewed actual demand and capacity across services during the 2022/23 against the capacity and demand returns for 2022/23, which identified the following key learning points for Cambridgeshire and Peterborough for hospital discharge capacity and demand:

Demand/Capacity Pathway	**Key points/learning**
Pathway 0 – low level support for simple hospital discharges – e.g. voluntary sector or community support	• Demand for pathway 0 was marginally lower than forecast each month on a consistent basis throughout 2022/23. However, this is based on acute based reported data which is not verified as a system prior to reporting.
Pathway 1: Reablement in a person's own home to support discharge	• Included reablement and intermediate care at home demand and capacity. • Acute demand was similar to forecast levels for 2022/23. Despite recruitment and retention being an ongoing issue within this area, we responded well to demand, prioritising hospital discharge demand into the service.
Pathway 2: Step down beds	• Interim health beds were largely as forecast in terms of both demand and capacity. However, we did increase capacity slightly for a short period over the winter months to respond to immediate acute pressures.
Pathway 3: Discharge from hospital (with reablement) to long term residential care	• Pathway 3 demand was close to forecast numbers for 2022/23. • Capacity for pathway 3 is not finite and we spot purchase a large number of health and social

	care placements. This meant that we were able to respond with capacity to meet demand and our modelling was based on this assumption.

Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

- Discharge to usual place of residence

BCF funding supports delivery of this objective and the associated metric of discharge to usual place of residence in the following areas:

- BCF funding of social care home care placements, ensuring there is sufficient capacity for people to be supported to return home with adequate care and support needs.
- Significant contribution towards reablement and intermediate care provision.
- Investment in Community Equipment and Technology Enabled Care.
- Improved Better Care Funding is utilised to fund additional provision, including nursing capacity in Peterborough and discharge block car capacity in Cambridgeshire.
- Significant Improved Better Care Funding in our local Discharge plans, this includes funding of specific interventions such as our local care home trusted assessor model, discharge team social worker capacity and CHC assessment capacity.
- Funding of voluntary sector support to provide low level support for discharge.
- Use of ASC Discharge Funding to fund additional capacity across social care and intermediate care to support patient flow.

In 2023-25, we plan to invest additional discharge funding in the following areas, which also supports this objective and metric:

- Investment in intermediate care capacity – ensuring we have sufficient capacity for pathway 1.
- Additional health investment in Technology Enabled Care (TEC) in Peterborough.
- Workforce development initiatives to aid recruitment and retention for targeted roles – a dedicated focus on improving recruitment and retention on posts across reablement and occupational therapy.
- Commissioning capacity to support strategic joint commissioning of discharge capacity and pathway modelling.

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

We have undertaken a review of our self-assessment against the implementation of the High Impact Change Model (HICM) and have identified a number of areas for further improvement, including:

Change	Status	System Actions
Change 1: Early discharge planning	Established/ Plans in place	• Trusted assessor pilot for pathway 1 admissions avoidance/early facilitated discharge from front door services in the acute. • Review of acute discharge planning teams' structures and ways of working leading to development of improvement plans to embed best practice in planning for discharge from point of admission.
Change 2: Monitoring and responding to system demand and capacity	Plans in place	• Transfer of Care Hub (TOCH). • Digital TOCH solution. • High level discharge pathways review is being undertaken. • Wider review of demand and capacity across pathways to ensure resource allocation across services matches need.
Change 3: Multi-disciplinary working	Established	• Community and acute MDT working in place. • Integrated Patient Tracker List (PTL): daily afternoon multi-disciplinary huddles launched, allowing a focus on the most complex and unresolved cases. Huddles are embedding well and there are further changes to the process being discussed with partners to ensure continuous improvement.
Change 4: Home first	Established	• Pathway 1 efficiency and recruitment to increase capacity in intermediate care. • Focus of Transfer of Care hub to increase trusted assessment. • Discharge to assess pathway 2 pilot: commenced roll out in south, with 7 beds commissioned. • Voluntary Sector alliance: commissioned single point of discharge access to the voluntary sector. • Virtual wards
Change 5: Flexible working patterns	Established/ Plans in place	• Staff and services in place 7 days but recognition of opportunity to improve volume of weekend discharges • Transfer of Care Hub digital solution to provide greater insight into referral and discharge patterns and barriers
Change 6: Trusted assessment	Established	• Care provider trusted assessment provision in place and currently being reviewed and retendered • Trusted assessor pilot: rolled out to 12 wards in Cambridgeshire University NHS Foundation Trust (CUHFT). Additional pilot has commenced for pathway 1 admission avoidance / early facilitated discharge from front door services in the acute. This involves collaborative working between intermediate care, reablement and CUHFT, building on the virtual ward principles. Further training is being rolled out to staff

		to support the roll out of the model to pathway 1 in the north.
Change 7: Engagement and choice	Established	• CUH/CPFT work to on trusted assessment and reducing duplication of assessments to improve LOS, outcomes and release therapy capacity • Expanding approach system-wide, focus on Pathway 1 • Secured dedicated capacity across system to support TOCH work and ensure consistent engagement, support and delivery.
Change 8: Improved discharge to care homes	Established	• Care forum, support and communication for providers in place • Focus on provider resilience and issues in daily system escalation calls/MDT discharge working • Rapid discharge incentivisation scheme in place and to continue.
Change 9: Housing and related services	Established	• Support and training offered to improve duty to refer rates • Embedding housing within TOCH model • Discretionary housing grants to be embedded to support discharge

National Condition 3 (cont)

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

Both local authorities have a range of statutory duties we have to legally comply with under the Care Act 2014. BCF funding contributes to delivery of a number of these statutory duties as outlined in the table below.

Care Act 2014 Duty	**BCF Investment that supports delivery**
General Responsibilities of Local Authorities • Promoting individual wellbeing • Preventing needs for care and support • Promoting integration of care and support with health services etc • Providing information and advice • Promoting diversity and equality in provision of services	• Reablement capacity to support independence. • Investment voluntary sector prevention and early intervention, including community navigators, day opportunities, information and advice and sensory services. • Investment in community equipment and Technology enabled care. • Investment in adult early help services.
Meeting needs for care etc	• Significant investment in care placement costs, including home care, residential and nursing care placements.
Assessing needs • Assessment of an adults needs for care and support • Assessment of a carers needs for support	• Funding in core social care team capacity, including community teams, discharge teams, continuing health care and review teams.
Duties and powers to meet needs • Duty to meet needs for care and support • Power to meet needs for care and support • Duty and power to meet a carers needs for support	• Investment in care placement costs for cared for – including home care, residential and nursing home placements. • Investment in carers services, including respite. Direct payments and information and advice.

Direct payments	• Direct payment budget.
Provider failure	• Commissioning and contract management capacity to support provider quality and issues, including providers of concern.
Market oversight	• Commissioning capacity to support developing of joint commissioning approaches and market capacity.
Miscellaneous • Discharge of hospital patients with care and support needs	• Social worker discharge teams. • Reablement capacity to support pathway 1. • Brokerage capacity to organise care placements. • Care placement costs for both residential/nursing home and home care placements to support pathway 3. • Block domiciliary discharge cars commissioned capacity. • Low level voluntary sector discharge capacity to support pathway 0.

Supporting unpaid carers

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

We are focused on improving outcomes for carers by ensuring that they receive the right support at the right time, from the right person. This means:

- Carers are identified early, meaningful conversations are carried out and carers are prevented from reaching crisis point and breakdown.
- Carers have access to information, tools and support to enable them to manage their health and wellbeing and support them to maintain their caring role.

Cambridgeshire County Council (CCC), Peterborough City Council (PCC) and the Cambridgeshire and Peterborough Integrated Commissioning Board (ICB) have worked collaboratively to commission and co-ordinate services around Carers and their families. Commissioned services for carers have not changed significantly since our 2022/23 Better Care Fund plan and continue to include:

1. Joint working across health and social care:
    - We have a commissioned all age carers service that provides a holistic and accessible range of support.
    - Supporting carers by identifying local activities and services that help prevent carer breakdown is key to our local place-based vision. We have a co-funded carers social prescriber post in East Cambridgeshire and we are working in other areas to identify gaps and opportunities to support carers.
2. Early Identification of Carers: we undertook a 3-month media campaign targeting hidden carers, resulting in the identification of 4,418 new carers who could then be offered support.
3. Access to information, advice and support: we have commissioned services to provide information and support, including the Carers Helpline.
4. Carers work/training/education - life balance: the Caring Together Carers Directory gives easy access to support online to find support including work, training and education.
5. Improved carer/professional relationships: We have made a significant change to how we engage with you since 2018. We have moved away from a one size fits all model of undertaking carers assessments and reviews as a way of understanding what you need. This is in acknowledgement that most often a lengthy assessment is not what you want. As a result, the majority of interactions with you are now in the form of conversations, often with externally contracted partners, which can lead to a wider variety of tailored outcomes. Accordingly, less of you have received a formal carer assessment in keeping with our deliberate shift towards more nuanced and more timely conversations.
6. Reduced breakdown of care at home: we have commissioned the services of 3 Rapid Responders to offer agile and responsive support for activated '***What If***' plans. This is a free service funded by Cambridgeshire County Council and Peterborough City Council, to look after adults with care needs during an emergency involving their Carer.

7. Young carers are supported when moving into adulthood: we have commissioned Centr33 to provide young adult carers aged 16 to 25 with a transition service. Young carers tell us it can be difficult to navigate moving to adult services. We know that young adult carers often do not engage with adult service professionals. Centre 33 are piloting this young adult carers project from the 1st June 2023 and will report their initial findings in June 2024 with a full evaluation in 2025. This transition service focuses on empowering young adult carers navigate access adult carer support services provided by Caring Together and Making Space. It will help young caring adults consider their options in relation to education, training, and employment.
8. Advocacy access: We have commissioned the services of Voiceability to support our local Carers.
9. Carers have a voice in how services are designed and delivered: We have commissioned Healthwatch to organise and develop five Partnership Boards in Cambridgeshire and Peterborough. Each board's role is to support and improve care for people who use health and adult social care services.

In addition, we also provide carers with services including respite care, direct payments and the family prescription service. Our online information and advice for carers can be found on the links below:

- Peterborough Information Network | Caring for someone in Peterborough (Adults)
- Looking after someone - support for carers - Cambridgeshire County Council

In 2022, a Carers Experts by Experience panel was brought together to inform and guide the development of a refreshed systemwide all age Carers Strategy for 2022-26, which is shortly due for publication. This has been co-produced with carers and system wide partners and sets out strategic intentions for how we support carers:

1. Joint working across health and social care for all Carers
2. Reaching and Identifying Young Carers and Parent Carers
3. Ensuring easy access to information
4. Supporting Carers at risk of domestic abuse
5. Supporting the emotional and psychological wellbeing of carers
6. Young carers are supported when moving into adulthood

Disabled Facilities Grant (DFG) and wider services

What is your strategic approach to using housing support, including DFG funding, that supports independence at home?

In Cambridgeshire, DFG monies are passed to the District Council. The full sum of DFG allocation is being passported to the District Councils, and none of this is being retained by the County Council. In Peterborough, as a unitary authority, responsibility for the DFG sits with Peterborough City Council. DFG monies are used to support home adaptations and to better support people to remain in their homes for longer. We continue to have a strong local commitment to ensure we use adaptations, Technology Enabled Care (TEC) and Community Equipment (ICES) proactively to support independence.

The role of the District Councils, Peterborough City Council and the Home Improvement Agencies (HIAs) are fundamental to this approach.

We continue to have a County-wide Housing Renewals Policy that have introduced discretionary funding in addition to mandatory funding, so we are able to use funding more flexibly; e.g., to expedite hospital discharges and discretionary funding has been utilised across a number of districts for this purpose. However, due to increasing demands, especially as a result of rising building/contractor costs, we are experiencing growing pressures on the use of discretionary funding.

As part of the additional discharge funding allocation, we have been able to allocate some of this funding for discretionary housing grant purposes to support hospital discharges. This is typically used for small adaptations under the DFG minimum threshold, deep cleans and more flexible purposes that will aid a discharge. This is something we plan to continue in 2023-25.

In addition, as outlined in 2022/23 plans, we commission a Cambridgeshire wide handy person service which forms a key element of delivering on the prevention and early intervention agenda.

The service makes a key contribution to maintaining and improving the condition of housing, promoting wellbeing, making people safe, reducing the risks of falls and facilitating early discharge from hospital.

ICES and TEC work hand in hand with the DFG to ensure we have a holistic approach to maximising independence in the home. The ICES service operates as a pooled budget across the local authorities and health; alongside a pooled budget for TEC in Cambridgeshire. This enables an integrated approach to embedding TEC first to address people's health and care needs in a 'one stop' approach.

An integrated approach to housing, to address health inequalities, and deliver our local system health and care priorities, is a key strand of our local joint HWB/ICS priorities:

Deliver improved quality and availability of housing that meets health and wellbeing needs

Following the recent local Housing and Health Summit to review progress to date, a detailed action plan has been developed to support delivery of the following key deliverables:

- Deliver new homes to meet health and well-being need:
- Improving quality of housing to enable health and wellbeing resilience
- Increasing the proportion of residents in safe and secure housing.
- Supporting mental health at home (for new and existing homes).

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? (Y/N)

Yes

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

The following Districts utilise this and have allocated the following amounts of funding for this use:

- Peterborough City Council- £270k
- Fenland District Council - £104k
- East Cambridgeshire - £9k

The other three districts do not utilise any of their DFG funding for discretionary uses, however they are topping up budgets with Council funding to enable discretionary grants and DFG top ups to be funded. The extent of this additional funding per annum is outlined below.

- Huntingdonshire District Council - £400k-£900k
- South Cambridge District Council - £121k
- Cambridge City Council - £195k

Equality and health inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include

- Changes from previous BCF plan
- How equality impacts of the local BCF plan have been considered
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Changes to local priorities related to health inequality and equality and how activities in the document will address these
- Any actions moving forward that can contribute to reducing these differences in outcomes
- How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.

Health Inequalities

The local system is committed to addressing health inequalities and improving the health and wellbeing of all residents. 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 (PHM) approaches.

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 reduce the gap in health outcomes between different population groups, including those from disadvantaged backgrounds.
- To promote healthy lifestyles and behaviours and increase access to early intervention services.
- To improve access to healthcare services for vulnerable and marginalised populations.
- To improve the quality of care and patient experience.
- To ensure that resources are allocated effectively to address health inequalities, taking a Core20PLUS approach.
- To work closely with research and innovation functions to adopt and implement both clinical and non-clinical best practice to better support our underserved communities.

