ADULTS AND HEALTH

Thursday, 13 January 2022

10:00

Democratic and Members' Services
Fiona McMillan
Monitoring Officer

New Shire Hall
Alconbury Weald
Huntingdon
PE28 4YE

Multi Function Room, New Shire Hall, Alconbury Weald, Huntingdon PE28 4YE
[Venue Address]

AGENDA

Open to Public and Press by appointment only

CONSTITUTIONAL MATTERS

1.	**Apologies for absence and declarations of interest** *Guidance on declaring interests is available at* http://tinyurl.com/ccc-conduct-code	
2.	**Adults and Health Committee Minutes - 9 December 2021**	**5 - 26**
3.	**Petitions and Public Questions**	

STRATEGIC ISSUES

4.	**COVID-19 Update**	**27 - 30**
5.	**Integrated Care System (ICS) - Cambridgeshire County Council position paper**	**31 - 54**

KEY DECISIONS

6.	**Adult Market Pressure Payments**	**55 - 68**
7.	**Adult Social Care Retention Payments**	**69 - 76**

INFORMATION AND MONITORING

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BREAK

HEALTH SCRUTINY

9.	**Neuro-Rehabilitation Consultation** To follow	
10.	**Integrated Care System for Cambridgeshire and Peterborough**	**95 - 106**

Date of Next Meeting

17 March 2022

Attending meetings and COVID-19

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The Adults and Health comprises the following members:

Councillor Richard Howitt (Chair) Councillor Susan van de Ven (Vice-Chair) Councillor David Ambrose Smith Councillor Gerri Bird Councillor Chris Boden Councillor Steve Corney Councillor Adela Costello Councillor Claire Daunton Councillor Nick Gay Councillor Anne Hay Councillor Mark Howell Councillor Edna Murphy Councillor Kevin Reynolds Councillor Philippa Slatter and Councillor Graham Wilson Councillor Sam Clark (Appointee) Councillor Lis Every (Appointee) Councillor Corinne Garvie (Appointee) Councillor Jenny Gawthorpe Wood (Appointee) Councillor Sarah Wilson (Appointee)

Clerk Name:	Tamar Oviatt-Ham
Clerk Telephone:	01223 715668
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Adults and Health Committee Minutes

Date: Thursday 9 December 2021

Time: 10.00 am – 16.00 pm

Venue: New Shire Hall, Alconbury Weald, PE28 4XA

Present: Councillors David Ambrose Smith, Chris Boden, Sam Clark (Appointee, Part 2 only), Steve Corney, Adela Costello, Claire Daunton, Lis Every (Appointee, Part 2 only), Anna Garvie (Appointee, Part 2 only), Jenny Gawthorpe Wood (Appointee, Part 2 only), Nick Gay, Bryony Goodliffe, Anne Hay, Mark Howell, Richard Howitt (Chair), Edna Murphy, Kevin Reynolds, Philippa Slatter, Susan van de Ven (Vice-Chair), Graham Wilson and Sarah Wilson (Appointee, Part 2 only)

Part 1 – 10.00am – 13.00pm

42. Apologies for Absence and Declarations of Interest

Apologies were received from Councillor Gerri Bird, substituted by Councillor Bryony Goodliffe.

Councillor Graham Wilson declared an interest in item 4 as his wife worked at a COVID vaccination centre.

Councillor Howell declared an interest in item 7, as he was a friend of the presenting officer. However he stated this would not impact his decision making or scrutiny.

The Chair congratulated Charlotte Black on her new role as Interim Executive Director: People and Communities which she would be stepping into in January 2022 following Wendi Ogle Welbourn's retirement. The Chair thanked Wendi for her service. Debbie McQuade Assistant Director will be covering Charlotte's role for the 6 month period.

The Chair announced that an urgent decision had been added to the Committee agenda, which was circulated to the Committee the day before the meeting via email and published on the Council's website. The Chair explained that the decision was in relation to the 'Allocation of Infection Control, Rapid Testing, Vaccination and Workforce Recruitment and Retention Funding' in response to the COVID-19 Pandemic. He clarified that the Constitution allowed an urgent item to be added to an agenda which had been published if it met the urgency criteria set out in Part 4 – Rules of Procedure, Part 4.4(a) – The Procedure for Taking Urgent Decisions. As the Chair of the Committee he had received an explanation as to why this decision was urgent. Firstly, the Council needed to be able to respond quickly where failure to do so would not be in the public interest. Secondly, the procedure for taking urgent decisions was being used because failure to take the decision quickly would, or would be likely to, harm the interests of the Council and the public. In this case the grounds were a service not being provided and the public being put at serious risk of

harm. He explained that he had authorised the inclusion of the urgent report so that Members of the committee could take the decision. He explained that the report would be taken before item 9 on the agenda.

43. Minutes – 14 October 2021 and Action Log

The minutes of the Adults and Health Committee meeting held on 14 October 2021 were agreed as a correct record and signed by the Chair. The action log was noted.

44. Petitions and Public Questions

There were no petitions or public questions.

45. Update on Enhanced Response Area Status

The Committee received a report that gave an update on the Enhanced response area status in Cambridgeshire.

In particular, the Director of Public Health highlighted:

- Enhanced response area status was granted to Cambridgeshire for five weeks from 1 November 2021 after rates of Covid-19 in schools were measured higher than the East of England average; high levels of hospitalisation in North West Anglia Foundation Trust Hospitals; pressures in hospital staffing capacity; and low vaccination uptake.

- Enhanced response area status had been extended until 24 December 2021

- Schools had benefited from the interventions including local contact testing and Lateral Flow Testing in Primary Schools.

- It would be difficult to measure the impact on infection rates due to fluctuations in infection rates. The impact of the surge rapid response team on vaccination uptake will also be difficult to measure as omicron variant announcements had led to a surge in vaccine uptake.

- Infections were highest in the younger population with the current rates in the over 60's under 150 per 100,000.

- The delta variant was currently still the predominant variant circulating in Cambridgeshire but omicron doubling every two to three days and there was a difficult period ahead.

Individual Members raised the following points in relation to the report:

- Highlighted that Cambridgeshire was the only authority that had enhanced response status and the only authority to have had their ERA status extended and thanked the Director of Public Health for ensuring that the authority received support from government.

- Queried why 11-year-olds were not receiving the vaccinations. The Director of Public Health stated that the Joint Committee on Vaccination and Immunisation (JCVI) where actively considering lowering the age range.

- Questioned whether there were any further guidelines for employers to encourage their employees to become vaccinators. The Director of Public Health stated that currently in Cambridgeshire they had a high number of volunteers coming forward and there were current challenges in processing these, the priority was getting the right people to the right places to support vaccine roll out. However, given the scale of the task, more volunteers would be welcomed.

- Thanked Public Health colleagues for a calm and reasoned update on the current situation in relation to the new omicron.

- Queried whether Public Health would be circulating a document that sets out clearly and in a straight-forward manner why individuals should get vaccinated. The Director of Public Health explained that there an infographic had gone out to members and it would be going out shortly on social media and that they had been using real patient stories to get the message in the press.

- Queried at what stage should councils make representations to Government about going back to virtual meetings. The Director of Public Health stated that these representations should be made now.
- Requested that Covid 19 Updates were scheduled on to the agenda plan for future meetings due to the current situation. ACTION

It was resolved unanimously to:

Provide support for measures in place as an Enhanced Response Area.

46. Adult Social Care Self-Assessment

The Committee considered a report that provided an overview of the Self-Assessment for Adult Social Care in Cambridgeshire, carried out as part of the Association of Directors of Adult Social Services (ADASS) regional sector led improvement programme.

Reporting officer gave a presentation which summarised the report that can be found here.

Individual Members raised the following points in relation to the report:

- Praised the in-person training that they had been given which gave Members an overview of the Adult Social Care Customer Journey including Prevention & Early Intervention Services and Long-Term Complex Services. Members

also highlighted the importance of the wrap around care which looked as families as a whole.

- Sought clarity on the work with community catalyst to develop micro-enterprises. Officers explained that the community catalysts were a group that had experience of supporting small businesses to set themselves up as micro enterprises to deliver home care. Officers stated that there was an early pilot in East Cambridgeshire and it was focused on support people to become mini care agencies, to make care more local.

- Queried whether the areas for development covered all the areas where the authority scored less than the national average. Officers explained that the majority were covered. Officers stated that the only one that had not been covered related to learning disabilities were there was a separate piece of work around the learning disability vision and learning disability day service.

- Questioned the score of 19.4 for the quality-of-life indicator and what the target was for this indicator and if there was a maximum score. Officers explained that there was an annual survey of service users that receive long term care and support and in the survey they were asked a number of questions about quality of life. Officers stated that the questions were weighted between one and five, with the maximum score being 25. Officers explained that most local authorities perform between 18 and 19 so Cambridgeshire performed comparatively well to performance both regionally and nationally.

It was resolved unanimously to:

a) Note the findings of the self-assessment.

b) Approve the public facing 'Local Account' for publication.

47. Day Opportunities for Older People and Physical Disabilities

The Committee received a report that detailed the Service's planned offer for activities for older people and those with physical disabilities in their local communities. It aimed to develop the longer-term vision and approach to commissioning Day Opportunities. Key focuses were early intervention and prevention to meet a range of support needs.

In particular, the reporting officer highlighted:

- The offer currently provided three in-house and 25 grant funded opportunities.