Key areas of focus that we wish to embed across all areas of delivery are aligned to the NHS England Core20PLUS5, and the CPICS Health Inequalities Strategy 2020. Place-based approaches through our North and South partnerships and integrated neighbourhood teams will play a key role in this. Promoting prevention and early intervention: Building upon the work underway in the delivery of primary, secondary and tertiary prevention, we will work with all health and care providers, primary care networks, public health teams, acute providers and voluntary sector organisations to address the behaviour and risk factors in relation to a variety of conditions that drive health inequalities.

Where we want to be in the future and how we will measure improvement:

- A reduction in health inequalities between different population groups, as measured by a range of indicators for life expectancy, healthy life expectancy, infant mortality and disease prevalence. Residents from disadvantaged backgrounds will experience better health outcomes and quality of life.
- 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 and improved financial sustainability over the longer term.

To support our ambitions, the new Strategic Commissioning Unit of the Integrated Commissioning Board (IBC) 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 also expand its capabilities to identify, develop and recommend innovative solutions which reduce health inequalities and improve patient outcomes.

We are adopting a health in all policies approach, to embed delivering services that maximise the impact on health outcomes and address health inequalities across the system and we continue to embed this approach through our local practice, delivery and commissioning and approaches. A recent example of this is how we have embedded the health outcome of 'increasing physical activity for older adults' across all policy areas, as outlined in the example below.

SOCIAL CARE	PUBLIC HEALTH
Care planning: discussions with individuals about how they want to be supported to be active. Where a need is identified, incorporate it into care plan.	Ensure provision of strength and balance classes. Ensure commissioned health trainer service accessible for older people.

Commissioning: all commissioned services offer support to service users to engage with physical activity. Reablement: supports preventing deconditioning.	Develop understanding of how to engage older people in activity and what attractive community offer looks like. Health promotion to older people to increase physical activity.
INTEGRATED NEIGHBOURHOODS Primary care staff have confidence, skills and knowledge to offer advice to patients on physical activity. Community grant funding: increased range of activities for older people.	ACUTE HOSPITAL Prevention of deconditioning: older adults do not decondition following admission to hospital. Embed approach into inpatient services.

Population Health Management (PHM)

Our long-term vision is that all organisations within the ICS have the skills, resource, and information they need to use PHM approaches. All partners will use 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 to allocate resource, manage risk and identify system priorities. We will develop a PHM platform and support provider partnerships and Integrated Neighbourhoods in using high-quality PHM approaches. Examples of progress to date include:

- Across Cambridgeshire and Peterborough, we have rolled out the Eclipse tool (provided by Prescribing Services Ltd). This 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. Eclipse allows GP practices to understand variation in their patient groups. An example of this is diabetes, where you can compare current achievement of the Care and Treatment targets compared to other practices across your Primary Care Network,

ICS and nationally. This system has been used to improve the care for patients with diabetes by identifying their unmet needs.

Over the coming months we will be working to develop our PHM capability further to be able to understand current and future demand for different patient cohorts and to help prevent ill health. We will do this by:

- Building on the C&P Analytics Community to develop an ICS Intelligence Function which also supports wider system aims.
- Providing the tools for our intelligence function & system partners to understand the needs of the population via segmentation and stratification techniques.
- Using this data to understand the drivers of variation in our populations.
- Continuously researching wider data sources that could be added to the data set to allow more nuanced intelligence insights and multi-agency approaches to health and care problem sets.
- Creating the capability to derive short, medium- and long-term intelligence forecasting through advanced actuarial and risk stratification analysis.
- Developing the infrastructure through the creation of a linked data set across health and care.
- Supporting Client Level Data (CLD) returns by providing more granular levels of reported social care activity data that can then be mapped to wider health data on a pseudonymised data to be used for PHM purposes.

PHM will enable us to direct resources and interventions to target key risk and inequality areas at system, place and Primary Care Network level through a balanced top-down and bottom-up approach. We will come together as a system to plan how incentives can be best used as part of this approach.

Appendix 1 – Care Together Objectives and Deliverables

Care Together Objectives	What Care Together will do	How services and the way we commission will change

• Introduce a place-based approach to commissioning care and support for older people in the community • Improve the homecare offer available to local people • Improve older people's early intervention and prevention services, helping to delay people's need for long-term health and social care	• Create dedicated place-based commissioners in each Integrated Neighbourhood to build connections with local people and partners and co-design future services with them • Support the creation and growth of voluntary, community and social enterprises (VCSEs) that support older people to remain living independently for longer in collaboration with Communities and the Local Economic Partnership • Reshape council funded homecare over time to become more personalised, outcome focused and locally delivered • Introduce different types of providers into the homecare market to increase capacity and choice for all • Develop a place-based early intervention / prevention offer in partnership with Public Health to promote independence and ageing well • Pursue opportunities to commission place-based care and support services for older people in partnership with Health, as the	• We will develop place-based commissioning practices. We will use data on a district and community level to better understand the nuances of demand across the county and work intensively with local communities and partners to codesign services on a more local level. This will inform how Adult Social Care commissions in the future. • Through more creative ways of commissioning, it will become easier for small local VCSEs to bid for funding or contracts with the council. • We will re-align some of our grants into local seed funding pots to help create and grow VCSEs which support older people living at home. We aspire to create Integrated Neighbourhood seed funding pots in partnership with Health over the programme duration. • Holistic, personalised and outcome focused care will become part of the council's specification for homecare (pending evaluation by Cambridge University), replacing traditional 'time and task' models • The council's current system for purchasing homecare will

	Integrated Care System develops	be replaced with a place-based alternative to encourage more local working • Introduction of Individual Service Funds (ISF) as part of the council's offer will increase older people's choice and control over the care and support that they receive. • 3 Care Micro-Enterprise Development Officers will work in local communities to promote and support the creation of care microenterprises (self-employed care workers), introducing new and different providers to the market • We will review and improve the early intervention/prevention services commissioned by Adult Social Care and Public Health to ensure there is a comprehensive, evidence-led offer available in each district/community that is well promoted. We aspire to producing a shared vision and service offer for Ageing Well with our colleagues in Health as the Integrated Care System develops. • We aspire to widen the use of GP Frailty data to reach

		older people in the community who may benefit from early intervention / prevention services to maintain their independence for longer (pending evaluation of impact from Cambridgeshire University)

Appendix 2 – Examples of local Integrated Neighbourhoods

Peterborough

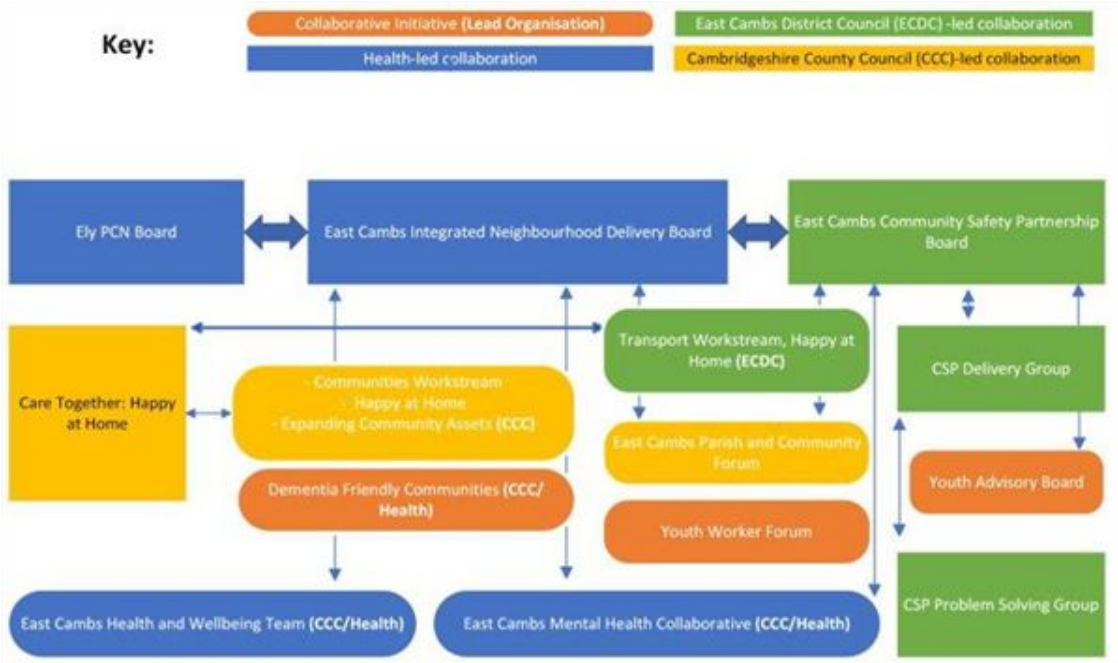
In Peterborough, we have developed integrated approaches to delivering health and care at a place-based level through our integrated neighbourhoods, examples of how this works in practice includes:

- Collaborative working across social prescribers and local authority prevention and early intervention services, to share knowledge, training, best practice and to facilitate multi-disciplinary case discussions.
- Implemented Pink Button on SystmOne, which enables easy referral to local authority home services delivery model services (holistic reablement, occupational therapy, Technology Enabled Care and Care and Repair).
- High Impact user pilot projects to reduce hospital and GP attendances.
- Joy Platform implemented and improving information and access to services to support seamless social prescribing services.
- Integrated neighbourhood meetings with multi-disciplinary representation across health, social care and community/voluntary sector representation.
- Through the NESTA work we built stronger relationships with the voluntary sector
- The Integrated Neighbourhood Managers are part of the Peterborough Falls working group

- Joint health and care work across Central, Thistlemoor and Thorp PCN and Paston and Boroughbury PCN as part of their working groups working on their Population Health Management Development Programme to develop cohorts of clients where we can affect prevention and early intervention wrap around services to reduce presentations to the GPs and Acutes
- Roll out of strength- based conversation training from an adult social care trainer to ensure a joined-up approach with patient conversations across the local system.
- Local Faith working group looking at themes and information sharing. Currently working on ensuring volunteers have been to the smart flat so that they can promote TEC and that group leaders attend our Adult Early Help team meetings.
- PCC Reablement team are working with public health and the CPFT falls prevention lead to deliver stronger for longer exercise readiness (for relevant clients) as part of the reablement offer to support falls prevention, confidence development and promoting independence

East Cambridgeshire

Our most progressed Integrated Neighbourhood, we have a strong history of partnership and collaboration in East Cambridgeshire and this has resulted in an established governance structure that oversees traction and delivery of the local priorities, which can be seen below.



Locally partners are working together in the following ways:

- A neighbourhood team of 'anchor people'
- A shared set of principles and priorities
- A network of forums, collaboratives and project teams
- Focusing on local relationships and delivering through our collective strengths
- Open to new ideas, flexible in our planning and agile in our responses
- Listening to local people and communities and starting to co-produce
- Seeing setbacks and mistakes as an opportunity to do things differently
- Pooling budgets and role generosity

In January 2020, we held our first local integrated neighbourhood stakeholder event, which outlined what we wanted to achieve, but showed how messy things were, as can be seen below.

When we came back together in July 2021, although things were still messy, we were embracing the complexity and partnerships were evolving and we were learning as we moved forwards together, as can be seen below.

At the end of 2022, we published our first annual report for the East Cambridgeshire Integrated Neighbourhood, which highlights some of the significant developments and successes we have made over the past 12 months.

Cambridge City Integrated Neighbourhood

6

Winter Wellbeing Case Study
An 85-year-old who lives on his own in Abbey ward in Cambridge, following the recent death of his wife. The first time he had been out on his scooter in 2 years was to attend his wife's funeral. He has regular visits from family. He has multiple long-term conditions and has carers support to help hoist him from bed to his chair each day. Through the initial engagement, the PCN picked up that he was overdue an asthma and a COPD review which have now taken place. What is important to him is to continue to live in his own home:

- He was worried about bills
- He is chair and bed bound and spends his days reading the paper, doing crosswords, and watching television and would like more comfortable riser chair
- He said he would like to have more social contact

As a result of the 'what matters to me' conversation and personalised care and support plan:
- He received a Household Support fund payment of £110 to help with his utility bills
- He had a full benefit check to see if he can maximise his regular income
- He received a heated over blanket to help him stay warm at home, funded by local businesses through charity Allia
- He bought a new riser chair using his £250 personal budget (total was £509)
- He was referred to the Age UK's befriending scheme and has been matched to a volunteer following a home visit from their Sharing Time Co-ordinator - they will be introduced next week.
- Upon their second visit, Age UK were asked to use the key-safe but this was so stiff to open and so they contacted the Bobby Scheme, they have been out to service it and oiled it so this will be easier to use by carers and family members when visiting.

Fenland / South Fenland Integrated Neighbourhood

Weekly multi-disciplinary falls prevention service is in place with Doddington, which includes:

- Multi-factorial Falls Risk Assessments (Healthy You)
- FaME programme (Healthy You)
- Pre-Fit and Strength and Balance classes (Active Fenland)

Number of participants for classes are increasing therefore Healthy You and Active Fenland are now exploring larger venues within Doddington to accommodate this demand.

South Cambridgeshire Integrated Neighbourhood

Neighbourhood: Meridian

- Melbourn Wellbeing Hub - Moving heath & wellbeing services out to the community delivering support alongside VCS including Timebank.
- Worthwhile waiting – utilising community activity (provided by VCS) to help improve wellbeing while waiting for surgery.

- Priority Subgroups – Multiagency groups working on a specific focus (CYP mental health, loneliness, digital inclusion, older people, waiting lists) taking a collaborative approach.
- Peer Support – Carers café, menopause Café, Long Covid Clinic.
- Winter Pressure - project to better connect to SCDC / Age Uk Mobile Warden Scheme. Expanding cohort to first contact ASC below threshold.
- Melbourn Underpass – local collaboration to improve community safety and bring community together.