- The last 18 months had a significant impact on the provision of day services and this was detailed in 1.5 – 1.7 of the report.

- Work would focus on co-designing services with communities and service users ensuring that services were fit for purpose and met their needs for the future.

- The extension would support the council to undertake this work in partnership with key stakeholders.

- Flexibility had been built into the extension to allow for improvements to be implemented earlier.

Individual Members raised the following points in relation to the report:

- Queried whether officers had a sense of some of the learning that had taken place that could be taken into account during the retendering process. .

- Expressed concerns in relation to the number of contract extensions that were coming forward and highlighted the required improvements to the councils procurement process that had been discussed at the last Audit and Accounts Committee. The Chair explained that there had been a full discussion at the Audit and Accounts Committee in relation to past issues with the procurement process and that this would not be repeated at this Committee. Officers explained that there were four key elements and principles that surrounded the commissioning reports which included;

    - value for money;
    - balancing recommissioning in a co-produced way;
    - impacts of covid including the impacts on providers, with the overriding priority of maintaining stability in services;
    - Following the regulations and engaging procurement colleagues throughout the process.

    Officers stated that they conduct all procurement using the three principles of equalness, fairness and transparency. Officers explained that they had looked at how they could use existing procurement regulations to support the process. Officers stated that a procurement note was issued in the light of covid which allowed authorities to extend contracts and that is something that the authority had sought to invoke. Officers explained that unfortunately this process did not satisfy all three criteria in the note principally that the value of the extension could not exceed 50% of the value of the contract. Officers explained that the second principle that they were able to satisfy was to publish a Voluntary Ex-Ante Transparency notice which sat as part of the procurement regulations and sets out what the authority intend to do and allowed for anyone who are unsatisfied with the process to challenge it.

- Questioned whether discussions in relation to the contracts could be taken in private session so that Members could bring in some local knowledge to discussions. The Chair acknowledged that this was an important question and highlighted that it was in the public interest that the Committee took these decisions in public. He explained that all Members had the opportunity to write to officers if they had individual concerns in relation to providers. He

also stated that spokes meetings could also be used to raise issues in private. The Chair agreed to discuss with officers how a combined approach could be used in the future. ACTION

It was resolved unanimously to:

a) Recommend approval of grant extensions for Older People/Physical Disability Day Services as shown in Appendix 2 for 24 months. The total value for the 24-month period is £1,338,620.

b) Note the approach to the transformation of Day Services for Older People and Learning Disabilities.

48. Accommodation Based Supported Living Service for People with Moderate to Severe Mental Health Needs in Cambridgeshire – Exemption Request

The Committee received a report detailing the current accommodation offer for individuals with moderate to severe mental health needs that to enable them to develop the skills required for independent living. The service was provided by Sanctuary Supported Living who offered visits to intensive support.

Current challenges of the service included: housing required by individuals for greater than two years; co-occurring conditions; void management; referrals; increase in mental health challenges; workforce capacity.

Individual Members raised the following points in relation to the report:

- Expressed concern in relation to the request as this was the second request for an extension to the contract which had been let back in September 2017. Members requested that more planning be put in place so that in future there would be less reliance on extensions. Members also expressed their concerns in relation to the length of the extension requested. Officers stated that the length of the contract was due to the significant amount of work required to ensure that the process was robust and that the full impacts of the pandemic were understood and taken into account and delivered value for money.

- Queried the legal sign off of the report as it stated that a response had not been received by the Monitoring Officer. The Chair explained that sign off would be sought from the Monitoring Officer so that a decision could be made subject to their sign off. (Note : The Chair confirmed to Members before agenda item 10 that the relevant sign off had been received via email).

- Raised concerns in relation to the voids raised within the report and asked that alternative ways of using the housing were sought. Officers stated that the actions were being reviewed under the void monitoring project and that officers were looking at all of the properties to ensure that they were fit for

purpose and proactively looking at where there is overcapacity or the wrong type of property that can be used elsewhere

- Highlighted that the providers had been part of a serious case review that had gone to the Safeguarding Board that the Chair was a member of. The Chair asked for clarification from officers that they were aware of the review and had fully assessed that the providers were fully compliant and that the contract was a fair and good contract to reflect the needs arising from the lessons of the case. Officers stated that they were fully aware of the review and that there was ongoing contract monitoring which took place with the contracts team to ensure the provider was fully compliant

It was resolved unanimously to:

Recommend that the 'Accommodation Based Supported Living Service for People with Moderate to Severe Mental Health Needs in Cambridgeshire' is exempted for a period 15 months from 1/4/2022 to 30/6/2023 for a total value of £1,005,449.65.

49. Adult Social Care Transport Tendering

The Committee received a report seeking the continuation of tendering transport services for adults with disabilities and older people, as implemented in 2018 and 2019 and delivered under the Council's 2016 Transport Framework Agreement. The cost of this service was £2.1 million per annum.

In particular, the reporting officer highlighted:

- Funding would enable the service to:
    - review transport arrangements for efficiency and benchmarking with children's school transport;
    - review direction of service operations over the next eighteen months in the light of the pandemic; lower carbon emissions.

Councillor Boden proposed an amendment to recommendation c which was seconded by Councillor Corney, as follow:

Delete recommendation c) and replace with:

"c) in light of the recently published CCC External Auditor's value for money opinion 2017-18 in respect of CCC procurement process weaknesses, and in light of the discussion and resolutions relating to this issue at the meeting of the Council's Audit & Accounts Committee on 25th November 2021, to bring a report on the Adult Social Care Transport Tendering procurement process back to the earliest available meeting of the Adults & Health Committee for determination of the award of the new contract."

In putting the amendment to the vote the amendment fell.

In debating the report Members;

- Highlighted that the wording of options two and three was confusing , both options stated retender now and you had to read through the options to see that there was a recommendation for different contract lengths. Officers stated that they would make this clearer in future reports.

- Commented that police were still investigating two community transport providers. A member raised a point of order and clarified that he was a council appointed trustee for one of the bodies referred to and that the police investigation was in relation to an individual that defrauded the organisation and not the organisation itself. Officers stated that any provider would have gone through a quality assurance process to be awarded a place on the framework and could be considered for this particular tender.

- Highlighted the future use of electric vehicles and how providers could be supported in taking this forward. Officers stated that tendering plans remained flexible to operating Electric Vehicles at a future date due.

It was resolved unanimously to give approval to:

a) The general procurement approach for a contract value of £8.1m over four years;

b) Procuring transport provider in line with the recommended option as set out in paragraph 2.2; and

c) Delegate the award of the new contract to the Executive Director of People and Communities.

50. Additional Homecare Block Provision for Winter Pressures

The Committee received a report seeking £1,622,790 over a six-month period to ensure there was immediately available homecare capacity to support winter pressures on the Health Service. This would secure support for people returning home and regaining independence upon discharge from hospital. Pressures had increased as a result of the pandemic.

In particular, the reporting officer highlighted:

- Sought approval for a 12-month contract to an existing provider, who had been able to guarantee the Council a total of 85,176 homecare hours, at a total cost of £1,622,790.

- Homecare related to any support service that a person might need in their own home.

- Block provision will allow people to return home from hospital and those with increasing care needs to stay in their own home.

- The authority was seeing a rise in hospitalisations and people being discharged with the need for care at home. The additional homecare provision would mitigate the risk.

- It was an integrated approach funded by Health for the initial six months and then will be monitored over a further six months to review if the demand is there.

- The work would form part of a wider response to system winter pressures.

Councillor Boden proposed an amendment to recommendation which was seconded by Councillor Wilson, as follow

In the recommendation, after "£1,622,790" insert ", subject (given the potential non-compliance with the Public Contracts Regulations 2015 as detailed in paragraph 4.2) to no relevant challenge having been received within ten days of publication of a Voluntary Ex-Ante Transparency notice detailing this award on the Find a Tender Service website."

In putting the amendment to the vote it was passed unanimously.

Debating the report, individual Members raised the following points:

- Highlighted the importance of the Caring Together work and Community Catalysts, and that Communities had great potential in supporting this area.

- Queried whether the proposal involved any match funding. Officers reiterated that the first six months would be funded by Health and the following six months would be funded by social care and there are other contracts that are jointly funded.

- Queried whether the report had been signed off by legal. Officers confirmed that the report had been signed off prior to the report being published.

- Highlighted that this work was crucial in supporting the massive pressures that where imminent in relation to covid and a surge in demand on the health service.

- Queried why the contract was for 12-months and not six. Officers stated that providers were generally reluctant to take on six-month contracts in this area due to the need to lease the cars as part of the contract which was generally on a yearly basis. Officers explained that they met regularly to check the demand and supply.

It was resolved to:

> Award a 12-month contract to an existing provider, who have been able to guarantee the Council a total of 85,176 homecare hours, at a total cost of £1,622,790, subject (given the potential non-compliance with the Public Contracts Regulations 2015 as detailed in paragraph 4.2) to no relevant challenge having been received within ten days of publication of a Voluntary Ex-Ante Transparency notice detailing this award on the Find a Tender Service website.

51. Urgent Decision: Allocation of Infection Control, Rapid Testing, Vaccination and Workforce Recruitment and Retention Funding in response to the COVID-19 Pandemic

The Committee considered a report in relation to the allocation of Infection Control, Rapid Testing, Vaccination and Workforce Recruitment and Retention Funding in response to the Covid 19 Pandemic.

It was resolved unanimously to:

> approve the recommended allocation of the discretionary elements of the Infection Control, Rapid Testing, Vaccination and Recruitment and Retention Grants which have been issued by central government on a one-off basis to cover spend between the 1st October 2021 and 31st March 2022 where this falls in line with grant conditions set.

52. Finance Monitoring Report – October 2021/22

The Committee received a report which considered the financial position of services within its remit as at the end of October 2021/22.

In particular, the reporting officer highlighted:

- At the end of October, Adults forecast an underspend of £4,645k (2.66%), and Public Health an underspend of 3.8% of budget (£1,468k). The underspends reflected the impacts of covid and there was uncertainty around the forecast position moving into the winter period. Officers stated that it was particularly unclear if, and at what point, demand-led budgets would return to expected levels of growth in spend and that activity and spend levels would be kept under review throughout the year to determine if demand growth was returning to pre-pandemic levels or increasing faster.

- Members were being asked to endorse for approval by Strategy and Resources Committee, the transfer of £2m from the current year underspend in the Adults and Safeguarding Directorate to the Adult Social Care risk reserve to mitigate against future pressures arising in 2022-23 and beyond.

Officers explained that there was a proposal which was part of the Business Planning process to reduce the budget permanently for Adult Social Care.

- Members were being asked to review the current position on Public Health reserves and endorse, for approval by Strategy and Resources Committee, proposals for the use of uncommitted reserves totalling £2.9m. Officers explained that some of the reserve needed to be left back as they were still unclear whether the public health grant settlement would cover NHS pay award risks.

- The approved waivers from full contract procedure rules that have been granted in the Public Health Directorate during the exceptional circumstances of the covid pandemic. Officers explained that due to the pandemic there had been a lot more waivers than there would normally be.

Individual Members raised the following points in relation to the report:

- Highlighted that the Public Health proposals were not one off spends and a Member stated that they felt that the authority was being too cautious with the utilisation of the public health reserves. Members also highlighted that no provision was being made for Public Health underspends in 2022-23, that it was reasonable to assume that there will be an underspend due to ongoing covid pressures. The Chair stated that he felt that the comprehensive work had been carried out by the Public Health team to find meaningful ways to utilise the underspends and was comfortable with the remaining underspend. Officers clarified that from a prudence perspective that the grant would be equivalent to what had been received this year but that the authority was not expecting any more than that, so there was a reluctance to commit into next years. The Director of Public Health paid tribute to her colleagues who had developed the proposals and that further proposals could be developed in the future subject to if underspends were not utilised.

- Raise questions on the savings tracker in relation to client contributions policy change being red and whether any clients were subject to new charges. Officers clarified that there were no new charges and that there had been no change in the contributions policy.

- Queried the block care provision were there was sub-contracting with some of the provision in care homes and whether the authority was making a profit from the utilisation of beds by self funders, therefore where not having to use spot purchase. Officers explained that where the authority block purchased residential based beds, one way in which voids were managed was to release the beds to self-funders. Officers stated that in exchange the authority asked for a discount or a proportion of income to reduce the overall cost of the block.

It was resolved by majority to:

a) Review and comment on the relevant sections of the People and Communities and Public Health Finance Monitoring Report as at the end of October 2021;

b) Endorse for approval by Strategy and Resources Committee, the transfer of £2m from the current year underspend in the Adults and Safeguarding Directorate to the Adult Social Care risk reserve to mitigate against future pressures arising in 2022-23 and beyond;

c) Review the current position on Public Health reserves and endorse, for approval by Strategy and Resources Committee, proposals for the use of uncommitted reserves totalling £2.9m; and

d) Note the approved waivers from full contract procedure rules that have been granted in the Public Health Directorate during the exceptional circumstances of the covid pandemic.

53. Review of Draft Revenue Business Planning Proposals for 2022-2027

The Committee received a paper which provided an overview of the updates to the Council's financial position since October/Nov 2021 (including a pandemic impact review) and set out the changes to key assumptions impacting financial forecasts, further risks and opportunities and next steps required to balance the budget and agree the Council's Business Plan for 2022-27.

In particular, the reporting officer highlighted:

- The key changes to the proposals since the last committee included;
    - the feedback from the committee being reflected in the business cases;
    - the national living wage increase had been incorporated which had an impact of £3.2 million;
    - The Health and Social care Levy which had an impact of £1 million;
    - An investment so that more providers could pay the living wage and the introduction of Health Impact Assessments.
- It was an iterative process and officers were still working on the emerging pressures.

Individual Members raised the following points in relation to the report:

- Highlighted under the assumptions and risks section of the report on page 178 it highlighted the High Needs Deficit and that the government would have to fund the deficit. The Chair of the Children and Young Peoples Committee who was substituting at the meeting stated that it was an ongoing issue in relation to Special Educational Needs and was a consideration for the Children and Young Peoples Committee and not the Adults and Health Committee.

- Acknowledged the enormity and importance of the work undertaken as part of the Business Planning process and gave special thanks to officers for their continued work and input to the process.

It was resolved unanimously to:

a) Note the progress made to date and next steps required to develop the business plan for 2022-2027.

b) Comment on the budget and savings proposals that are within the remit of the Committee as part of consideration of the Council's overall Business Plan.

c) Note the updates to Fees and Charges for 2022-23

54. Adult Social Care and Public Health Performance Key Performance Indicators

This item was deferred.

55. Adults and Health Committee Agenda Plan and Training Plan

This item was deferred.

Part 2 – 14.00pm – 16.00pm – Health Scrutiny

56. a) Healthwatch Primary Care Intelligence

People champions for health and social care services in Cambridgeshire and Peterborough presented a report for scrutiny on the primary care service. The paper presented detailed: appointments, website information; tests and results, registration, and referrals.

The officer highlighted the inconsistency between GP services across the County. In particular, the public complained about the circular nature of reporting and the need to chase referrals from GPs, 111 and A&E. She stated that an upcoming report would focus on the wait for care, but that encouraging the self-management of conditions was a current mitigation measure.

In response to Member's questions, officers:

- Complimented Cams Online, but noted concern about digital engagement for service users less technologically savvy. To mitigate this, the service was looking to upskill users through training.

- Explained that there was a natural bias to survey responses, as those with a negative experience were more likely to offer feedback.

- Noted that medication retrieval following discharge could break down, but that the CCG would be able to provide more information on the distribution of routine medication.

In response to the report, a co-opted member requested a table of data be provided in future.

Members raised the difficulty of getting routine blood test results.

It was resolved to note the contents of the report.

b) Primary Care Access

The Committee received a report for scrutiny regarding access to GP primary care which had functioned throughout the pandemic both online and in-person, with some data showing a consequent 20% rise in demand. The report detailed: management of demand through increased triaging; local access improvement initiatives (with support from Healthwatch); workforce; and financial pressures. In particular, disparity across General Practices of the online and telephony support offer was highlighted.

The service had recently received £250m of Winter Access Support Funding. Planned use of this grant included: call centre staffing; a communications campaign, community response service; increased minor unit capacity; virtual support; bank staffing; electronic dispensing; and structured medication reviews.

There had been 9 million Covid-19 infections across England, with 90% patient contacts occurring through primary care. In response to increased demand for vaccination, the Service had delivered 692,000 of 1.6 million vaccines in Cambridgeshire as of 8 December 2021.

The officer asked Members to acknowledge that responses from the GP National Survey had been contrary to press reporting.

In response to the report, Members:

- Raised concerns regarding the restricted out of hours GP service and the way in which this had been absorbed into hospital care.

- Expressed hope that inter-organisational support and outsourcing into the community would occur more, should this help the service.

- Stated that their GP was not currently performing minor surgeries.

- Suggested that forms for triaging were done online, rather than over the telephone or in person to improve cross-service triaging and reduce the need

for patients to repeat their medical history. The officer confirmed this was done in some services, but in others would just create another channel of access for an already overstretched workforce to monitor.

- Thanked the service and condemned abuse against staff.

In response to Member's questions, the representatives explained that:

- Workforce shortages: Workforce shortages predated the pandemic and was a result of poor workforce projections by the government. However, through the pandemic, there had been a 6% reduction in fulltime equivalent GP workforce coupled with a 4.5% population increase, resulting in GP appointment requests have doubled (34 million GP appointments had been requested in October).

  The representative noted that while there was in increase in GP medical school capacity students, this would not solve immediate staff shortages.

- There was a shortage of blood test bottles, which had created a backlog of routine blood tests.

- In response to the question around other non GP providers for to increase test capacity the officer explained that the Care Quality Commission monitored healthcare delivery which limits the provision of non-clinical offsite services.

- Recently the Health Secretary had made changes to increase capacity for GP team vaccination programmes.

- GPs were funded by an enhanced service contract to carry out minor surgeries, but all practices have had to prioritise on the basis of clinical value which means waiting lists may continue.

- Online and in-person appointments: There was hope that, in future, the service would provide a blended offer. Currently, two thirds of appointments were delivered face to face and one third virtually. Virtual appointments were especially beneficial for patients on zero hours contracts.

- The out of hours GP service was provided by a third party and it was confirmed that the service is staffed by GPs and not hospital staff . Access to the service is through the 111-telephone line who triage the patients need and would refer to A&E if more appropriate. Demand of 111 had risen by 40%

- Officers noted the message for patients to understand is that we are operating with a 5 million waiting list and similar unaddressed health needs which was affecting the services ability to perform business as usual activities. Primary care is also supporting the national flu vaccination and the Covid Vaccination programme.