Neighbourhood: North Villages

- Northstowe Support Partnership - hyperlocal level to improve wellbeing a counteract poor outcomes often seen in new communities. Utilising S106 funding to run projects & initiatives to improve local wellbeing.
- Craft Shed Bar Hill – supporting the Bar Hill's version of Men's Shed, link with social prescriber.
- Bar Hill Refugee Community Support – coordinated localised support connecting agencies together.
- Walking football – new groups in Bar Hill, Histon & Milton) in partnership with Living Sport, Cambridge United, Healthy You and PCN to take a personalised care approach to improve physical and mental wellbeing for men.
- HI Friends – Supporting team delivering two-week wellbeing festival promoting community-led carers support, Mental Health, parenting, diabetes, dementia.
- Northstowe Arts – Facilitated the development of community group connecting and improving the wellbeing of the community.
- Over Day Center - working with the facility to develop future scope.

Neighbourhood: Granta

- Menopause Group Consults- providing education, treatment and lifestyle advice Linked to the community-led Menopause Café.
- Men's Health – focused on inactive men with high BMI working with them to tackle loneliness, activity & diet started in Royston rolling out to Sawston & Linton.
- Join the dots – collaboration with VCS to avoid re-admission. Restarted with winter funding.
- Health Hub - Ambition to develop a co-funded outreach mental health service.
- Wellbeing Hub – multiagency joint working across sectors.
- Cross boundary – working to resolve boundary issues to improve access to services.

Better Care Fund 2022-23 End of Year Template

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2022-23, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities, NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

The key purposes of BCF reporting are:
1) To confirm the status of continued compliance against the requirements of the fund (BCF)
2) To confirm actual income and expenditure in BCF plans at the end of the financial year
3) To provide information from local areas on challenges, achievements and support needs in progressing the delivery of BCF plans
4) To enable the use of this information for national partners to inform future direction and for local areas to inform improvements

BCF reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICB's, local authorities and service providers) for the purposes noted above.

BCF reports submitted by local areas are required to be signed off by HWBs as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website in due course.

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a grey background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.
The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut & paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy & paste', please use the 'Paste Special' operation and paste Values only.

The details of each sheet within the template are outlined below.

ASC Discharge Fund-due 2nd May

This is the last tab in the workbook and must be submitted by 2nd May 2023 as this will flow to DHSC. It can be submitted with the rest of workbook empty as long as all the details are complete within this tab, as well as the cover sheet although we are not expecting this to be signed off by HWB at this point. The rest of the template can then be later resubmitted with the remaining sections completed.

After selecting a HWB from the dropdown please check that the planned expenditure for each scheme type submitted in your ASC Discharge Fund plan are populated.
Please then enter the actual packages of care that matches the unit of measure pre-specified where applicable.
If there are any new scheme types not previously entered, please enter these in the bottom section indicated by a new header. At the very bottom there is a totals summary for expenditure which we'd like you to add a breakdown by LA and ICB.

Please also include summary narrative on:
1. Scheme impact
2. Narrative describing any changes to planned spending – e.g. did plans get changed in response to pressures or demand? Please also detail any underspend.
3. Assessment of the impact the funding delivered and any learning. Where relevant to this assessment, please include details such as: number of packages purchased, number of hours of care, number of weeks (duration of support), number of individuals supported, unit costs, staff hours purchased and increase in pay etc
4. Any shared learning

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.
3. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:
england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)

4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2022-23 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.

https://www.england.nhs.uk/publication/better-care-fund-planning-requirements-2022-23/

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, the HWB is expected to contact their Better Care Manager in the first instance.

In summary, the four national conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: NHS contribution to adult social care is maintained in line with the uplift to NHS Minimum Contribution
National condition 3: Agreement to invest in NHS commissioned out-of-hospital services
National condition 4: Plan for improving outcomes for people being discharged from hospital

4. Metrics

The BCF plan includes the following metrics: Unplanned hospitalisation for chronic ambulatory care sensitive conditions, Proportion of discharges to a person's usual place of residence, Residential Admissions and Reablement. Plans for these metrics were agreed as part of the BCF planning process.

This section captures a confidence assessment on achieving the plans for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes that have been achieved.
The BCF Team publish data from the Secondary Uses Service (SUS) dataset for Dischaege to usual place of residence and avoidable admissions at a local authority level to assist systems in understanding performance at local authority level.

The metrics worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric plans and the related narrative information and it is advised that:
- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy data.
- In providing the narrative on Challenges and Support needs, and Achievements, most areas have a sufficiently good perspective on these themes and the unavailability of published metric data for one/two of the three months of the quarter is not expected to hinder the ability to provide this useful information. Please also reflect on the metric performance trend when compared to the quarter from the previous year - emphasising any improvement or deterioration observed or anticipated and any associated comments to explain.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

5. Income and Expenditure

The Better Care Fund 2022-23 pool constitutes mandatory funding sources and any voluntary additional pooling from LAs (Local Authorities) and NHS. The mandatory funding sources are the DFG (Disabled Facilities Grant), the improved Better Care Fund (iBCF) grant, minimum NHS contribution and additional contributions from LA and NHS. This year we include final spend from the Adult Social Care discharge fund.

Income section:
- Please confirm the total HWB level actual BCF pooled income for 2022-23 by reporting any changes to the planned additional contributions by LAs and NHS as was reported on the BCF planning template.
- In addition to BCF funding, please also confirm the total amount received from the ASC discharge fund via LA and ICB if this has changed.
- The template will automatically pre populate the planned expenditure in 2022-23 from BCF plans, including additional contributions.
- If the amount of additional pooled funding placed intothe area's section 75 agreement is different to the amount in the plan, you should select 'Yes'. You will then be able to enter a revised figure. Please enter the **actual income** from additional NHS or LA contributions in 2022-23 in the yellow boxes provided, **NOT** the difference between the planned and actual income.
- Please provide any comments that may be useful for local context for the reported actual income in 2022-23.

Expenditure section:
- Please select from the drop down box to indicate whether the actual expenditure in your BCF section 75 is different to the planned amount.
- If you select 'Yes', the boxes to record actual spend, and explanatory comments will unlock.
- You can then enter the total, HWB level, actual BCF expenditure for 2022-23 in the yellow box provided and also enter a short commentary on the reasons for the change.
- Please include actual expenditure from the ASC discharge fund.
- Please provide any comments that may be useful for local context for the reported actual expenditure in 2022-23.

6. Year End Feedback

This section provides an opportunity to provide feedback on delivering the BCF in 2022-23 through a set of survey questions
These questions are kept consistent from year to year to provide a time series.
The purpose of this survey is to provide an opportunity for local areas to consider the impact of BCF and to provide the BCF national partners a view on the impact across the country. There are a total of 5 questions. These are set out below.

Part 1 - Delivery of the Better Care Fund

There are a total of 3 questions in this section. Each is set out as a statement, for which you are asked to select one of the following responses:

- Strongly Agree
- Agree
- Neither Agree Nor Disagree
- Disagree

- Strongly Disagree

The questions are:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality
2. Our BCF schemes were implemented as planned in 2022-23
3. The delivery of our BCF plan in 2022-23 had a positive impact on the integration of health and social care in our locality

Part 2 - Successes and Challenges
This part of the survey utilises the SCIE (Social Care Institue for Excellence) Integration Logic Model published on this link below to capture two key challenges and successes against the 'Enablers for integration' expressed in the Logic Model.

Please highlight:
4. Two key successes observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2022-23.
5. Two key challenges observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2022-23?

For each success and challenge, please select the most relevant enabler from the SCIE logic model and provide a narrative describing the issues, and how you have made progress locally.
SCIE - Integrated care Logic Model

1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care

Department of Health & Social Care | Department for Levelling Up, Housing & Communities | Local Government Association | NHS England

Better Care Fund 2022-23 End of Year Template

2. Cover

Version 1.0

Please Note:

- The BCF end of year 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 BCE) 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@peterborough.gov.uk		Yes
Contact number:	7976832188		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 21/07/2023	<< 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

Please see the Checklist on each sheet for further details on incomplete fields

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. Income and Expenditure actual	Yes
6. Year-End Feedback	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2022-23 End of Year Template

3. National Conditions

Selected Health and Wellbeing Board: Cambridgeshire

Confirmation of Nation Conditions			Checklist
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in 2022-23:**	Complete:
1) A Plan has been agreed for the Health and Wellbeing Board area that includes all mandatory funding and this is included in a pooled fund governed under section 75 of the NHS Act 2006? (This should include engagement with district councils on use of Disabled Facilities Grant in two tier areas)	Yes		Yes
2) Planned contribution to social care from the NHS minimum contribution is agreed in line with the BCF policy?	Yes		Yes
3) Agreement to invest in NHS commissioned out of hospital services?	Yes		Yes
4) Plan for improving outcomes for people being discharged from hospital	Yes		Yes

Better Care Fund 2022-23 End of Year Template

4. Metrics

Selected Health and Wellbeing Board: Cambridgeshire

National data may be unavailable at the time of reporting. As such, please utilise 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 2022-23 planning	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements	Checklist Complete:
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	765.0	On track to meet target	ICB 22/23 operational plan was to reduce avoidable admissions to below the pre-pandemic level of 825.2. Performance against this metric was achived based on the reduced annual rate to 749.75. However, it	Achievement in Quarter 1 (192.54 actual against a target of 196) & Quarter 2 (182.75 actual against a target of 193). In Quarter 3, actual performance of 201.24 was higher than plan of 191. Quarter 4 actual (172.23	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	90.9%	On track to meet target	To ensure that patients are discharged onto the right pathway, a System wide, multi-disciplinary team Transfer of Care Hub (TOCH) has been implemeted. This enables earlier identification of challenges, supports	The ambition for 22/23 was to hold a steady position of 90.9%. Data for all Quarters is above target (Q1=91.0%, Q2=91.3%, Q3=91.4%, Q4=91.2%), the average actual performance was 91.2% for 22/23, thus	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	603	Not on track to meet target	A high percentage of new admissions in 2021/22 (79.3%) were due to the rapid deployment of a number of local Discharge to Assess beds during the pandemic - 94% of these were open for less than 8 weeks and	Numbers of new community packages for older people increased from 1137 to 1207, indicating we are supporting more people to retain their independence at home.	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	72.2%	On track to meet target	91 day reviews carried out during Jan-Mar 2023 for older people who received reablement post discharge during the qualifying period of Oct - Dec 22 found 72.7% to be still at home. This might be	When looking at all older people access reablement, not just those discharged from hospital, which would include those referred via intermediate care a higher percentage (77%) remained at home 91 days later	Yes

Better Care Fund 2022-23 End of Year Template

5. Income and Expenditure actual

Selected Health and Wellbeing Board: Cambridgeshire

Income

	2022-23	
Disabled Facilities Grant	£5,069,551	
Improved Better Care Fund	£15,171,304	
NHS Minimum Fund	£45,441,112	
Minimum Sub Total		£65,681,967

	Planned		Actual			
NHS Additional Funding	£3,512,222		Do you wish to change your additional actual NHS funding?	No		
LA Additional Funding	£0		Do you wish to change your additional actual LA funding?	No		
Additional Sub Total		£3,512,222				£3,512,222

	Planned 22-23	Actual 22-23
Total BCF Pooled Fund	£69,194,189	£69,194,189

	ASC Discharge Fund					
	Planned		Actual			
LA Plan Spend	£1,936,714		Do you wish to change your additional actual LA funding?	No		
ICB Plan Spend	£2,512,476		Do you wish to change your additional actual ICB funding?	No		
ASC Discharge Fund Total		£4,449,190				£4,449,190

	Planned 22-23	Actual 22-23
BCF + Discharge Fund	£73,643,379	£73,643,379

Please provide any comments that may be useful for local context where there is a difference between planned and actual income for 2022-23	

Expenditure

	2022-23
Plan	£69,194,189

Do you wish to change your actual BCF expenditure?	No
Actual	

	ASC Discharge Fund
Plan	£4,449,190

Do you wish to change your actual BCF expenditure?	No
Actual	

Please provide any comments that may be useful for local context where there is a difference between the planned and actual expenditure for 2022-23	

Checklist Complete:
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes

6

Better Care Fund 2022-23 End of Year Template

6. Year-End Feedback

The purpose of this survey is to provide an opportunity for local areas to consider and give feedback on the impact of the BCF.
There is a total of 5 questions. These are set out below.

Selected Health and Wellbeing Board: Cambridgeshire

Part 1: Delivery of the Better Care Fund

Please use the below form to indicate to what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.

Statement:	Response:	Comments: Please detail any further supporting information for each response	Checklist Complete:
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Agree	Local joint working between health and social care continues to be strong. A joint Health and Wellbeing /Integrated Care Partnership Board has been established across Peterborough and Cambridgeshire. Joint priorities have been established which inform the joint Health and Wellbeing & ICS Strategy. This embodies the strong local leadership	Yes
2. Our BCF schemes were implemented as planned in 2022-23	Agree	There has been good progress implementing the Better Care Fund schemes. This includes progress in implementing place based integrated neighbourhoods, which we continue to build upon and roll out across the footprint. We have also made strong progress on implementing digital solutions such as the Shared Care Record, which phase 1 of the	Yes
3. The delivery of our BCF plan in 2022-23 had a positive impact on the integration of health and social care in our locality	Agree	local health and social care integration has continued to progress over the past 12 months, including development of local integrated place based delivery and commissioning, transfer of care hub and virtual wards. Whilst the BCF pooled budget has not been directly attributable to all of these areas it funds a number of key enablers to support delivery of	Yes

Part 2: Successes and Challenges

Please select two Enablers from the SCIE Logic model which you have observed demonstrable success in progressing and two Enablers which you have experienced a relatively greater degree of challenge in progressing.
Please provide a brief description alongside.

4. Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2022-23	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest successes	
Success 1	2. Strong, system-wide governance and systems leadership	There is a strong leadership commitment to integraton, including a shared vision and priorities across health and social care. This is driven by the establishment of our joint Health and Wellbeing /Integrated Care Partnership Board for Cambridgeshire and Peterborough. Joint priorities, alongside a joint Health and Wellbeing / Integrated Care Strategy have been developed. We are one of a handful of areas to have taken this approach to date and it is a significant step in leadership commitment and governance to support us to deliver on our local integration agenda.	Yes
Success 2	Other	We continue to develop our Integrated Neighbourhoods work and have started to make good progress on this locally, with a clear set of local priorities which are being implemented. We have made real progress in implementing an integrated place based approach in East Cambridgeshire across health and social care, through the Integrated Neighbourhood and Council's Care Together programme resulting in the local teams working in an integrated manner to develop the local offer. We have deployed an appreciative enquiry approach with the community to understand local needs, which will continue to	Yes

5. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2022-23	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest challenges	
Challenge 1	5. Integrated workforce: joint approach to training and upskilling of workforce	Workforce recruitment and retention continues to be a challenge locally for us, which is in line with the national challenges that are being faced. This is affecting all partners across the system, including private providers. We continue to support this in a number of ways, including the development of local and regional workforce programmes , including more effective use of apprenticeships, overseas recruitment, working with local education providers, universities and adult learning to create career pathways for health and social care.	Yes
Challenge 2	6. Good quality and sustainable provider market that can meet demand	The local health and social care system continues to face significant financial and workforce pressures. This is particularly evident in the private provider market, who have been hit hard by the rising rates of inflation and workforce costs, and this in turn is impacting on rising costs for providing care. Whilst we continue to provide a range of support to the market, there is an a continued ongoing impact on capacity and financial resilience.	Yes

Footnotes:
Question 4 and 5 are should be assigned to one of the following categories:
1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care
Other

Better Care Fund 2022-23 End of Year Template

ASC Discharge Fund

Selected Health and Wellbeing Board: Cambridgeshire

Please complete and submit this section (along with Cover sheet contained within this workbook) by 2nd May

For each scheme type please confirm the impact of the scheme in relation to the relevant units asked for and actual expenditure. Please then provide narrative around how the fund was utilised, the duration of care it provided and and any changes to planned spend. At the very bottom of this sheet there is a totals summary, please also include aggregate spend by LA and ICB which should match actual total prepopulation.
The actual impact column is used to understand the benefit from the fund. This is different for each sheme and sub type and the unit for this metric has been pre-populated. This will align with metrics reported in fortnightly returns for scheme types.
1) For 'residential placements' and 'bed based intermediary care services', please state the number of beds purchased through the fund. (i.e. if 10 beds are made available for 12 weeks, please put 10 in column H and please add in your column K explanation that this achieve 120 weeks of bed based care).
2) For 'home care or domiciliary care', please state the number of care hours purchased through the fund.
3) For 'reablement in a person's own home', please state the number of care hours purchased through the fund.
4) For 'improvement retention of existing workforce', please state the number of staff this relates to.
5) For 'Additional or redeployed capacity from current care workers', please state the number of additional hours worked purchased through the fund purchased.
6) For 'Assistive Techonologies and Equipment' , please state the number of unique beneficiaries through the fund.
7) For 'Local Recruitment Initiatives', please state the additional number of staff this has helped recruit through the fund.

If there are any additional scheme types invested in since the submitted plan, please enter these into the bottom section found by scrolling further down.

Scheme Name	Scheme Type	Sub Types	Planned Expenditure	Actual Expenditure	Actual Number of Packages	Unit of Measure	Did you make any changes to planned spending?	If yes, please explain why	Did the scheme have the intended impact?	If yes, please explain how, if not, why was this not possible	Do you have any learning from this scheme?
Additional Capacity	Improve retention of existing workforce	Incentive payments	£71,600	£0	0	number of staff	Yes	on reflection care homes take nursing placements within the proposed timescales, thus not providing additionality.	No	ICB reallocated to other schemes.	None
Administration	Administration		£19,367	£19,364	0	N/A	No	Supported financial and metric tracking to enable fortnightly returns to NHSE.	Yes	Additional capacity was needed to support tracking and reporting requirements associated with this grant.	Capacity to support reporting and monitoring was crucial.
Brokerage Capacity	Additional or redeployed capacity from current care workers	Costs of agency staff	£70,000	£56,732	2,986	hours worked	Yes	Due to recruitment timelines, we underpsent on original budget.	Yes	Impact = additional brokerage staffing to support care placement brokerage recruited to, delivering a cumulative total of 2,986 additional hours.	Additional capacity enabled dedicated resource to support discharge
Care Home Discharges - Incentivisation	Residential Placements	Care home	£242,400	£22,800	19	Number of beds	Yes	Incentive scheme took longer to embed and implement than originally planned. Underspend was reallocated to alternative schemes.	Yes	19 care home discharges benefitted from the incentivisation payment.	Incentivisation payments were beneficial lever with providers to speed up
Community Equipment	Assistive Technologies and Equipment	Community based equipment	£250,000	£250,000	288	Number of beneficiaries	Yes	99% of same day discharge orders received (288 during Jan-Mar 23) were successfully completed same day.	Yes	99% of same day discharge orders received (288 during Jan-Mar 23) were successfully completed same day.	Increasing workforce capacity in the community equipment supplier had
Discharge support - HIU's	Other		£179,000	£179,000	0	N/A	No	The funding has been included in a collaborative invitation to the voluntary sector to support innovation to deliver health and wellbeing improvements.	No	Healthier Futures bid has been launched with an element for supporting discharges and HIUs. Applications by 1 Aug.	
Discharge support - Hinch	Other	Other	£48,100	£48,100	0	N/A	No	none	No	Delivery planned for 23/24.	
Discharge support - Transport	Home Care or Domiciliary Care	Other	£223,392	£223,392	0	Hours of care	No	none	Yes	additional cars across 3 acute trust sites to support discharges from wards and support Emergency Department discharges if they have capacity.	
Disretionary Housing Grants	Other		£50,000	£0	0	N/A	Yes	This funding was not utilised and was reallocated to other schemes.	No	Funding was not utilised.	Better embedding of awareness amongst discharge planning staff
Home Care Discharges - Incentivisation	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	£292,000	£53,000	0	Hours of care	Yes	Incentive scheme took longer to embed and implement than originally planned. Underspend was reallocated to alternative schemes.	Yes	53 hospital discharges were supported by this incentive scheme. It was apayment per discharge to speed up the discharge timescale, so did not pay for hours of care delivery, so	Incentivisation payments were beneficial lever with providers to speed up
Intensive Dementia Support	Reablement in a Person's Own Home	Other	£78,760	£78,760	0	Hours of care	No	recruitment is still ongoing. 1 position filled via secondment. 2 x positions reviewing applications. Discussions have taken place with acute trusts discharge planning teams and specialist	No	Delayed start due to recruitment process. Realisation of impact in 23/24.	Alzheimers Society are learning from other schemes, best practice,
Mental Health Discharge Support	Reablement in a Person's Own Home	Other	£85,920	£106,635	0	Hours of care	Yes	£20,712 of the local authority allocation was reallocated to provide additional discharge package support for those being discharged with mental health issues.	Yes	CPSL Mind are currently recruiting to the extended buddy scheme. Estimated start date 1 May 23. Interim support to liaison psychiatric service is showing an increase in the number	
OOA Discharge Support (Hinch))	Local recruitment initiatives		£33,300	£33,300	0	number of additional staff	No	none	No	Planned recruitment of Band 7 post. Delivery planned for 23/24	None
Public Health Plot - Strength and Balance	Other		£30,000	£0	0	N/A	Yes	Scheme did not progress due to lack of capacity in acute trust. Allocation reallocated to other schemes.	No	Scheme did not progress.	Capacity over winter months to support short term schemes in the acutes
Reablement - retention payments	Improve retention of existing workforce	Retention bonuses for existing care staff	£98,500	£357,696	240	number of staff	Yes	Winter retention payments were paid to staff as planned. However, reallocated funding was used to pay for enhancements to staff, to support additional capacity during	Yes	240 staff benefitted from retention payments. During Jan - Mar turnover rate was 4.6% for the quarter.	Early promotion of payments is needed to maximise staff awareness
Reablement Capacity	Increase hours worked by existing workforce	Overtime for existing staff.	£149,000	£167,828	10,800	hours worked	No	None	Yes	Additional overtime paid for existing staff enabling additional capacity in the service, equating to an additional 10,800 cumulative hours of staff time.	None
Social Care Discharge Capacity	Additional or redeployed capacity from current care workers	Costs of agency staff	£485,447	£529,490	0	hours worked	No	none	Yes	600 assessments and reviews completed. Note that metric is number of assessments and not number of hours worked.	Block usage of agency addressed some of the workforce challenges.
Transfer of Care Hub - Digital Solution	Other		£465,400	£465,400	0	N/A	No	none	No	JD for Senior Digital Lead to support developing the Digital solution specification and commissioning has been drafted and is sitting with CUH HR for job matching.	Governance processes delays in delivery. Recruitment also impacts
Transfer of Care Hub - workforce	Additional or redeployed capacity from current care workers	Local staff banks	£393,800	£393,800	0	hours worked	No	none	No	· Clarified the governance process to secure the Home First ASC funding bid and submitted an Investment Committee documentation to the host organisation for approval.	The current CSCP workforce arrangement for the delivery of the Home
VCS Alliance	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	£1,040,004	£1,249,093	0	Hours of care	Yes	Local authority reallocated funding to commission additional low level discharge support from voluntary sector organisations - Care Network, Age UK and Caring Together.	No	Establishing a single point of access VCS hub to coordfinate low level discharge support and ensure a coordfnated offer. Expected impact from April 2023.	None
Workforce	Improve retention of existing workforce	Wellbeing measures	£143,200	£0	0	number of staff	Yes	Scheme not progressed.	No	ICB reallocated to other schemes.	None

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Schemes added since Plan											
Bridging capacity (NWAFT)	Reablement in a Person's Own Home	Reablement to support to discharge – step down		£35,800	0	Hours of care	Yes	Reallocated funds to extend bridging service at NWAFT. Providing short term home care provision.	No	Expected impact from April 23 due to late reallocation	none
Community IV at Home	Other	Other		£179,000	0	N/A	Yes	reallocated funds to community IV at Home service, to provide additional capacity.	No	Expected impact from April 23 due to late reallocation	none

Planned Expenditure	£4,449,190
Actual Expenditure	£4,449,190
Actual Expenditure ICB	£2,512,476
Actual Expenditure LA	£1,936,714

6

BCF Planning Template 2023-25

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).
3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with the word 'no', should be completed before sending to the Better Care Fund Team.
4. The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'.

5. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
6. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
7. Please ensure that all boxes on the checklist are green before submission.
8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority.

4. Capacity and Demand

Please see the guidance on the Capacity&Demand tab for further information on how to complete this section.

5. Income

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2023-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations and allocations of ASC Discharge Fund grant to local authorities for 2023-24. The iBCF grant in 2024-25 is expected to remain at the same value nationally as in 2023-24, but local allocations are not published. You should enter the 2023-24 value into the income field for the iBCF in 2024-25 and agree provisional plans for its use as part of your BCF plan

2. The grant determination for the Disabled Facilities Grant (DFG) for 2023-24 will be issued in May. Allocations have not been published so are not pre populated in the template. You will need to manually enter these allocations. Further advice will be provided by the BCF Team.

3. Areas will need to input the amount of ASC Discharge Fund paid to ICBs that will be allocated to the HWB's BCF pool. These will be checked against a separate ICB return to ensure they reconcile. Allocations of the ASC discharge funding grant to local authority will need to be inputted manually for Year 2 as allocations at local level are not confirmed. Areas should input an expected allocation based on the published national allocation (£500m in 2024-25, increased from £300m in 2023-24) and agree provisional plans for 2024-25 based on this.

4. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

5. Please use the comment boxes alongside to add any specific detail around this additional contribution.

6. If you are pooling any funding carried over from 2022-23 (**i.e. underspends from BCF mandatory contributions**) you should show these as additional contributions, but on a separate line to any other additional contributions. Use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

7. Allocations of the NHS minimum contribution are shown as allocations from each ICB to the HWB area in question. Where more than one ICB contributes to the area's BCF plan, the minimum contribution from each ICB to the local BCF plan will be displayed.

8. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

6. Expenditure

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, units, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Condition 4 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 6b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Expected outputs
- You will need to set out the expected number of outputs you expect to be delivered in 2023-24 and 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.
- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.
- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be found in tab 6b. Expenditure Guidance.

You do not need to fill out these columns for certain scheme types. Where this is the case, the cells will turn blue and the column will remain empty.

6. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "NHS minimum" then the planned spend would count towards eligible expenditure on social care under National Condition 4.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

7. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend on NHS commissioned out of hospital services under National Condition 4. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

8. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

9. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

10. Expenditure (£) 2023-24 & 2024-25:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

11. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

12. Percentage of overall spend. This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This is a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance. This estimate should be based on expected spend in that category in the BCF over both years of the programme divided by both years total spend in that same category in the system.

7. Metrics

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2023-25. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2023-24.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2023-24. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2021)
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Please use the ISR Tool published on the BCX where you can input your assumptions and simply copy the output ISR:
https://future.nhs.uk/bettercareexchange/view?objectId=143133861
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Falls
- This is a new metric for the BCF and areas should agree ambitions for reducing the rate of emergency admissions to hospital for people aged 65 or over following a fall.
- This is a measure in the Public Health Outcome Framework.
- This requires input for an Indicator value which is directly age standardised rate per 100,000. Emergency hospital admissions due to falls in people aged 65 and over.
- Please enter provisional outturns for 2022-23 based on local data for admissions for falls from April 2022-March 2023.
- For 2023-24 input planned levels of emergency admissions
- In both cases this should consist of:
    - emergency admissions due to falls for the year for people aged 65 and over (count)
    - estimated local population (people aged 65 and over)
    - rate per 100,000 (indicator value) (Count/population x 100,000)

- The latest available data is for 2021-22 which will be refreshed around Q4.
Further information about this measure and methodolgy used can be found here:
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/22401/age/27/sex/4

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2022-23, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2023-24 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

4. Residential Admissions:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

8. Planning Requirements

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Planning Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2023-2025 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

HM Government

NHS England

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. 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 BCE) 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.