It was resolved to:

Note the contents of this report and the actions taken by Cambridgeshire & Peterborough Clinical Commissioning group to improve access to GP Services across Cambridgeshire and to support Primary Care to manage the demands on their services over the winter period.

57. Cambridgeshire and Peterborough Foundation Trust (CPFT) Occupational Therapy Service Waiting Lists

The Committee received a report from occupational therapy. This service was delivered under CPFT through multidisciplinary teams in the community. The report explained the impact of the pandemic on waiting list length as a result of redeployment of workforce and uncapped referrals during the second wave. Average waiting time had increased from 3 weeks prior to the pandemic, to 10.2 weeks as of December 2021. The longest waiting period over the last two years was 35 weeks.

To combat this problem, the service was providing: an enhanced triage service with urgent referrals being prioritised and home solutions suggested; increased administrative staffing; increased working hours; technology enabled care training; and outsourcing. However, the reporting officer expressed concerns regarding staff wellbeing as a result of increased pressures.

In response to the report, Members:

- Complimented the service's careful use of occupational therapists to provide care to the most needing.

- Requested further information regarding accessing occupational therapy.

- Offered support from the local authority.

  The report presenter stated that current support from the local authority was sufficient.

In response to Members' questions, the report presenter explained that:

- Waiting lists: The service had looked at outsourcing and prioritisation to manage waiting list time.

- Workforce shortages: These were cross organisation in the region and elsewhere in country. Allied Professionals were reviewing recruitment possibilities, but solutions needed to avoid recruiting from elsewhere within the service and included apprenticeships (growing our own workforce) and international recruitment, as had occurred in nursing roles, Issues have been raised at a system level and the Chief Regional AHP had also provided support to CPFT .

- The impact of the pandemic on acute system services would impact demand for occupational therapy and how we plan for this in the longer term. The challenges are not unique and there are workforce issues across the region with pressures in other parts of the country.

- Clarity was provided that hospital discharge team was separate to the community occupational therapy team.

- The Section 75 agreement between CQC and CPFT was monitored across multiple forums.

The Committee reviewed the report.

58. East of England Ambulance Service Report

The Committee received a report for scrutiny from the East of England Ambulance Service which detailed: response to the September 2020 Care Quality Commission Inspection; termination of the apprenticeship offer; performance; pressures on the service resulting from pandemic impact; and winter preparations.

When introducing the report, the presenting officer stated that, nationwide, the ambulance service was facing a severe escalation in demand with sustained, continued pressure on the ambulance service, acute hospital service, hand over times, and staff absence.

In response to Member's questions, officers explained that:

- Learner schemes: There were around a thousand learners, including 661 apprentices. Following the Ofsted inspection, every apprentice was offered a 1:1 in person counselling/meeting session, for which uptake was 95%. From these sessions, learning regarding workplace culture had been undergone and disciplinary actions taken (including removal, suspension and retraining).

  The Service was looking to change the workplace culture to prevent racial and gender discrimination and multi-gendered sexual harassment. Actions taken included: conversations with the Trust Board and Workforce Committee; implementation of a concern raising forum; interventions (over 2000 of which had occurred thus far); employing a new Director of People Services and Cultural Director; and undertaking cultural legacy work.

  There were currently 90 open investigations and this number was expected to increase as mitigating actions empowered individuals to raise concerns.

  Since the inspection, 34 learners had completed the certificate 70% of which achieved merit or distinction.

- Public aggression: Verbal and physical aggression occurred with service responders and call handlers and could cause PTSD. Body cameras were available to all staff as a deterrent and evidence. In vehicle recording was also available.

- End-of-life care: Often those who are DNR will have ambulances called because the event is traumatic for those witnessing it. In these circumstances ambulances provide comfort. He described how paramedics will often need to have the end-of-life conversation with friends/family if resuscitation is not successful.

- Hospital hand over delays were a symptom of pressures in social care discharge, elective emergency care and workforce strains. Enabling pathways to care in the home through community support would reduce these delays.

- In response to the report, Members asked whether the Cambridgeshire service would introduce mental health cars, as existed in Norfolk.
  The officer noted that police provision is available but the 111 service Option 2 can also provide access to a mental health professional. The issue of providing a physical response vs having a rapid response was discussed and the Trust is working with a range of partners including the police.

- Volunteer first responders gave 38,000 hours a month to the community.

- The service was imminently reviewing their working methods in response to the new Plan B Government legislation.

- There was an ongoing business impact assessment on sustainability. This was being monitored by the Trust Foundation Board.

- Across the East of England 10% of ambulance services were private.

- Staffing: Staff turnover had stabilised but it was reported that some paramedics had moved to primary care. In Cambridgeshire & Peterborough the service is over the establishment (including those in training) but nationally there is an staffing pressure

  Anxiety was the largest cause of staff absence and this was not aided by continued pressure. To mitigate this, the wellbeing support offer and wellbeing team had increased with a 24-hour crisis line, occupational therapy, wellbeing hub, employee assistance programme, Mind Blue Light Programme, wellbeing champions, wellbeing gardens, trauma risk management, and uncapped counselling sessions.

The Committee resolved to note and comment on the report.

59. Date of the Next Meeting - 13 January 2022.

The Chair thanked all attendees and closed the meeting.

Chair

ADULTS AND HEALTH COMMITTEE MINUTES-ACTION LOG

This is the updated action log as at 5 January 2022 and captures the actions arising from the most recent Adults and Health Committee meeting and updates Members on the progress on compliance in delivering the necessary actions

Meeting 24 June 2021						
Minute No.	Report Title	Action to be taken by	Action	Comments	Status	Review Date
10	Procurement of Housing Related Support Services	Lisa Sparks	That Lot values were based on existing need and therefore Fenland and Cambridge City and South were prioritised. Per Member request, a future report would consider Huntingdonshire for housing provision, following an increase in rough sleepers.	The County Council were awarded additional funding from Central Government to enable Housing First to also be delivered in Huntingdonshire. This was in response to the increased number of rough sleepers reported across the district. County and District Council officers are working together to set this up. A support worker is now in post and discussions are taking place with local Registered Social Landlords to secure accommodation to support the scheme. The Housing First offer in Hunts is up and running.	Closed	
11	Healthy Weight	Val Thomas	Concerns that other weight problems such as anorexia and the need to look at these in future.	This will come back as part of an update on Healthy Weight to a future Adult & Health Committee meeting.	In progress	TBC

Meeting 22 September 2021						
Minute No.	Report Title	Action to be taken by	Action	Comments	Status	Review Date
22.	Use of Assistive Technology in Social Care	Grace Clark	Requested that Members visited the Smart Flat when it was up and running.	We are liaising with chorus homes to write new contracts and risk assess safety of flat prior to renovations	Closed	
27.	Finance Monitoring Report	Justine Hartley	Discussed the use of the Public Health reserves. Officers stated that the reserves were ringfenced for public health spend. Officers stated that 2-3 years ago there was a review of how the reserves could be used for transformative measures. Members highlighted their concern that if the Council did not review how to utilise the reserves they may receive reduced funding from government in the future. Officers to update in the next monitoring report to address these concerns.	The position on Public Health reserves is being reviewed as part of Business Planning for 2022-23 and beyond and proposals for usage of the reserve will be brought to the December Committee meeting for consideration. The Finance Monitoring Report brought to the same December Committee will report on the current and anticipated year end reserves position.	Closed	

35.	The provision of NHS Dental Services in Cambridgeshire	Kate Parker	Raised concerns that it was difficult to get urgent dental care and queried if there were new practices coming on stream as this had been an issue pre covid. Officers stated that the issue with new practices coming on stream was reliant on old practices being handed back when they folded. Officers stated that the data in the report was 6 months behind and that they would follow up with the Committee when they had up to date figures.	NHS England Officers have been contacted to remind them of the data updates requested. NHS England to provide further information. They have been chased twice now.	In progress	

Agenda Item No: 4

COVID-19 Update

To:	Adults and Health Committee
Meeting Date:	13 January 2021
From:	Jyoti Atri, Director of Public Health
Electoral division(s):	All
Key decision:	No
Forward Plan ref:	Not applicable
Outcome:	This report provides an update on the current Coronavirus pandemic.
Recommendation:	Adults and Health Committee is asked to note the update on the current Coronavirus pandemic.

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1. Background

1.1 For nearly two years we have continued to respond to the Coronavirus pandemic, including a second wave of Coronavirus and a second lockdown, and now the impact of the new Omicron variant.

1.2 The impact of the pandemic has affected all areas of life. The purpose of this paper is to provide the Adults and Health Committee with an update of the impact of the new Omicron variant.

2. Main Issues

2.1 In order to provide the Committee with the most up to date Coronavirus data, a presentation will be prepared for Committee and published on the Council's website for the public to access.

3. Alignment with corporate priorities

3.1 Communities at the heart of everything we do:

- The impact of COVID-19 has and will have significant implications upon communities in all aspects of their lives but especially upon their physical and mental health. However, COVID has also brought many communities together and there is evidence that communities have played an important part in tackling the pandemic.

3.2 A good quality of life for everyone:

- The impact of COVID has significantly affected the quality of life for residents.

3.3 Helping our children learn, develop and live life to the full:

- The impact of COVID has significantly affected children's learning.

3.4 Cambridgeshire: a well-connected, safe, clean, green environment:

- The reduced traffic volume during pandemic decreased levels of pollution.

3.5 Protecting and caring for those who need us:

- Organisations and communities worked and are continuing to work throughout the pandemic to provide support to those most in need.

4. Source documents

4.1 Source documents

Sources

Deaths in Cambridgeshire | Coronavirus in the UK (data.gov.uk)

Deaths registered weekly in England and Wales, provisional, ONS https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/weeklyprovisionalfiguresondeathsregisteredinenglandandwales, analysis by PHE.

https://coronavirus.data.gov.uk/

NHS Digital, https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-hospital-activity/

PHE Wider Impacts of COVID-19-19 on Health (WICH) 2021 Wider Impacts of COVID-19 (phe.gov.uk)

Integrated Care System (ICS) - Cambridgeshire County Council position paper

To:	Adults and Health Policy and Service Committee
Meeting Date:	13 January 2022
From:	Executive Director for People & Communities & Director of Public Health
Electoral division(s):	All
Key decision:	No
Forward Plan ref:	Not applicable
Outcome:	To provide a strategic overview of Cambridgeshire County Council's response to the establishment of an Integrated Care System for Cambridgeshire and Peterborough and secure member support for the County Council's approach.
Recommendation:	The Committee is asked to:

a) note the national and local context of the development of the ICS

b) support the principles and priorities set out in section 5.4.

c) note that the Health and Wellbeing Board and the Integrated Care Partnership Committee will be aligned and operate as a 'committee in common' with aligned membership of the Health and Well Being Board and Integrated Care Partnership

d) confirm the criteria at Section 5.7.1 that will be applied to any County Council decisions about ICS integrated services, joint appointments or joint commissioning arrangements.

e) confirm that the Council considers expanding its health policy capacity, to provide advice to members and officers in their work with the ICS.

f) champion the principle of local democratic accountability in the ICS, in accordance with Section 5.8 of the report.

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1.0 Background

1.1 The purpose of this report is to provide a briefing to committee on the Cambridgeshire and Peterborough Integrated Care System (ICS) and secure support for the Local Authority's role in delivering the required outcomes of the ICS. The national and local expectation is that Local Authorities will be key partners in ICS development and delivery and the ICS will be integral to the transformation and integration of health and social care. This will be an evolutionary process which will be developed and built upon in partnership with the NHS. This paper provides a strategic overview and orientation setting out for the Adults and Health Committee the key principles and priorities from a Local Authority perspective. This paper reflects the fact that the establishment of the ICS is at an early stage and the Committee will received regular updates as the ICS becomes more well established.

2.0 Summary position

2.1 The creation of an Integrated Care System for Cambridgeshire and Peterborough takes place in response to the national reforms of health and social care. These reforms sit alongside the recently published Social Care White Paper 'People at the Heart of Care' which sets out a 10-year vision for adult social care and changes to the way social care is funded and how people will contribute to their care costs. The ICS relates to the whole population and is also of direct relevance to the Children and Young People and Communities, Social Mobility and Inclusion Committees. Joint working across these committees will be essential.

2.2 The Local Authority has a statutory role within the structure of the ICS, with unique obligations around democratic accountability but also a potential to contribute through local knowledge, connections and leadership. This includes a public sector ethos and a commitment to involving the voluntary and community sector as well as the local community in key decisions and service developments. Local authority support and leadership working in partnership with the NHS will be crucial, championing the core principles of the ICS and the importance of prevention, population health management, tackling health inequalities and improving health and social care outcomes.

2.3 There will be a duty to collaborate across NHS and local government which will replace existing duties to cooperate. The Local Government Association (LGA) has articulated the local authority contribution to the ICS as ensuring emphasis is given to addressing health inequalities, improving population health and working with the NHS to take decisions that will support health and social care outcomes.

2.4 It is important to recognise that these developments are taking place at a time when all parts of the health and care system continue to operate during a pandemic, in the face of unprecedented demands and pressures on the workforce. The way in which local health and care organisations have worked together throughout the pandemic, developing solutions and working in partnership needs to be recognised and will be built upon by the ICS.

3.0 The national context

3.1 The Kings Fund National Descriptors of an Integrated Care System states 'Integrated care systems (ICSs) are geographically based partnerships (generally 1 million population) that bring together providers and commissioners of NHS services with local authorities and other local partners to plan, co-ordinate and commission health and care services. They are part of a fundamental shift in the way the health and care system are organised – away from competition and organisational autonomy and towards collaboration, with health and care organisations working together to integrate services and improve population health. ICSs have been developing for several years, under the banner of Sustainable Transformation Partnerships (STP's) – the Health and Care Bill will put them on a statutory footing from April 2022.'

Clinical Commissioning Groups will cease to exist, contracts and funding commitments will novate to the ICS and 106 CCGs nationally will be replaced by 42 ICSs, with new footprints set by government. A Cambridgeshire and Peterborough footprint has been mandated by government.

3.2 The ICS seeks to achieve four aims: -

- Improve outcomes in population health and health care
- Tackle inequalities in outcomes, experience, and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development

3.3 Collaborating as an ICS should help health and care organisations tackle complex challenges, including.

- Improving the health of children and young people
- Supporting people to stay well and independent
- Acting sooner to help those with preventable conditions
- Supporting those with long term conditions or mental health issues
- Caring for those with multiple needs as populations age
- Getting the best from collective resources so people get care as quickly as possible

3.4 Clinical Commissioning Groups have the legal duty to develop the Integrated Commissioning Board constitution. For Cambridgeshire and Peterborough this is being led by the ICS designate chair – John O'Brien; and ICS designate Chief Executive – Jan Thomas.

The statutory ICS will be made up of two key bodies – an Integrated Care Board (ICB) and Integrated Care Partnership (ICP).

3.5 **Integrated Care Boards**

Integrated Care Board (ICBs) will take on the NHS planning functions previously held by Clinical Commissioning Groups (CCGs) and are likely to absorb some planning roles from NHS England. ICBs will have their own leadership teams, which will include a chair and chief executive, Non-Executive members and members from NHS trusts/foundation trusts, local authorities, and general practice, selected from nominations made by each set of organisations. In consultation with local partners, the ICB will produce a five-year plan

(updated annually) for how NHS services will be delivered to meet local needs. In developing this plan and carrying out their work, the ICB must have regard to their partner ICP's Integrated Care Strategy and be informed by the joint Health and Wellbeing Strategies published by the Health and Wellbeing Boards in their area. Additionally, each ICB must outline how it will ensure public involvement and consultation.

ICBs will also contract with providers to deliver NHS services and will be able to delegate some funding to place level to support joint planning of some NHS and council-led services.

3.6 Integrated Care Partnerships

Integrated Care Partnerships (ICPs) will operate as a statutory committee, bringing together the NHS and local authorities as equal partners to focus more widely on health, public health and social care. ICPs will include representatives from the ICB, the local authorities within their area and other partners such as NHS providers, public health, social care, housing services, voluntary, community and social enterprise (VCSE) organisations. They will be responsible for developing the Integrated Care Strategy, which sets out how the wider health needs of the local population will be met. This should be informed by any relevant Joint Strategic Needs Assessments. (see below) In developing its Integrated Care Strategy, the ICP must involve the local Healthwatch, the VSCE sector, and people and communities living in the area. ICPs will not directly commission services. In Cambridgeshire and Peterborough, the Health and Wellbeing Board will play a pivotal role as will the Health and Wellbeing Board Strategy as described later in the paper.

3.7 Partnership and delivery structures

A number of partnership and delivery structures will operate within an ICS at system, place, and neighbourhood level. NHS providers will work together at scale through Provider Collaboratives, new partnerships operating across ICSs to improve services. Provider Collaboratives, which may involve voluntary and independent sector providers where appropriate, are expected to be operating across England by April 2022 and will agree delivery objectives with partner ICSs.

Health and Wellbeing Boards (HWBs) are formal committees of local authorities that bring together a range of local health and care partners to promote integration. They are responsible for producing a Joint Strategic Needs Assessment and a joint Health and Wellbeing Strategy for their local population.

Place-based partnerships will operate on a smaller footprint within an ICS, often that of a local authority. They are where much of the heavy lifting of integration will take place through multi-agency partnerships involving the NHS, local authorities, the VCSE sector and local communities themselves.

Primary Care Networks (PCNs) bring together General Practice and other primary care services, such as community pharmacies, to work at scale and provide a wider range of services at neighbourhood level.

3.8 **National bodies**

The NHS organisations within ICSs, including ICBs, NHS trusts and foundation trusts, will be accountable to NHS England for their operational and financial performance. There will also be a new planning role for NHS England regional bodies. The Care Quality Commission (CQC) will independently review and rate the quality of partnership working within ICSs, alongside its existing responsibilities for regulating and inspecting health and care services. This will include the inspection of Adult Social Care as part of the ICS as set out in the recently published White Paper 'People at the Heart of Care'.

3.9 It is important to recognise the limits of what legislation can achieve. Success will depend on implementation of the integration and prevention agenda, with behaviours and relationships that support collaboration needing to be developed, nurtured, and modelled right across the health and care system, including within national bodies. Evidence from previous attempts to integrate health and care indicates that these changes will take time to deliver results. Listening to patients and communities will also be key to improving services and understanding how efforts to join up health and care are progressing. As a local authority we are well placed to advocate on behalf of our residents and ensure the public are well informed and can inform the development of our local ICS.