Health and Wellbeing Board:	Peterborough	
Completed by:	Caroline Townsend	
E-mail:	caroline.townsend@peterborough.gov.uk	
Contact number:	7976832188	
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No	
If no please indicate when the HWB is expected to sign off the plan:	Fri 21/07/2023	<< Please enter using the format, DD/MM/YYYY

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	John	Howard	john.howard@peterborough.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Jan	Thomas	jan.thomas@nhs.net
	Additional ICB(s) contacts if relevant		John	O'Brien	john.obrien5@nhs.net
	Local Authority Chief Executive		Matthew	Gladstone	matthew.gladstone@peterborough.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Stephen	Taylor	stephen.taylor@peterborough.gov.uk
	Better Care Fund Lead Official		Oliver	Hayward	oliver.hayward@peterborough.gov.uk
	LA Section 151 Officer		Cecilie	Booth	cecilie.booth@peterborough.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->					

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

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Capacity&Demand	Yes
5. Income	Yes
6a. Expenditure	No
7. Metrics	Yes
8. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: Peterborough

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£2,236,384	£2,236,384	£2,236,384	£2,236,384	£0
Minimum NHS Contribution	£15,328,424	£16,196,013	£15,328,424	£16,196,013	£0
iBCF	£7,479,861	£7,479,861	£7,479,861	£7,479,861	£0
Additional LA Contribution	£0	£0	£0	£0	£0
Additional ICB Contribution	£1,077,287	£1,077,287	£1,077,287	£1,077,287	£0
Local Authority Discharge Funding	£1,048,665	£1,747,076	£1,048,665	£1,747,076	£0
ICB Discharge Funding	£1,146,287	£1,891,239	£1,146,287	£1,891,239	£0
Total	**£28,316,908**	**£30,627,860**	**£28,316,908**	**£30,627,860**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£4,242,998	£4,483,152
Planned spend	£6,164,584	£6,522,201

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£9,010,102	£9,520,074
Planned spend	£9,010,103	£9,520,075

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	185.1	161.7	195.3	171.3

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,575.4	1,559.0
	Count	491	486
	Population	30796	30796

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	92.3%	92.7%	92.6%	92.2%

Residential Admissions

		2021-22 Actual	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	462	630

Reablement

6

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	81.0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: Peterborough

Guidance on completing this sheet is set out below, but should be read in conjunction with the guidance in the BCF planning requirements

3.1 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.
Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template aligns tothe pathways in the hospital discharge policy, but separates Pathway 1 (discharge home with new or additional support) into separate estimates of reablement, rehabilitation and short term domiciliary care)

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.
The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.
Estimated levels of discharge should draw on:
- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

You should enter the estimated number of discharges requiring each type of support for each month.

3.2 Demand - Community

This section collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.
Further detail on definitions is provided in Appendix 2 of the Planning Requirements.
The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:
- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.
You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 7 types of service:
- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

Virtual wards should not form part of capacity and demand plans because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, pease select the relevant trust from the list. Further guidance on all sections is available in Appendix 2 of the BCF Planning Requirements.

Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	Below figures are based on modeled Acute demand data in22/23 and reported community demand. VCS services are commissioned across several organisations for different types of services, Pathway 0 has been reported for the main providers who identiy discharge data. Percentage responsiblity only relates to funding to support discharge. In most line community demand matched capacity as services are delivered by much larger multiskilled teams. A business case for additional home-based rehabilitation is being worked through.

Complete:	
3.1	Yes
3.2	Yes
3.3	Yes
3.4	Yes

3.1 Demand - Hospital Discharge

!!Click on the filter box below to select Trust first!!
Trust Referral Source (Select as many as you need)

Demand - Hospital Discharge													
Trust Referral Source	Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Social support (including VCS) (pathway 0)	0	0	0	0	0	0	0	0	0	0	0	0
NORTH WEST ANGLIA NHS FOUNDATION TRUST		71	86	72	63	62	73	73	94	73	78	51	83
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Reablement at home (pathway 1)	13	22	15	14	15	16	15	13	14	18	21	21
NORTH WEST ANGLIA NHS FOUNDATION TRUST		30	51	35	32	35	36	35	30	33	42	50	50
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Rehabilitation at home (pathway 1)	36	35	22	23	30	31	27	35	28	20	33	24
NORTH WEST ANGLIA NHS FOUNDATION TRUST		86	78	66	70	73	75	76	78	77	72	69	69
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Short term domiciliary care (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0
NORTH WEST ANGLIA NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Reablement in a bedded setting (pathway 2)	0	0	0	0	0	0	0	0	0	0	0	0
NORTH WEST ANGLIA NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Rehabilitation in a bedded setting (pathway 2)	33	32	29	32	30	31	25	30	30	30	30	30
NORTH WEST ANGLIA NHS FOUNDATION TRUST		18	17	16	17	18	17	14	16	16	16	16	16
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Short-term residential/nursing care for someone likely to require a longer-term care home placement	0	0	0	0	0	0	0	0	0	0	0	0
NORTH WEST ANGLIA NHS FOUNDATION TRUST	(pathway 3)	43	56	51	63	62	64	54	62	54	51	48	72
Totals	Total:	330	377	306	314	323	343	319	358	325	327	318	365

3.2 Demand - Community

Demand - Intermediate Care												
Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0	0	0
Urgent Community Response	268	273	273	289	291	285	366	370	374	376	315	335
Reablement at home	31	36	34	40	39	27	32	50	33	47	52	33
Rehabilitation at home	239	253	255	279	268	272	295	311	329	313	296	309
Reablement in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation in a bedded setting	4	4	2	0	2	1	1	3	2	1	0	3
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge														Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	71	86	72	63	62	73	73	94	73	78	51	83	29%	65%	6%
Reablement at Home	Monthly capacity. Number of new clients.	65	69	65	69	65	68	69	65	69	69	56	69	0%	100%	0%
Rehabilitation at home	Monthly capacity. Number of new clients.	68	68	68	68	68	68	68	68	68	68	68	68	100%	0%	0%
Short term domiciliary care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%
Reablement in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	45	46	44	46	46	45	46	47	48	48	44	48	100%	0%	0%
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	43	56	51	63	62	64	54	62	54	51	48	72	21%	79%	0%

3.4 Capacity - Community

Capacity - Community														Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%
Urgent Community Response	Monthly capacity. Number of new clients.	366	371	399	390	345	348	369	379	382	370	343	360	94%	6%	0%
Reablement at Home	Monthly capacity. Number of new clients.	31	36	34	45	39	27	32	50	33	47	52	33	0%	100%	0%
Rehabilitation at home	Monthly capacity. Number of new clients.	239	253	255	279	268	272	295	311	329	313	296	309	100%	0%	0%
Reablement in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	4	4	2	0	2	1	1	3	2	1	0	3	100%	0%	0%
Other short-term social care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Peterborough

Local Authority Contribution		
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2
Peterborough	£2,236,384	£2,236,384
DFG breakdown for two-tier areas only (where applicable)		
Total Minimum LA Contribution (exc iBCF)	**£2,236,384**	**£2,236,384**

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2
Peterborough	£1,048,665	£1,747,076

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2
NHS Cambridgeshire and Peterborough ICB	£1,146,287	£1,891,239
Total ICB Discharge Fund Contribution	£1,146,287	£1,891,239

iBCF Contribution	Contribution Yr 1	Contribution Yr 2
Peterborough	£7,479,861	£7,479,861
Total iBCF Contribution	**£7,479,861**	**£7,479,861**

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	No

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	**£0**	

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS Cambridgeshire and Peterborough ICB	£15,328,424	£16,196,013
Total NHS Minimum Contribution	**£15,328,424**	**£16,196,013**

Are any additional ICB Contributions being made in 2023-25? If yes, please detail below	Yes

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding
NHS Cambridgeshire and Peterborough ICB	£1,077,287	£1,077,287	commissioned services meeting BCF requirements
Total Additional NHS Contribution	**£1,077,287**	**£1,077,287**	
Total NHS Contribution	**£16,405,711**	**£17,273,300**	

	2023-24	2024-25
Total BCF Pooled Budget	**£28,316,908**	**£30,627,860**

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

ICB proposals against the Additional Discharge Fund are under development and will be allocated once assured meets Cambridgeshire and Peterborough principles and priority areas.

6

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Peterborough

<< Link to summary sheet

Running Balances	2023-24 Income	2023-24 Expenditure	2023-24 Balance	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£2,236,384	£2,236,384	£0	£2,236,384	£2,236,384	£0
Minimum NHS Contribution	£15,328,424	£15,328,424	£0	£16,196,013	£16,196,013	£0
iBCF	£7,479,861	£7,479,861	£0	£7,479,861	£7,479,861	£0
Additional LA Contribution	£0	£0	£0	£0	£0	£0
Additional NHS Contribution	£1,077,287	£1,077,287	£0	£1,077,287	£1,077,287	£0
Local Authority Discharge Funding	£1,048,665	£1,048,665	£0	£1,747,076	£1,747,076	£0
ICB Discharge Funding	£1,146,287	£1,146,287		£1,891,239	£1,891,239	£0
Total	**£28,316,908**	**£28,316,908**	**£0**	**£30,627,860**	**£30,627,860**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2023-24 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£4,242,998	£6,164,584	£0	£4,483,152	£6,522,201	£0
Adult Social Care services spend from the minimum ICB allocations	£9,010,102	£9,010,103	£0	£9,520,074	£9,520,075	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

>> Incomplete fields on row number(s):

58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93,

										Planned Expenditure										
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Expected outputs 2023-24	Expected outputs 2024-25	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
1	Integrated Neighbourhood Teams	Integrated Neighbourhood Teams	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£5,645,011	£5,645,013	11%
2	Carers Support	Carers Prescription Service	Carers Services	Other	Carers support	96	96	Beneficiaries	Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£65,581	£65,581	3%
3	Discharge Support	Help at Home and Admission Avoidance	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess					Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£13,697	£13,697	0%
4	Community Equipment	Integrated Community Equipment	Assistive Technologies and Equipment	Community based equipment		4550	4595	Number of beneficiaries	Community Health		Joint	65.0%	35.0%	Private Sector	Minimum NHS Contribution	Existing	£439,249	£439,249	12%
5	Community Equipment	Integrated Community Equipment	Assistive Technologies and Equipment	Community based equipment		3430	3465	Number of beneficiaries	Community Health		Joint	65.0%	35.0%	Private Sector	Additional NHS Contribution	Existing	£327,287	£327,287	9%
6	Healthcare at Home	Community IV antibiotic service to facilitate early discharge	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess					Community Health		NHS			Private Sector	Additional NHS Contribution	Existing	£750,000	£750,000	1%
7	Place based support	Support for HIU's in the community	Other						Primary Care		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	New	£154,783	£154,783	15%
8	Section 256 agreement: Care Placement Spend	Spend on care placement costs	Home Care or Domiciliary Care	Domiciliary care packages		235079	264585	Hours of care	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£4,223,453	£4,733,425	5%

9	Protecting adult social care services	Social work teams, including discharge planning team, review teams, adult early	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£3,166,650	£3,166,650	15%
10	Reducing DTOCs/ 7 day serices	Reablement teams and reablement flats	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		138	138	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£250,000	£250,000	1%
11	Person centred care	Technology Enabled Care / Assistive Technology	Assistive Technologies and Equipment	Assistive technologies including telecare		238	238	Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£100,000	£100,000	2%
12	Ageing Healthily and Prevention	Quality Improvement and Quality Assurance	Care Act Implementation Related Duties	Safeguarding					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£625,000	£625,000	63%
13	Care Act Implementation / Enhanced Offer	Ensuring compliance with statutory duties under the Care Act	Carers Services	Carer advice and support related to Care Act duties		1365	1365	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£407,000	£407,000	16%
14	Carers Support	Support and Respite	Carers Services	Carer advice and support related to Care Act duties		241	241	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£75,000	£75,000	3%
15	Further expansion of Enhanced Response Service	Social care urgent community response	Urgent Community Response						Social Care		LA			Local Authority	Minimum NHS Contribution	New	£80,000	£80,000	1%
16	Care Home Support Team	Support to care homes	Other						Social Care		LA			Local Authority	Minimum NHS Contribution	New	£83,000	£83,000	100%
17	Disabled Facilities Grant	Housing adaptations	DFG Related Schemes	Adaptations, including statutory DFG grants		197	197	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG	Existing	£2,236,384	£2,236,384	100%
18	Investment in Adult Social Care and Social Work	Care placement spend	Residential Placements	Care home		6	6	Number of beds/Placements	Social Care		LA			Local Authority	iBCF	Existing	£306,276	£306,276	0%
19	Falls Prevention	Falls Prevention programmes	Prevention / Early Intervention	Other	Falls				Social Care		LA			NHS Community Provider	iBCF	Existing	£30,000	£30,000	100%
20	Costed plan to support Discharge	capacity to support discharge flow	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Local Authority	iBCF	Existing	£753,190	£753,190	7%
21	Protection of adult social care	Care Placement spend	Residential Placements	Care home		108	108	Number of beds/Placements	Social Care		LA			Local Authority	iBCF	Existing	£5,483,734	£5,483,734	0%
22	Nursing home capacity	nursing home capacity	Residential Placements	Nursing home		18	18	Number of beds/Placements	Social Care		LA			Local Authority	iBCF	Existing	£793,661	£793,661	0%
23	Enhanced Response Service	Social care urgent community response	Urgent Community Response						Social Care		LA			Local Authority	iBCF	New	£113,000	£113,000	1%
25	Pathway 1 - Home First	Additional capacity for Pathway 1 discharges	Home-based intermediate care services	Rehabilitation at home (accepting step up and step down users)		50	0	Packages	Community Health		NHS			NHS Community Provider	ICB Discharge Funding	New	£886,287	£0	2%
26	Integrated Care Planning	NWFT support for discharge planning - OOA	Integrated Care Planning and Navigation	Care navigation and planning					Acute		NHS			NHS Acute Provider	ICB Discharge Funding	New	£100,000	£0	0%
27	Assistive Technology - levelling up	Upskilling workforce and earlier equipment provision	Assistive Technologies and Equipment	Assistive technologies including telecare		72	0	Number of beneficiaries	Social Care		NHS			Local Authority	ICB Discharge Funding	New	£160,000	£0	3%
28	Pathway 2 - Delirium	Additional bed capacity for Pathway 2 deliruim	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		0	35	Number of Placements	Community Health		NHS			Private Sector	ICB Discharge Funding	New	£0	£884,000	4%
29	Discharge support	Schemes to be confimred - to align with ICB discharge pathway pressures	Integrated Care Planning and Navigation	Other	Schemes to support discharge				Community Health		NHS			NHS Community Provider	ICB Discharge Funding	New	£0	£1,007,239	2%
30	Discretionary Housing Grants	Small grants to support discharge	Housing Related Schemes						Social Care		LA			Local Authority	Local Authority Discharge	Existing	£20,000	£20,000	100%
31	Additional Reablement Capacity	Additional capacity to support discharge	Home-based intermediate care services	Reablement at home (to support discharge)		204	289	Packages	Social Care		LA			Local Authority	Local Authority Discharge	Existing	£376,365	£533,307	2%
32	Workforce recruitment and retention	Focused recruitment and retention schemes	Workforce recruitment and retention						Social Care		LA			Local Authority	Local Authority Discharge	New	£49,000	£49,000	100%
33	Social care discharge capacity	additional social worker discharge capacity to support patient flow	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	Local Authority Discharge	Existing	£286,072	£307,466	3%
34	Administration	administration support for oversight of LA discharge funding	Other						Social Care		LA			Local Authority	Local Authority Discharge	Existing	£10,487	£17,471	100%
35	Discharge commissioner	Commissioning capacity to support capacity and demand	Enablers for Integration	Joint commissioning infrastructure					Social Care		LA			Local Authority	Local Authority Discharge	New	£47,958	£59,277	3%

36	Brokerage capacity	additional brokerage capacity to support discharge flow	High Impact Change Model for Managing Transfer of Care	Flexible working patterns (including 7 day working)					Social Care		LA			Local Authority	Local Authority Discharge	Existing	£85,940	£94,592	1%
37	rapid discharge incentive scheme	incentive scheme to care homes and home care providers to support rapid	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes					Social Care		LA			Local Authority	Local Authority Discharge	Existing	£114,400	£114,400	1%
38	Market and workforce capacity	Ensuring workforce and market capacity to support home first	High Impact Change Model for Managing Transfer of Care	Monitoring and responding to system demand and capacity					Social Care		LA			Local Authority	Local Authority Discharge	New	£58,443	£551,563	3%
39	Place based support	Schemes to support place based support	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS	Minimum NHS Contribution	New	£0	£357,615	0%

Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.