4.0 ICS development in other areas, opportunities and challenges ahead

4.1 ICS development is taking place at a similar pace across the Eastern Region and the country, and no ICSs are sufficiently well established to draw any firm conclusions about impact. There will inevitably be variation reflecting local circumstances.

4.2 There is some learning from Manchester where in April 2016, as part of its devolution deal, the Greater Manchester Health and Social Care Partnership (GMHSCP) took direct control of £6bn health and social care budget and assumed responsibility for health and social care across ten metropolitan boroughs. Each has become roughly coterminous with a Clinical Commissioning Group. The boroughs function as the geographical footprint for the place level of system-place-neighbourhood organisation, though they are termed Local Care Organisations (LCOs) rather than ICPs. Each of these oversees a Private Care Network (PCN).

4.3 The GMHSCP was one of the first bodies to try this new means of delivering health and social care, and as such will be one of the first to offer signs of what challenges and opportunities the model may present. It is difficult to draw firm conclusions from Manchester so far, as some metrics have improved and others have worsened, but this is at a time when the NHS and social care have been experiencing significant challenges and increased demand.

4.4 The LGA published 'Achieving integrated care: 15 best practice actions' which draws on evidence from international research and emerging best practice and sets out the following 15 actions which align well with County Council priorities and principles and the work already being undertake on place based working, decentralisation and changing the way we commission care through the 'Care Together' approach.

Realising person-centred coordinated care	Building place-based care and support systems	Leading for integration
1. Risk stratification Identify the people in your area that are most likely to benefit from integrated care and proactive support, and preventative support.	**6. Operational framework** Create an integrated care operational framework that is right for the local area, and which aligns service delivery and service changes to a clear set of benefits for local people.	**11. Common purpose** Agree a common purpose and a shared vision for integration, including setting clear goals and outcomes.
2. Access to information Ensure individuals and their carers have easy and ready access to information about local services and community assets. Also, that they are supported to navigate these options and to make informed decisions about their care.	**7. Integrated commissioning** Use integrated commissioning to enable ready access to joined-up health and social care resources and transform care.	**12. Collaborative culture** Foster a collaborative culture across health, social care and wider partners.
3. Multidisciplinary team training Invest in the development and joint training of multidisciplinary teams (MDTs) to transform their skills, cultures and ways of working.	**8. Shared records** Identify and tackle barriers to sharing digital care records to ensure providers and practitioners have ready access to the information they need.	**13. Resource allocation** Maintain a cross-sector agreement about the resources available for delivering the model of care; including community assets.
4. Personalised care plans Develop personalised care plans together with the people using services, their family and carers.	**9. Community capacity** Build capacity for integrated community-based health, social care and mental health services, focusing on care closer to home.	**14. Accountability** Provide system governance and assure system accountability.
5. Rapid response Provide access to integrated rapid response services for urgent health and social care needs through a single-point.	**10. Partnership with voluntary, community and social enterprise (VCSE) sector** Foster partnerships to develop community assets to provide easy access to a wide range of support.	**15. Workforce planning** Lead system-wide workforce planning to support delivery of integrated care.

4.5 The LGA has also published 'Shifting the centre of gravity: making place-based, person-centred health and care a reality' which describes the shifts that need to be made to achieve the benefits of integration and proposes 6 principles to achieve integrated care:

- Collaborative local leadership to develop a shared vision, culture and values
- Subsidiarity - decision-making as close to communities as possible
- Building on existing, successful local arrangements
- A person-centred and co-productive approach
- A preventative, assets-based and population-health management approach
- Achieving best value.

4.6 With such a major set of changes, it is inevitable that there will be challenges in implementation and associated risks for the County Council itself. It is important to identify and seek to manage those risks in advance. The King's Fund says there is a risk that responsibilities for NHS resources and performance crowd out wider system priorities

and weaken the sense of equal partnership across the NHS and local government that many ICSs have worked hard to nurture. They also point to the 'sweeping powers' of the Secretary of State to intervention local decisions, within the legislation.

4.7 The Social Care Institute for Excellence identifies how the ICS model is based on a new 'shared risk and benefit' system, initially developed in the United States. It is argued that proper objectives to manage cost by preventing the need to access (relatively more expensive) acute care could simply reproduce elements of competition from the existing 'purchaser-provider' split. Research for the NHS in the Midlands and Lancashire shows that there are inherent complexities and hazards in these 'risk and reward' arrangements, which they recommend should be approached cautiously and be carefully evaluated. This clearly would apply the local authority as one of the system partners.

4.8 There are also questions as to provisions in the legislation to remove the statutory duties to provide NHS hospital care in each area, and emergency care for everyone present in an area. The King's Fund also identified concerns about proposed integrated care provider contracts, (a new contractual form allowing commissioners to award a long-term contract to a single organisation to provide a wide range of health and care services to a defined population), with campaigners arguing that this could lead to health and care services coming under the control of private companies. The NHS Long Term Plan subsequently set an expectation that integrated care provider contracts would be held by public statutory providers. The British Medical Association also raised concerns that contracts could be handed to the private sector without proper scrutiny and argued that the new system should prioritise the NHS as the preferred provider, free from competition and privatisation.

4.9 The Health Foundation refers to the disadvantages in past major reorganisations of the Health Service, the major disruption which can be created and the risk of the benefits of integration being overstated. They also point to the difficulty of introducing these changes at a point when the Health Service if facing the critical pressures caused by the Covid Pandemic. The ultimate challenge is that the outcome is not organisational integration, but one which leads to service users feeling that their care is genuinely personalised and joined up.

5.0 Local Development of Cambridgeshire & Peterborough ICS

5.1 Below is a glossary to inform Section 5 of the report:

- ICB = integrated care board (Cambridgeshire & Peterborough) – Strategic Commissioning
- ICPC = integrated care partnership committee (Cambridgeshire & Peterborough) – Integrated Care Strategy/Plan.
- ICP North = integrated care partnership for the North (Huntingdonshire, Fenland, Peterborough – North West ANGLIA Foundation Trust hospital footprint) = community, primary care, elective, urgent and emergency care, cancer, and personalised care including continuing health care.
- ICP South = integrated care partnership for the south (Cambs South, City, East – Cambridgeshire University Hospital footprint) = community, primary care, elective, urgent and emergency care, cancer, and personalised care including continuing health care.
- Children & Maternity Collaborative (Cambridgeshire & Peterborough – Cambridgeshire Community Services Foundation Trust (CCS) footprint) = all provision and commissioning for children Mental Health
- Learning Disability Collaborative (Cambridgeshire & Peterborough – Cambridgeshire & Peterborough Foundation Trust (CPFT) footprint) = all provision and commissioning for adults with learning difficulties and mental health needs
- HWBB = Health and Wellbeing Board

5.2 Development of local governance arrangements

5.2.1 The Cambridgeshire & Peterborough ICB will be a statutory board that oversees the day-to-day running of the NHS locally. It will manage a single pot of NHS funding, for which it is directly accountable, and will develop a plan to meet the health needs of the population within the ICS.

5.2.2 While individual organisations within the ICS will continue to have direct responsibility for the staff in their own organisations, the ICB will be responsible for delivering the people functions for staff employed directly by the ICB, and for the NHS staff who work in their local area. This includes clinical and non-clinical people working in primary and community care (such as general practice, dentistry, optometry, and community pharmacy), secondary and tertiary care.

5.2.3 ICBs will be able to agree with specified other statutory organisations (NHS & Foundation Trusts and Local Authorities) that they will exercise their functions on behalf of the ICS. The ICB will remain legally accountable for any arrangements made regardless of any delegations made. From a local authority perspective any delegation would need to be agreed at the appropriate Committee.

5.2.4 ICB members will include the Chair and Chief Executive of the ICS, partner members including the local authority, NHS Trusts and Foundation Trusts, primary care (GP), Director of Finance, Medical Director, Director of Nursing and four independent non-executive members. The Local Authority representatives will be the Director of Public Health and the Executive Director People and Communities. The DPH will be a non-voting member while

the Executive Director of People and Communities will be a voting member. It is important to note that this is a significant development which has been facilitated by the coterminous arrangement that we have across Cambridgeshire and Peterborough, which many ICSs do not benefit from.

5.2.5 The Integrated Care Partnership Committee (ICPC) is a statutory body in its own right, which the ICB has established jointly with Cambridgeshire County Council and Peterborough City Council. The ICPC is responsible for the development of an Integrated Care Strategy. The ICB must have regard to this strategy when developing its own plans. The terms of reference for the ICPC and the ICB Constitution will be aligned to ensure that the ICS effectively meets health and care needs across our area and that as an ICS we deliver on our agreed vision 'All together for healthier futures – working together to improve the health and wellbeing of our local people throughout their lives'.

5.2.6 The ICPC - Integrated Care Partnership Committee; will have a wide system membership to reflect the local landscape of key partners and bring in the resident voice e.g., Healthwatch, VCS, local authorities, police, combined authority.

5.2.7 Two area Integrated Care Partnership (ICP) – North and South, based around acute hospitals - will have a Managing Director. Performance of the ICPs who will report into the Integrated Care Partnership Committee and ICB. We have senior officers on the North and South ICP's. There are also several thematic groups that are supporting the development of the ICS. The local authority has corporate representation on:

- Governance
- Digital
- Communications
- Transformation
- Finance
- Workforce

5.2.8 As a local authority we should and are expected to play a lead role in ICP development; ensuring local services are joined up for our residents and developed and understood in the context of the communities they live and work in and wrapped around primary care and community services. This is where communication and liaison with local Councillors will be important. The local authority will be advocating a focus on population health management and investment in prevention and neighbourhood or place-based approaches. Investing in prevention will lead to better efficiencies through more cost-effective interventions and an increase in years spent in good health. However, we know that the pandemic has seen people presenting with more complex and acute needs, so we do not underestimate the scale of the challenge.

5.3 The development of the draft constitution for the ICS and the County Council response

The draft constitution for the Cambridgeshire and Peterborough Integrated Care System including the Integrated Care Board and Integrated Care Partnership Committee has recently been consulted upon. This will not become statute until the passing of the Health and Care Bill in April 2022. The County Council has welcomed the opportunity to comment and responded to this as a key stakeholder and stressed the importance of making the ICP as equivalent to the ICB in status and influence as possible, pursuing an 'equal partnership

model' in the governance of the ICS, with an equal balance of power between the NHS, local government and other partners and building in the principle of subsidiarity and aligning the Health and Well Being Board and the Integrated Care Partnership.

5.4 Priorities and Principles

It is proposed that we will pursue the following priorities and seek to work with ICS partners to adopt strategies and plans that support:

- The real living wage for all health and care workers
- Social Value as the key driver in the development, delivery, and commissioning of services across the health and care sector
- Transparent decision making and accountability to the public
- Supporting democratic accountability
- Shifting resource towards prevention, community-based solutions, and moving of resources from acute to community, ensuring that resources are spent efficiently to deliver the best outcomes per pounds spent
- Measurably improving health and wellbeing outcomes and reduce health inequalities for the population.
- A Population Health Management' approach and agree what we all mean by this and what actions we can take to pursue this
- Promoting and adopting co production and participation as a default approach to developing new services making full use of the LA Partnership Boards that are run by Healthwatch and any other appropriate forums such as Parent Carer Forums
- Delivery of real progress through Integrated Neighbourhoods and make the links to the local authority work on Care at Home, place-based approaches, and decentralisation
- Further development of the integrated management and delivery of the Learning Disability Partnership and seek opportunities to further extend and embed this with the local authority as the lead provider
- Support for the Council's own commitment towards social and environmental criteria, local purchasing and developing in-house services where this will deliver the best outcome
- Continuation of integrated services where we think this will improve outcomes and sustain/ increase NHS investment in those services that are already jointly commissioned or provided through S75 agreements e.g., Occupational Therapy, Integrated Community Equipment Service and Assistive Technology
- Identifying new opportunities where the Local Authority could become the lead provider eg Discharge to Assess pathway
- Developing a single health and care record and finding way to share information in a way that will improve outcomes and is legally compliant

5.5 How the ICS will work with people and communities

5.5.1 The Integrated Care Board has proposed adopting the following ten principles set out by NHS England for working with people and communities as this supports the local authority's priorities and principles:

- Put the voices of people and communities at the centre of decision making and governance, at every level of the ICS.
- Start engagement early when developing plans and feedback to people and communities how it has influenced activities and decisions.

- Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is working.
- Build relationships with excluded groups – especially those affected by inequalities.
- Work with Healthwatch and the voluntary, community and social enterprise sector as key partners.
- Provide clear and accessible public information about vision, plans and progress to build understanding and trust.
- Use community development approaches that empower people and communities, making connections to social action.
- Use co-production, insight, and engagement to achieve accountable health and care services.
- Co-produce and redesign services and tackle system priorities in partnership with people and communities.
- Learn from what works and build on the assets of all ICS partners – networks, relationships, activity in local places.

5.5.2 These principles are very welcome and are congruent with the County Council's ambitions in relation to decentralisation and delivering services at the most local level. This can be seen in the proposals to change the way in which we commission domiciliary care through 'Care Together', work on Think Communities and the County Council's focus on promoting independence and supporting people to stay at home. The County Council has a strong track record in both adults and children's services of strong collaboration through long-standing joint work with all parts of the local NHS including primary care, Cambridge and Peterborough Foundation Trusts and Cambridgeshire Community Services.

5.6 Most Capable Provider and Provider Collaboratives

5.6.1 To award NHS contracts to partners for delivery of substantial functions in return for significant funding, there needs to be a process that assures the ICB that the receiving organisation and their partners have the capacity and capability to hold the clinical and financial risk. The CCG are adapting the proven 'Most Capable Provider' Framework, to use as a governance process.

5.6.2 The Most Capable Provider approach covers a range of areas and asks the receiving parties to explain how they will discharge their accountability, and more importantly drive a strong culture of delivery and transformation that improves outcomes for our citizens. The ICB will undertake a 'Capable Provider' process to decide who is best to deliver functions. Detailed guidance is currently being drawn up about this and how the most capable provider will be identified.

5.6.3 NHS England has produced significant guidance on the approaches, capabilities and roles of various organisations in the development of Provider Collaboratives. The guidance is clear in all examples that the host, lead or provider contractually responsible is an NHS trust or foundation trust. The role of Local Authorities is to be part of the Provider Collaboratives, but there is not a role to be the host. There is provision to discharge functions to the local authority via a Section 75 agreement and this will be important to enable us to continue to build on our existing integrated services for Learning Disability, Mental Health, Occupational Therapy, Community Equipment and Tech Enabled Care.

5.6.4 At a high level, the assumptions of the NHS on who may be capable providers are:

- **North & South Places** (led by North West Anglia Foundation Trust & Cambridgeshire University Hospital) deals with all the community, primary care, elective, Urgent and Emergency Care, Cancer and personalised care including Continuing Health Care.
- **Strategic commissioning** focuses on population health, citizen-based data, strategic planning, and outcomes setting.
- **Mental Health/Learning Disability Collaborative** (led by Cambridgeshire & Peterborough Foundation Trust) and **Childrens and Maternity Collaborative** (led by Cambridgeshire Community Services) has some overlaps that need to be worked through, but as they already have ICS approaches in place these will continue.

5.6.5 Senior officers from organisations such as the acute sector, community health, primary care, VCS, and local authority are working together in the development of the North and South partnerships (ICP's) and the Children & Maternity and Mental Health & Learning Disability Collaboratives. The Director of Children's Services and Executive Director People and Communities are co-leading the Children's Collaborative development. The Director of Adult Social Care is involved in the development of the Mental Health/Learning Disability Collaborative. These are at an early stage of development and are where detailed plans are being developed in partnership to drive the prevention agenda and integrated service delivery wrapped around groups of GP practices, (primary care networks) or in the case of children and young people, schools.

5.7 Criteria to inform decisions and decision-making processes that impact on County Council responsibilities and services

5.7.1 The creation of the ICS will create opportunities for the integration of health and social care and opportunities will arise to support this way of working. It will be important to apply some agreed criteria that support delivery of the Local Authority priorities and principles, reduce organisational barriers and improve outcomes for our residents when considering opportunities which could include joint posts, joint commissioning arrangements or integrated services. The following criteria are proposed to inform decision making:

- Evidence that outcomes will be improved
- Congruence with County Council priorities
- Operating in line with the statutory and legislative framework for social care
- Supporting the improvement in quality, practice and outcomes that will form the basis for the external assurance of all social care services
- Improving and strengthening the County Council's focus on promoting independence and managing increased levels of demand on Council services
- Supporting the development of a place based or neighbourhood approach and the County Council's commitment to decentralisation.

5.7.2 It is important that when thinking about integration we draw on past learning to inform future partnership working to improve outcomes. The Local Authority has experience of developing integrated services when over ten years ago, all staff and budgets associated with Older People, Mental Health and Learning Disability Services were transferred to the NHS. There were some benefits but the County Council made a decision to transfer all the Older People's staff and budgets back in house due to concerns about financial control and professional direction. A decision was made to continue with the integrated models for Learning Disability, Mental Health and Occupational Therapy. This process showed that relying on structural change is not enough on its own.

5.7.3 We continue to have a pooled budget for learning disability which is currently under review and a jointly funded Tech Enabled Care Service and a joint contract for Community Equipment. It will be necessary to agree how these arrangements continue to be developed within the ICS framework. Integrated services are all governed through a Section 75 arrangement which enables the NHS or the Local Authority to delegate functions to each other. As part of this governance the effectiveness and outcomes are under constant review and where needed changes are made. There is a clear process for giving notice if the arrangement is no longer working in the interests of either party.

5.8 Accountability and democratic participation in the ICS decision making processes

5.8.1 Local health partners are committed to the objective of good accountability for decisions made by the ICS, recognising accountability to the NHS and to the national objectives of the NHS Long-Term Plan, but which the NHS Confederation says should be only 'one component' of accountability to a broader based local strategy for improving the health and wellbeing of the local population.

5.8.2 Accountability involves system actors taking responsibility for their actions and recognising the need to explain and be answerable for them. This applies at many levels including to employees, internal partners, regulators and to patients, people and communities. It also involves seeking to ensure transparency, through decision-making processes which are as simple, accessible and made in public as possible.

5.8.3 The local authority has a crucial role to play in ensuring local democratic accountability is properly fulfilled within the system. This will involve the County Council in enhancing its scrutiny function to recognise that it is likely to engage in increasing partnership arrangements within the system and must retain appropriate scrutiny and overview for actions taken. The priorities and principles set out in this paper will be used to guide officers and member representatives involved. This includes ensuring that decisions which potentially have significant or strategic impact on the authority's own responsibilities or finances will continue to be subject to prior approval by elected members and to subsequent review. This is also important to maintain accountability for councillors themselves to the local electorate.