12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care and Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed Based Intermediate Care Services	Number of placements
Home Based Intermeditate Care Services	Packages
Residential Placements	Number of beds/placements
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Peterborough

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	198.8	176.2	217.4	203.0	Comparing 21/22 rate of 882.34 and 22/23 rate of 781.25, a reduction of 101.09 was 53.75 above plan. The plan for 23/24 has been set to continue the trend taking into consideration fluctuation in Q3 setting a yearly target average rate of 713.4.	Embeding Call Before Convey service and further develoment of UCR services to reduce admissions. Increased use of virtual wards. PHM initiative for prevention having a positive impact (CVD, Diabetes,Asthma)
	Number of Admissions	396	351	433	-		
	Population	202,626	202,626	202,626	202,626		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Indicator value	185.1	161.7	195.3	171.3		

>> link to NHS Digital webpage (for more detailed guidance)

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,865.1	1,575.4	1,559.0	PCC benchmarks significantly lower than the national average for falls admissions per 100,000 population of over 65s. It benchmarks in line with the national average for hip fractures for over 65s. The current system focus is on reducing hip fractures, as this is the relevant health outcome.	Fall strategy sets out ambition to to reduce hip fractures by 1% across the local system. The IBCF currently contributes £30,000 to falls prevention work. Delivers strength and balance training and multi-factorial falls assessments. UCR services across health and social care, including 111 call before you convey, crisis
	Count	585	491	486		
	Population	30,796	30796	30796		

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Percentage of people, resident in the HWB, who are	Quarter (%)	92.2%	92.8%	92.3%	92.1%	The acutal average rate for 22/23 was 92.1%, equal to plan. Taking into consideration historical trends and variation, an improving ambition has been	Use of Additional Discharge Fund to support Pathway 1- Home First initiatives. Increasing market capacity for Home based care
	Numerator	3,618	3,727	3,787	3,605		
	Denominator	3,926	4,018	4,105	3,914		

discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan	variation, an improving ambition has been set for 23/24 at an average of 92.4% people discharged to usual place of residence.	care.
	Quarter (%)	92.3%	92.7%	92.6%	92.2%		
	Numerator	3,614	3,600	3,567	3,522		
	Denominator	3,916	3,884	3,853	3,821		

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	462.4	464.9	631.4	629.9	There was significant increased demand for residential care for older people during 2022/23, which is largely being driven by co-morbidity of dementia and physical frailty. This should be seen alongside the increase in the average number of hours of home	Review of carers strategy and increasing support for carers, preventing carer breakdown and people tipping into residential care. Integrated neighbourhoods and focus on community based prevention and early
	Numerator	141	148	201	205		
	Denominator	30,493	31,833	31,833	32,544		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	74.1%	74.0%	80.9%	81.0%	Improved performance delivered in 22/23 following the pandemic where we saw dipped performance. Approach is to embed and maintain this continued level of performance to ensure sustained outcomes delivered. We believe this is a stretch	Significant investment in reablement and intermediate care from BCF, including additional capacity through discharge funding. Aligned discharge to assess pathway 1 offer. TOCH being implemented to
	Numerator	83	71	76	81		
	Denominator	112	96	94	100		

Please note that due to the demerging of Cumbria information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- Actuals and plans for Cumberland and Westmorland and Furness are using the Cumbria combined figure for all metrics since a split was not available; Please use comments box to advise.
- 2022-23 and 2023-24 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2021-22 estimates.

	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	PR1	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated approval? *Paragraph 11* Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? *Paragraph 11* Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned? Have all elements of the Planning template been completed? *Paragraph 12*	Expenditure plan Expenditure plan Narrative plan Validation of submitted plans Expenditure plan, narrative plan	Yes	HWB chairs have reviewed the plan, but full approval will be sought at the formal joint HWB/ICP board on the 21/7/23 as stated on expenditure plan. Narrative plan, Pages 2, 3.		
	PR2	**A clear narrative for the integration of health, social care and housing**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integration of health, social care and housing services including DFG to support further improvement of outcomes for people with care and support needs *Paragraph 13* • The approach to joint commissioning *Paragraph 13* • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered *Paragraph 14* - Changes to local priorities related to health inequality and equality and how activities in the document will address these. *Paragraph 14* The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5. *Paragraph 15*	Narrative plan	Yes	Narrative plan. Joint approach to health social care and housing and joint commissioning - pages 5-13, 31 and 32. Health inequalities - pages 33-39		
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? *Paragraph 33* • Does the narrative set out a strategic approach to using housing support, including DFG funding that supports independence at home? *Paragraph 33* • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils? *Paragraph 34*	Expenditure plan Narrative plan Expenditure plan	Yes	Narrative plan - pages 31-32. Expenditure plan		

NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	**PR4**	**A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home**	Does the plan include an approach to support improvement against BCF objective 1? *Paragraph 16* Does the expenditure plan detail how expenditure from BCF sources supports prevention and improvement against this objective? *Paragraph 19* Does the narrative plan provide an overview of how overall spend supports improvement against this objective? *Paragraph 19* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objctive and has the narrative plan incorporated learnings from this exercise? *Paragraph 66*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan	Yes	Narrative plan - pages 9-16.		
Additional discharge funding	**PR5**	**An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.**	Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? *Paragraph 41* Does the plan indicate how the area has used the discharge funding, particularly in the relation to National Condition 3 (see below), and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvement for patients? *Paragraph 41* Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the workforce capacity needed for additional services? *Paragraph 44* Has the area been identified as an area of concern in relation to discharge performance, relating to the 'Delivery plan for recovering urgent and emergency services'? If so, have their plans adhered to the additional conditions placed on them relating to performance improvement? *Paragraph 51* Is the plan for spending the additonal discharge grant in line with grant conditions?	Expenditure plan Narrative and Expenditure plans Narrative plan Narrative and Expenditure plans	Yes	Narrative plan - pages 19-28		
NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	**PR6**	**A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**	Does the plan include an approach to how services the area commissions will support people to receive the right care in the right place at the right time? *Paragraph 21* Does the expenditure plan detail how expenditure from BCF sources supports improvement against this objective? *Paragraph 22* Does the narrative plan provide an overview of how overall spend supports improvement against this metric and how estimates of capacity and demand have been taken on board (including gaps) and reflected in the wider BCF plans? *Paragraph 24* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objective and has the narrative plan incorporated learnings from this exercise? *Paragraph 66* Has the area reviewed their assessment of progress against the High Impact Change Model for Managing Transfers of care and summarised progress against areas for improvement identified in 2022-23? *Paragraph 23*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan Expenditure plan Narrative plan	Yes	Narrative plan - pages 19-28. Expenditure plan.		

NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	**PR7**	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift to the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? *Paragraphs 52-55*	Auto-validated on the expenditure plan	Yes	As per expenditure plan		
Agreed expenditure plan for all elements of the BCF	**PR8**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Do expenditure plans for each element of the BCF pool match the funding inputs? *Paragraph 12* Has the area included estimated amounts of activity that will be delivered, funded through BCF funded schemes, and outlined the metrics that these schemes support? *Paragraph 12* Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? *Paragraph 73* Is there confirmation that the use of grant funding is in line with the relevant grant conditions? *Paragraphs 25 – 51* Has an agreed amount from the ICB allocation(s) of discharge funding been agreed and entered into the income sheet? *Paragraph 41* Has the area included a description of how they will work with services and use BCF funding to support unpaid carers? *Paragraph 13* Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement? *Paragraph 12*	Auto-validated in the expenditure plan Expenditure plan Expenditure plan Expenditure plan Expenditure plan Narrative plans, expenditure plan Expenditure plan	Yes	as per expenditure plan Carers - narrative plan, pages 28-30 Care Act Implementation - narrative plan, pages 27-28		
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Have stretching ambitions been agreed locally for all BCF metrics based on: - current performance (from locally derived and published data) - local priorities, expected demand and capacity - planned (particularly BCF funded) services and changes to locally delivered services based on performance to date? *Paragraph 59* Is there a clear narrative for each metric setting out: - supporting rationales for the ambition set, - plans for achieving these ambitions, and - how BCF funded services will support this? *Paragraph 57*	Expenditure plan Expenditure plan	Yes	Expenditure plan rationale - metrics tab.		

BCF Planning Template 2023-25

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).
3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with the word 'no', should be completed before sending to the Better Care Fund Team.
4. The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'.

5. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
6. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
7. Please ensure that all boxes on the checklist are green before submission.
8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority.

4. Capacity and Demand

Please see the guidance on the Capacity&Demand tab for further information on how to complete this section.

5. Income

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2023-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations and allocations of ASC Discharge Fund grant to local authorities for 2023-24. The iBCF grant in 2024-25 is expected to remain at the same value nationally as in 2023-24, but local allocations are not published. You should enter the 2023-24 value into the income field for the iBCF in 2024-25 and agree provisional plans for its use as part of your BCF plan

2. The grant determination for the Disabled Facilities Grant (DFG) for 2023-24 will be issued in May. Allocations have not been published so are not pre populated in the template. You will need to manually enter these allocations. Further advice will be provided by the BCF Team.

3. Areas will need to input the amount of ASC Discharge Fund paid to ICBs that will be allocated to the HWB's BCF pool. These will be checked against a separate ICB return to ensure they reconcile. Allocations of the ASC discharge funding grant to local authority will need to be inputted manually for Year 2 as allocations at local level are not confirmed. Areas should input an expected allocation based on the published national allocation (£500m in 2024-25, increased from £300m in 2023-24) and agree provisional plans for 2024-25 based on this.

4. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

5. Please use the comment boxes alongside to add any specific detail around this additional contribution.

6. If you are pooling any funding carried over from 2022-23 (**i.e. underspends from BCF mandatory contributions**) you should show these as additional contributions, but on a separate line to any other additional contributions. Use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

7. Allocations of the NHS minimum contribution are shown as allocations from each ICB to the HWB area in question. Where more than one ICB contributes to the area's BCF plan, the minimum contribution from each ICB to the local BCF plan will be displayed.

8. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

6. Expenditure

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, units, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Condition 4 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 6b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Expected outputs
- You will need to set out the expected number of outputs you expect to be delivered in 2023-24 and 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.
- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.
- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be found in tab 6b. Expenditure Guidance.

You do not need to fill out these columns for certain scheme types. Where this is the case, the cells will turn blue and the column will remain empty.

6. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "NHS minimum" then the planned spend would count towards eligible expenditure on social care under National Condition 4.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

7. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend on NHS commissioned out of hospital services under National Condition 4. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

8. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

9. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

10. Expenditure (£) 2023-24 & 2024-25:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

11. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

12. Percentage of overall spend. This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This is a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance. This estimate should be based on expected spend in that category in the BCF over both years of the programme divided by both years total spend in that same category in the system.

7. Metrics

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2023-25. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2023-24.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2023-24. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2021)
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Please use the ISR Tool published on the BCX where you can input your assumptions and simply copy the output ISR:
https://future.nhs.uk/bettercareexchange/view?objectId=143133861
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Falls
- This is a new metric for the BCF and areas should agree ambitions for reducing the rate of emergency admissions to hospital for people aged 65 or over following a fall.
- This is a measure in the Public Health Outcome Framework.
- This requires input for an Indicator value which is directly age standardised rate per 100,000. Emergency hospital admissions due to falls in people aged 65 and over.
- Please enter provisional outturns for 2022-23 based on local data for admissions for falls from April 2022-March 2023.
- For 2023-24 input planned levels of emergency admissions
- In both cases this should consist of:
    - emergency admissions due to falls for the year for people aged 65 and over (count)
    - estimated local population (people aged 65 and over)
    - rate per 100,000 (indicator value) (Count/population x 100,000)

- The latest available data is for 2021-22 which will be refreshed around Q4.
Further information about this measure and methodolgy used can be found here:
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/22401/age/27/sex/4

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2022-23, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2023-24 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

4. Residential Admissions:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

8. Planning Requirements

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Planning Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2023-2025 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

HM Government

NHS England

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. 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 BCE) 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.

Health and Wellbeing Board:	Cambridgeshire	
Completed by:	Caroline Townsend	
E-mail:	caroline.townsend@peterborough.gov.uk	
Contact number:	7976832188	
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No	
If no please indicate when the HWB is expected to sign off the plan:	Fri 21/07/2023	<< Please enter using the format, DD/MM/YYYY

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Susan	Van de Ven	susanvandeven5@gmail.com
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Jan	Thomas	jan.thomas@nhs.net
	Additional ICB(s) contacts if relevant		John	O'Brien	john.obrien5@nhs.net
	Local Authority Chief Executive		Stephen	Moir	stephen.moir@cambridgeshire.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Patrick	Warren-Higgs	patrick.warren-higgs@cambridgeshire.gov.
	Better Care Fund Lead Official		Will	Patten	will.patten@cambridgeshire.gov.uk
	LA Section 151 Officer		Michael	Hudson	Michael.hudson@cambrudgeshire.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->					

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

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Capacity&Demand	Yes
5. Income	Yes
6a. Expenditure	No
7. Metrics	Yes
8. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: Cambridgeshire

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£5,069,550	£5,069,550	£5,069,550	£5,069,550	£0
Minimum NHS Contribution	£48,013,079	£50,730,620	£48,013,079	£50,730,620	£0
iBCF	£15,171,304	£15,171,304	£15,171,304	£15,171,304	£0
Additional LA Contribution	£0	£0	£0	£0	£0
Additional ICB Contribution	£3,360,606	£3,360,606	£3,360,606	£3,360,606	£0
Local Authority Discharge Funding	£2,126,993	£3,543,570	£2,126,993	£3,543,570	£0
ICB Discharge Funding	£2,461,969	£5,253,567	£2,461,970	£5,253,567	-£1
Total	**£76,203,502**	**£83,129,217**	**£76,203,502**	**£83,129,217**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£13,749,753	£14,527,989
Planned spend	£27,225,712	£28,810,446

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£20,014,259	£21,147,066
Planned spend	£20,014,259	£21,147,066

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	173.2	172.1	181.1	175.1

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,829.3	1,810.0
	Count	2381	2357
	Population	127606	127606

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	91.3%	91.6%	91.6%	91.4%

Residential Admissions

		2021-22 Actual	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	602	486

Reablement

6

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	77.7%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: Cambridgeshire

Guidance on completing this sheet is set out below, but should be read in conjunction with the guidance in the BCF planning requirements

3.1 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.
Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month.
The template aligns tothe pathways in the hospital discharge policy, but separates Pathway 1 (discharge home with new or additional support) into separate estimates of reablement, rehabiitation and short term domiciliary care)

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.
The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.
Estimated levels of discharge should draw on:
- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

You should enter the estimated number of discharges requiring each type of support for each month.

3.2 Demand - Community

This section collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.
Further detail on definitions is provided in Appendix 2 of the Planning Requirements.
The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:
- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.
You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 7 types of service:
- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

Virtual wards should not form part of capacity and demand plans because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, pease select the relevant trust from the list. Further guidance on all sections is available in Appendix 2 of the BCF Planning Requirements.

Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	Below figures are based on modeled Acute demand data in22/23 and reported community demand. VCS services are commissioned across several organisations for different types of services, Pathway 0 has been reported for the main providers who idenity discharge data. Percentage responsiblity only relates to funding to support discharge. In most line community demand matched capacity as services are delivered by much larger multiskilled teams. A business case for additional home-based rehabilitation is being worked through.

	Complete:
3.1	Yes
3.2	Yes
3.3	Yes
3.4	Yes

3.1 Demand - Hospital Discharge

!!Click on the filter box below to select Trust first!! | Demand - Hospital Discharge

Trust Referral Source (Select as many as you need)	Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Social support (including VCS) (pathway 0)	53	60	55	47	53	43	64	93	68	64	53	62
NORTH WEST ANGLIA NHS FOUNDATION TRUST		17	17	17	17	15	17	16	20	19	19	10	21
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Reablement at home (pathway 1)	194	199	181	188	179	182	193	169	192	217	176	204
NORTH WEST ANGLIA NHS FOUNDATION TRUST		61	63	57	60	56	58	61	54	60	68	55	64
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Rehabilitation at home (pathway 1)	114	111	71	72	93	98	87	110	88	63	104	76
NORTH WEST ANGLIA NHS FOUNDATION TRUST		202	183	155	164	171	175	176	181	178	169	162	162
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Short term domiciliary care (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0
NORTH WEST ANGLIA NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Reablement in a bedded setting (pathway 2)	0	0	0	0	0	0	0	0	0	0	0	0
NORTH WEST ANGLIA NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Rehabilitation in a bedded setting (pathway 2)	76	75	67	74	70	72	60	70	70	70	70	70
NORTH WEST ANGLIA NHS FOUNDATION TRUST		41	40	36	40	38	39	32	38	38	38	38	38
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Short-term residential/nursing care for someone likely to require a longer-term care home placement	128	121	183	206	206	182	190	224	190	155	181	201
NORTH WEST ANGLIA NHS FOUNDATION TRUST	(pathway 3)	12	13	12	12	12	12	12	12	12	12	12	12
Totals	**Total:**	898	882	834	880	893	878	891	971	915	875	861	910

3.2 Demand - Community

Demand - Intermediate Care Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	0	0	0	0	0	0	0	0	0	0	0	0
Urgent Community Response	891	957	1059	1043	857	888	965	1022	1070	1023	894	917
Reablement at home	115	119	115	124	127	89	118	134	104	134	123	110
Rehabilitation at home	557	591	596	652	629	635	688	725	769	731	691	722
Reablement in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation in a bedded setting	1	2	2	0	2	1	3	1	1	1	1	1
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	70	77	72	64	68	60	80	113	87	83	63	83	75%	9%	16%
Reablement at Home	Monthly capacity. Number of new clients.	161	269	161	269	269	161	269	159	269	269	149	269	0%	100%	0%
Rehabilitation at home	Monthly capacity. Number of new clients.	160	166	160	166	166	160	166	162	166	166	150	166	100%	0%	0%
Short term domiciliary care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%
Reablement in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	88	91	23	91	91	92	91	91	94	94	87	94	100%	0%	0%
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	140	134	195	218	218	194	202	236	202	167	193	213	33%	77%	0%

3.4 Capacity - Community

Capacity - Community Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%
Urgent Community Response	Monthly capacity. Number of new clients.	1043	1057	1138	1110	983	990	1052	1079	1088	1055	979	1023	64%	36%	0%
Reablement at Home	Monthly capacity. Number of new clients.	115	119	115	124	127	89	118	134	104	134	123	110	0%	100%	0%
Rehabilitation at home	Monthly capacity. Number of new clients.	557	591	596	652	629	635	688	725	769	731	691	722	100%	0%	
Reablement in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	1	2	2	0	2	1	3	1	1	1	1	1	100%	0%	0%
Other short-term social care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0%	0%	0%

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Cambridgeshire

Local Authority Contribution		
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2
Cambridgeshire	£5,069,550	£5,069,550
DFG breakdown for two-tier areas only (where applicable)		
Cambridge	£847,451	£847,451
East Cambridgeshire	£690,078	£690,078
Fenland	£1,214,776	£1,214,776
Huntingdonshire	£1,492,102	£1,492,102
South Cambridgeshire	£825,144	£825,144
Total Minimum LA Contribution (exc iBCF)	**£5,069,550**	**£5,069,550**

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2
Cambridgeshire	£2,126,993	£3,543,570

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2
NHS Cambridgeshire and Peterborough ICB	£2,461,969	£5,253,567
Total ICB Discharge Fund Contribution	£2,461,969	£5,253,567

iBCF Contribution	Contribution Yr 1	Contribution Yr 2
Cambridgeshire	£15,171,304	£15,171,304
Total iBCF Contribution	**£15,171,304**	**£15,171,304**

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	No

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	**£0**	

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS Cambridgeshire and Peterborough ICB	£48,013,079	£50,730,620
Total NHS Minimum Contribution	**£48,013,079**	**£50,730,620**

Are any additional ICB Contributions being made in 2023-25? If yes, please detail below	Yes

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding
NHS Cambridgeshire and Peterborough ICB	£3,360,606	£3,360,606	Commissioned services meeting BCF requirements
Total Additional NHS Contribution	**£3,360,606**	**£3,360,606**	
Total NHS Contribution	**£51,373,685**	**£54,091,226**	

	2023-24	2024-25
Total BCF Pooled Budget	**£76,203,502**	**£83,129,217**

Funding Contributions Comments Optional for any useful detail e.g. Carry over
ICB proposals against the Additional Discharge Fund are under development and will be allocated once assured meets Cambridgeshire and Peterborough principles and priority areas. A review of BCF funded scheme is planned in 2023/24, the uplift in NHS Minimal Contribution (Health) will be allocated following the review to areas which contribute to BCF metrics.

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Cambridgeshire

<< Link to summary sheet

Running Balances	2023-24 Income	2023-24 Expenditure	2023-24 Balance	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£5,069,550	£5,069,550	£0	£5,069,550	£5,069,550	£0
Minimum NHS Contribution	£48,013,079	£48,013,079	£0	£50,730,620	£50,730,620	£0
iBCF	£15,171,304	£15,171,304	£0	£15,171,304	£15,171,304	£0
Additional LA Contribution	£0	£0	£0	£0	£0	£0
Additional NHS Contribution	£3,360,606	£3,360,606	£0	£3,360,606	£3,360,606	£0
Local Authority Discharge Funding	£2,126,993	£2,126,993	£0	£3,543,570	£3,543,570	£0
ICB Discharge Funding	£2,461,969	£2,461,970		£5,253,567	£5,253,567	£0
Total	**£76,203,502**	**£76,203,502**	**£0**	**£83,129,217**	**£83,129,217**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2023-24 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£13,749,753	£27,225,712	£0	£14,527,989	£28,810,446	£0
Adult Social Care services spend from the minimum ICB allocations	£20,014,259	£20,014,259	£0	£21,147,066	£21,147,066	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

>> Incomplete fields on row number(s):

58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101,

										Planned Expenditure										
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Expected outputs 2023-24	Expected outputs 2024-25	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
1	Promoting Independence	Assistive Technologies & Environmental Controls	Assistive Technologies and Equipment	Assistive technologies including telecare		580	580	Number of beneficiaries	Community Health		NHS			Charity / Voluntary Sector	Additional NHS Contribution	Existing	£125,000	£125,000	12%
2	Intermediate Care and Reablement	Intermediate Care Beds Step down (discharge to assess pathway-2)	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		400	400	Number of Placements	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£4,119,498	£4,119,498	35%
3	Integrated Neighbourhood Teams	Integrated Neighbourhood Teams	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£15,721,599	£15,721,599	30%
4	Carers Support	Carers Prescription service and help at home / home support	Carers Services	Other	Carers support	304	304	Beneficiaries	Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£345,770	£345,770	13%
5	Community Health	Intermediare care workers at home/2 hour crisis response	Home-based intermediate care services	Rehabilitation at home (accepting step up and step down users)		1916	1935	Packages	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£2,506,946	£2,506,946	14%
6	Discharge to Assess	Community beds to support D2A	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement accepting step up and step down users		912	912	Number of Placements	Community Health		NHS			Private Sector	Minimum NHS Contribution	Existing	£2,209,743	£2,209,743	19%

7	Community Equipment	Integrated Community Equipment Store	Assistive Technologies and Equipment	Community based equipment		14700	14850	Number of beneficiaries	Community Health		Joint	51.8%	48.2%	Private Sector	Minimum NHS Contribution	Existing	£1,603,959	£1,603,959	9%
8	Community Equipment	Integrated Community Equipment Store	Assistive Technologies and Equipment	Community based equipment		7850	7930	Number of beneficiaries	Community Health		Joint	51.8%	48.2%	Private Sector	Additional NHS Contribution	Existing	£663,049	£663,049	2%
9	Healthcare at Home	Community IV antibiotic service to facilitate early discharge	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess					Community Health		NHS			Private Sector	Minimum NHS Contribution	Existing	£649,484	£649,484	1%
10	Hospice at Home	Hospice at home service to support home first model and early discharge	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			Charity / Voluntary Sector	Additional NHS Contribution	Existing	£1,995,309	£1,995,309	4%
11	Hunts Forum	Engagement in development of ICS	Enablers for Integration	Voluntary Sector Business Development					Community Health		NHS			Charity / Voluntary Sector	Additional NHS Contribution	Existing	£17,710	£17,710	1%
12	Palliative Care Hub	Specific option for 111 greeting to direct patients/carers	Enablers for Integration	Integrated models of provision					Community Health		NHS			NHS Community Provider	Additional NHS Contribution	Existing	£368,911	£368,911	20%
13	Information and Advice	signposting, information and advice for older people	Integrated Care Planning and Navigation	Care navigation and planning					Community Health		NHS			Charity / Voluntary Sector	Additional NHS Contribution	Existing	£30,540	£30,540	0%
14	Support of Discharge	volunteer visits to support patients/carers on discharge	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess		144	144	Hours of care	Community Health		NHS			Charity / Voluntary Sector	Additional NHS Contribution	Existing	£10,087	£10,087	0%
15	Discharge Support	discharge support and planning with acutes	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Acute		NHS			Charity / Voluntary Sector	Additional NHS Contribution	Existing	£150,000	£150,000	1%
16	Place based support	Support to reduce visits/admission for frequent users	Community Based Schemes	Other	support to address health inequalities				Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	New	£841,821	£841,821	2%
17	Promoting Independence	Prevention and Early Intervention e.g. Technology enabled care, community	Prevention / Early Intervention	Social Prescribing					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,925,000	£1,925,000	96%
18	Intermediate Care and Reablement	Reablement	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		3200	3200	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£8,798,111	£8,798,111	48%
19	Carers Support	Carers Services	Carers Services	Carer advice and support related to Care Act duties		3014	3014	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,584,900	£1,584,900	62%
20	VCS Joint Commissioning	Voluntary Sector Support	Prevention / Early Intervention	Social Prescribing					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£2,060,370	£2,060,370	96%
21	Discharge Planning and DTOC	Discharge Planning Teams	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£997,430	£997,430	9%
22	Protection of Adult Social Care	Delivery of statutory duties of social care including assessment/review teams	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£3,219,192	£3,219,192	15%
23	Social Care Commissioning and Protection	Commissioning	Other						Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£357,131	£357,131	16%
24	Disabled Facilities Grant	Housing Adaptations	DFG Related Schemes	Adaptations, including statutory DFG grants		424	424	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG	Existing	£5,069,550	£5,069,550	100%
25	Social Care Investment and Capacity	Capacity to support delivery of statutory duties	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Social Care		LA			Local Authority	iBCF	Existing	£1,337,427	£1,337,427	6%
26	Costed Plan to support discharge	capacity to support discharge flow	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Local Authority	iBCF	Existing	£2,338,367	£2,338,367	21%
27	Protection of Adult Social Care	Care Placement spend	Residential Placements	Care home		251	251	Number of beds/Placements	Social Care		LA			Local Authority	iBCF	Existing	£9,501,549	£9,501,549	6%
28	Reablement	Additional reablement capacity to support discharge	Home-based intermediate care services	Reablement at home (to support discharge)		200	200	Packages	Social Care		LA			Local Authority	iBCF	Existing	£300,000	£300,000	2%
29	Domiciliary Care	Discharge car capacity	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess		281554	281554	Hours of care	Social Care		LA			Local Authority	iBCF	Existing	£1,693,961	£1,693,961	2%
30	Protection of Adult Social Care - Uplift	Care Placement Spend	Residential Placements	Nursing home		25	51	Number of beds/Placements	Social Care		LA			Local Authority	Minimum NHS Contribution	New	£1,072,125	£2,204,932	1%
31	Pathway 1 - Home First	Additional capacity for Pathway 1 discharges	Home-based intermediate care services	Rehabilitation at home (accepting step up and step down users)		1900	0	Packages	Community Health		NHS			NHS	ICB Discharge Funding	New	£2,461,970	£0	7%
32	Pathway 2 - Delirium	Additional bed capacity for Pathway 2 deliruim	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		0	70	Number of Placements	Community Health		NHS			Private Sector	ICB Discharge Funding	New	£0	£2,455,616	10%

33	Discharge support	Schemes to be confirmed - to align with ICB discharge pathway pressures	Integrated Care Planning and Navigation	Other	supporting discharge priorities				Community Health		NHS			NHS	ICB Discharge Funding	New	£0	£2,797,951	6%
35	Discretionary housing grants	Discretionary small grants to support discharge	Housing Related Schemes						Social Care		LA			Local Authority	Local Authority Discharge	Existing	£86,000	£86,000	100%
36	Social Care Discharge capacity	additional social worker capacity to support discharge	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Social Care		LA			Local Authority	Local Authority Discharge	New	£0	£553,436	1%
37	Discharge Fund administration	administration support for managing discharge funding	Other						Social Care		LA			Local Authority	Local Authority Discharge	Existing	£21,270	£35,436	0%
38	Workforce development	Focused workforce recruitment and retention to support discharge	Workforce recruitment and retention						Social Care		LA			Local Authority	Local Authority Discharge	New	£174,172	£200,000	59%
39	Brokerage Capacity	Additional brokerage capacity to support discharge flow	High Impact Change Model for Managing Transfer of Care	Flexible working patterns (including 7 day working)					Social Care		LA			Local Authority	Local Authority Discharge	Existing	£170,901	£241,446	2%
40	Rapid discharge incentive scheme	Incentive scheme for care home and home care to support rapid discharges	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes					Social Care		LA			Local Authority	Local Authority Discharge	Existing	£1,258,400	£1,258,400	11%
41	Reablement capacity	Workforce retention and recruitment, including winter bonus scheme	Workforce recruitment and retention						Social Care		LA			Local Authority	Local Authority Discharge	Existing	£120,185	£120,185	41%
42	Reablement and occupational therapy capacity	additional capacity to support discharge flow	Home-based intermediate care services	Reablement at home (to support discharge)		120	150	Packages	Social Care		LA			Local Authority	Local Authority Discharge	Existing	£186,752	£206,643	1%
43	Early Discharge Planning	social worker capacity to support early discharge planning	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Social Care		LA			Local Authority	Local Authority Discharge	New	£41,580	£52,391	0%
44	Community equipment	Additional equipment and TEC support for discharge	Assistive Technologies and Equipment	Assistive technologies including telecare		3543	3543	Number of beneficiaries	Social Care		LA			Local Authority	Local Authority Discharge	New	£67,733	£85,344	3%
45	Market and workforce capacity	Ensuring workforce and market capacity to support home first	High Impact Change Model for Managing Transfer of Care	Monitoring and responding to system demand and capacity					Social Care		LA			Local Authority	Local Authority Discharge	New	£0	£704,289	3%
46	Place based support	Schemes to support system priorities	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS	Minimum NHS Contribution	New	£0	£1,584,734	2%

Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.

12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care and Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed Based Intermediate Care Services	Number of placements
Home Based Intermeditate Care Services	Packages
Residential Placements	Number of beds/placements
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Cambridgeshire

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	191.1	181.4	198.5	185.0	Comparing 21/22 rate 797.79 and 22/23 rate 747.75, a reduction of 48.4 was 17.2 above plan. The plan for 23/24 has been set to continue the trend taking into consideration fluctuation in Q3 setting a yearly target rate of 701.7.	Embeding Call Before Convey service and further develoment of UCR services to reduce admissions. Increased use of virtual wards. PHM initiative for prevention having a positive impact (CVD, Diabetes,Asthma)
	Number of Admissions	1,416	1,344	1,471	-		
	Population	653,537	653,537	653,537	653,537		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Indicator value	173.2	172.1	181.1	175.1		

>> link to NHS Digital webpage (for more detailed guidance)

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,027.1	1,829.3	1,810.0	CCC benchmarks in line with the national average for falls admissions per 100,000 population of over 65s and for hip fractures for over 65s. The current system focus is on reducing hip fractures, as this is the relevant health outcome. Current work is set out in the C&P falls strategy.	" Fall strategy sets out ambition to to reduce hip fractures by 1% across the local system. Public health funded falls prevention programmed delivers strength and balance training and multi-factorial falls assessments. UCR services across health and social care,
	Count	2,640	2381	2357		
	Population	127,606	127606	127606		

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Percentage of people, resident in the HWB, who are	Quarter (%)	91.0%	91.3%	91.4%	90.9%	The acutal average rate for 22/23 was 91.2%, 0.3% above plan of 90.9%. Taking into consideration historical trends and variation, an improving ambition has been	Use of Additional Discharge Fund to support Pathway 1- Home First initiatives. Increasing market capacity for Home based care
	Numerator	11,805	11,501	11,427	11,758		
	Denominator	12,973	12,603	12,507	12,930		

discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan	set for 23/24 at an average of 91.5% people discharged to usual place of residence.	
	Quarter (%)	91.3%	91.6%	91.6%	91.4%		
	Numerator	11,325	11,285	11,207	11,105		
	Denominator	12,405	12,320	12,235	12,150		

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	602.4	602.8	487.8	485.7	A hight percentage of new admissions in 2021/22 (79.3%) were due to the rapid deployment of a number of local discharge to assess beds during to the pandemic - 94% of these were open for less than 8 weeks and hence not permanent,	"Review of carers strategy and increasing support for carers, preventing carer breakdown and people tipping into residential care. Integrated neighbourhoods and focus on community based prevention and early
	Numerator	767	792	641	650		
	Denominator	127,322	131,393	131,393	133,820		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	72.5%	72.2%	77.7%	77.7%	Improved performance delivered in 22/23 following the pandemic where we saw dipped performance. Approach is to embed and maintain this continued level of performance to ensure sustained outcomes delivered. We believe this is a stretch	Significant investment in reablement and intermediate care, including additional capacity through discharge funding. Aligned discharge to assess pathway 1. TOCH being implemented to coordinate hospital discharge flow and triage, as well
	Numerator	287	283	306	307		
	Denominator	396	392	394	395		

Please note that due to the demerging of Cumbria information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- Actuals and plans for Cumberland and Westmorland and Furness are using the Cumbria combined figure for all metrics since a split was not available; Please use comments box to advise.
- 2022-23 and 2023-24 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2021-22 estimates.

	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated approval? *Paragraph 11* Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? *Paragraph 11* Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned? Have all elements of the Planning template been completed? *Paragraph 12*	Expenditure plan Expenditure plan Narrative plan Validation of submitted plans Expenditure plan, narrative plan	Yes	HWB chairs have reviewed the plan, but full approval will be sought at the formal joint HWB/ICP board on the 21/7/23 as stated on expenditure plan. Narrative plan, Pages 2, 3.		
	PR2	**A clear narrative for the integration of health, social care and housing**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integration of health, social care and housing services including DFG to support further improvement of outcomes for people with care and support needs *Paragraph 13* • The approach to joint commissioning *Paragraph 13* • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered *Paragraph 14* - Changes to local priorities related to health inequality and equality and how activities in the document will address these. *Paragraph 14* The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5. *Paragraph 15*	Narrative plan	Yes	Narrative plan. Joint approach to health social care and housing and joint commissioning - pages 5-13, 31 and 32. Health inequalities - pages 33-39		
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? *Paragraph 33* • Does the narrative set out a strategic approach to using housing support, including DFG funding that supports independence at home? *Paragraph 33* • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils? *Paragraph 34*	Expenditure plan Narrative plan Expenditure plan	Yes	Narrative plan - pages 31-32. Expenditure plan		
NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	**PR4**	**A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home**	Does the plan include an approach to support improvement against BCF objective 1? *Paragraph 16* Does the expenditure plan detail how expenditure from BCF sources supports prevention and improvement against this objective? *Paragraph 19* Does the narrative plan provide an overview of how overall spend supports improvement against this objective? *Paragraph 19* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objctive and has the narrative plan incorporated learnings from this exercise? *Paragraph 66*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan	Yes	Narrative plan - pages 9-16.		
Additional discharge funding	**PR5**	**An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.**	Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? *Paragraph 41* Does the plan indicate how the area has used the discharge funding, particularly in the relation to National Condition 3 (see below), and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvement for patients? *Paragraph 41* Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the workforce capacity needed for additional services? *Paragraph 44* Has the area been identified as an area of concern in relation to discharge performance, relating to the 'Delivery plan for recovering urgent and emergency services'? If so, have their plans adhered to the additional conditions placed on them relating to performance improvement? *Paragraph 51* Is the plan for spending the additonal discharge grant in line with grant conditions?	Expenditure plan Narrative and Expenditure plans Narrative plan Narrative and Expenditure plans	Yes	Narrative plan - pages 19-28		

NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	**PR6**	**A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**	Does the plan include an approach to how services the area commissions will support people to receive the right care in the right place at the right time? *Paragraph 21* Does the expenditure plan detail how expenditure from BCF sources supports improvement against this objective? *Paragraph 22* Does the narrative plan provide an overview of how overall spend supports improvement against this metric and how estimates of capacity and demand have been taken on board (including gaps) and reflected in the wider BCF plans? *Paragraph 24* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objective and has the narrative plan incorporated learnings from this exercise? *Paragraph 66* Has the area reviewed their assessment of progress against the High Impact Change Model for Managing Transfers of care and summarised progress against areas for improvement identified in 2022-23? *Paragraph 23*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan Expenditure plan Narrative plan	Yes	Narrative plan - pages 19-28. Expenditure plan.		
NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	**PR7**	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift to the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? *Paragraphs 52-55*	Auto-validated on the expenditure plan	Yes	As per expenditure plan		

Agreed expenditure plan for all elements of the BCF	**PR8**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Do expenditure plans for each element of the BCF pool match the funding inputs? *Paragraph 12* Has the area included estimated amounts of activity that will be delivered, funded through BCF funded schemes, and outlined the metrics that these schemes support? *Paragraph 12* Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? *Paragraph 73* Is there confirmation that the use of grant funding is in line with the relevant grant conditions? *Paragraphs 25 – 51* Has an agreed amount from the ICB allocation(s) of discharge funding been agreed and entered into the income sheet? *Paragraph 41* Has the area included a description of how they will work with services and use BCF funding to support unpaid carers? *Paragraph 13* Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement? *Paragraph 12*	Auto-validated in the expenditure plan Expenditure plan Expenditure plan Expenditure plan Expenditure plan Narrative plans, expenditure plan Expenditure plan	Yes	as per expenditure plan Carers - narrative plan, pages 28-30 Care Act Implementation - narrative plan, pages 27-28		
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Have stretching ambitions been agreed locally for all BCF metrics based on: - current performance (from locally derived and published data) - local priorities, expected demand and capacity - planned (particularly BCF funded) services and changes to locally delivered services based on performance to date? *Paragraph 59* Is there a clear narrative for each metric setting out: - supporting rationales for the ambition set, - plans for achieving these ambitions, and - how BCF funded services will support this? *Paragraph 57*	Expenditure plan Expenditure plan	Yes	Expenditure plan rationale - metrics tab.		

Additional ICB Discharge Funding 2023-24 and 2024-25: ICB to HWB allocation template

Guidance

Additional Funding for activity to support discharge from hospital has been provided via ICBs and LAs. This funding must be pooled into local Better Care Fund plans and used in line with the conditions set out in the BCF Planning Requirements.

Half of the Discharge funding has been distributed via ICB allocations. The funding must be pooled into HWB level BCF plans. Allocations to HWB (LA) level have not been set centrally and it is for systems to agree how to distribute this funding at HWB level. The distribution to HWB level should be agreed between the ICB and local authorities.

Agreed contributions from the ICB element of the discharge funding should be included in individual BCF Planning Templates. These HWB allocations will need to be agreed in sufficient time for local BCF plans to be finalised and agreed in time for the 28 June deadline. This template is for ICBs to confirm the distribution of ICB allocated funding across all HWBs within their footprint. ICB finance leads are responsible for ensuring that a completed version of this template is returned for each ICB to england.bettercarefundteam@nhs.net (copied to the Better Care Manager) on 28 June, separately from HWB level plans.

You should ensure that the total sum distributed to HWBs for 2023-24 and 2024-25 from your ICB is equal to the total allocation from the ASC DIscharge Fund.

As with all BCF templates, the information from this template will be shared with national partners, including finance colleagues. ICBs may be asked to report further on the use of this funding during the year.

	Yellow sections indicate required input
ICB name	NHS Cambridgeshire and Peterborough ICB

	2023-24	2024-25
Total allocation	£3,668,797.16	£7,273,990.71

Name of person completing this form	Sandra Pedley

HWB	2023-24 Funding	2024-25 Funding
Cambridgeshire	£2,461,969.66	£5,253,567.05
Hertfordshire	£60,540.24	£129,186.08
Peterborough	£1,146,287.26	£1,891,237.58
Total (Must equal allocation)	£3,668,797.16	£7,273,990.71

Cambridgeshire and Peterborough Health and Wellbeing Board and Integrated Care Board Agenda Plan

Notes

The definition of a key decision is set out in the Council's Constitution in Part 2, Article 12.
* indicates items expected to be recommended for determination by full Council.
+ indicates items expected to be confidential, which would exclude the press and public.

The following are standing agenda items which are considered at every Board meeting:

- Apologies for absence and declarations of interest
- Minutes of previous meeting and Action Log
- Forward Agenda Plan

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
20 October 2023	*ICS Estate Strategy Next Steps	Kit Connick			
	HWB Integrated Care Priority Update (two chapters scheduled TBC)				
19 January 2024	HWB Integrated Care Priority Update (chapter TBC)				
	Director of Public Health Annual Report 2023/24	Jyoti Atri			
22 March 2024	Content to be agreed				

Please contact Democratic Services democraticservices@cambridgeshire.gov.uk if you require this information in a more accessible format