5.8.4 The Local Government Association (LGA) has advocated that local government must be treated as 'equal partners' in the ICS, which otherwise risks the "danger of missing the real prize of collaborative place-based leadership to achieve greater investment in prevention and community-based health and wellbeing services." The LGA position informs the proposals in this paper to seek to ensure that the Health and Wellbeing Board continues to be regarded as the forum that has lead responsibility for ensuring the development and agreement of the joint strategic needs assessment and the joint health and wellbeing strategy for our local population

5.8.5 The LGA together with NHS Clinical Commissioners also recommend that ICS bodies should adopt a 'subsidiarity' principle, in which decision-making is as close to communities as possible. Seeking to ensure place-based partnerships at local level within the ICS are included as far as possible in the Council's own evolving plans for decentralisation, can both help avoid unnecessary duplication and assist engagement with local communities.

5.8.6 Unanimous agreement between the local authorities and health partners was established at the October development day on 'Working together as a System' to bring the work of the Health and Wellbeing Board(s) as close together with the ICP Committee as possible, setting out a 'Committee in Common' approach. Agreement was unanimous on the establishment of one plan and one set of priorities.

5.8.7 The Integrated Care Partnership Committee and Health and Wellbeing Boards must take place in public, ensuring transparency. Relevant decisions that need to be taken at the Integrated Care Board will be shared at the Integrated Care Partnership Committee to ensure the Integrated Care Board is fully aware of the wider partners' views.

5.8.8 The local authority officers who are members of the ICB will be championing the social care agenda and Joint Administration's (JA) priorities. At the same time, it is recognised that the ICS financial envelope is accountable to NHS England and there are national requirements and targets on how money is spent. (not to mention the deficit that must be dealt with as well) The local authority will use our financial resources and relationships to influence priorities where appropriate.

5.8.9 The four priorities established at the HWBB/ICP October development day affirms the Joint Administration's focus on population health management, prevention, and inequalities:

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

5.8.10 Our Director of Public Health will lead on the delivery of these priorities, in collaboration with priority leads. We are working with partners to identify leads to set targets and develop and deliver the outcomes' supported by appropriate KPIs.

5.8.11 To promote parity of esteem across health and social care and equality of voice we will advocate a rotating chair arrangement between Local Authorities and the NHS for the HWB/ICP Committee.

5.8.12 Health Scrutiny will, as it does now, be able to request evidence of performance against the ICS plans – this would likely be focused on the difference we are making as an ICS to the lives and outcomes of our residents. Again, this is in public and therefore providing transparency. It will be necessary to identify resource implications of effective Scrutiny and if additional resources are needed to explore whether there is any internal capacity that can be redirected to support effective Scrutiny or to seek resources through the business planning process.

5.8.13 The key areas where health and the local authority currently have joint accountabilities and have joint KPIs include:

- Discharge to assess (ensuring timely discharge from hospital into appropriate setting and services)
- Avoiding hospital admissions (health and care professionals working together to prevent the need for residents to go into hospital)

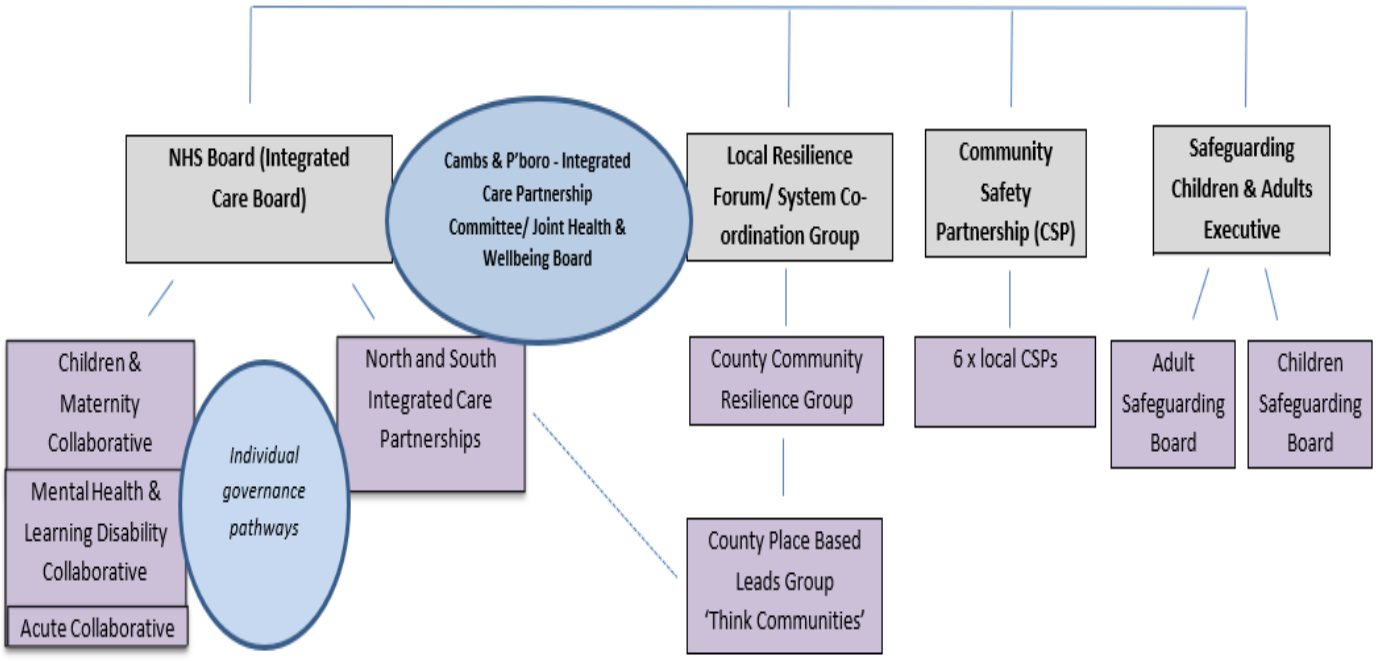
- Joint commissioning (making sure we are not competing for resources and we are securing the resources that meet need and represent value for money, including social value)
- Special educational needs and disabled children and children with complex needs
- Supporting those with mental health and learning difficulties to live independently

5.8.14 In these areas we align budgets or have S75 agreements (where we give the money to health to deliver services on our behalf or where health gives us money to deliver on their behalf) and develop joint strategies and plans. Much of this work is now being taken forward by the North and South ICPs and Collaboratives. Performance will be reported into the Integrated Care Partnership Committee/HWBB and Integrated Care Board. In addition, much of this work is reported into service committees as well. (Adults & Health and Children & Young People) Health Scrutiny will be asking for evidence of impact on residents.

5.8.15 At present health and LA business planning processes do not align, the LA start and end the business planning process in advance of health; health does not get agreement of their settlement until April – May each year. The only example of joint business planning is the Better Care Fund, this is signed off at the HWBB. This is an area for development in the ICS.

5.8.16 The structure below seeks to describe how the new Integrated Care System governance interplays with other statutory boards across the Cambridgeshire and Peterborough footprint.

CAMBRIDGESHIRE AND PETERBOROUGH STATUTORY GOVERNANCE STRUCTURE



6. Alignment with corporate priorities

6.1 Communities at the heart of everything we do
There are no significant implications for this priority.

6.2 A good quality of life for everyone
There are no significant implications for this priority.

6.3 Helping our children learn, develop and live life to the full
There are no significant implications for this priority.

6.4 Cambridgeshire: a well-connected, safe, clean, green environment
There are no significant implications for this priority.

6.5 Protecting and caring for those who need us
The creation of an Integrated Care System for Cambridgeshire and Peterborough takes place in response to the national reforms of health and social care. These reforms sit alongside the recently published Social Care White Paper 'People at the Heart of Care' which sets out a 10-year vision for adult social care and changes to the way social care is funded and how people will contribute to their care costs. The ICS relates to the whole population and is also of direct relevance to the Children and Young People and Communities, Social Mobility and Inclusion Committees. Joint working across these committees will be essential.

7. Significant Implications

7.1 Resource Implications
There are no significant implications within this category.

7.2 Procurement/Contractual/Council Contract Procedure Rules Implications
There are no significant implications within this category.

7.3 Statutory, Legal and Risk Implications
The report above sets out the implications for this priority in section 5.7

7.4 Equality and Diversity Implications
There are no significant implications within this category.

7.5 Engagement and Communications Implications
There are no significant implications within this category.

7.6 Localism and Local Member Involvement
There are no significant implications within this category.

7.7 Public Health Implications
This will support promotion of public health

7.8 Environment and Climate Change Implications on Priority Areas:

7.8.1 Implication 1: Energy efficient, low carbon buildings.
Positive/neutral/negative Status: neutral
Explanation: No direct impact

7.8.2 Implication 2: Low carbon transport.
Positive/neutral/negative Status: neutral
Explanation: No direct impact

7.8.3 Implication 3: Green spaces, peatland, afforestation, habitats and land management.
Positive/neutral/negative Status: neutral
Explanation: No direct impact

7.8.4 Implication 4: Waste Management and Tackling Plastic Pollution.
Positive/neutral/negative Status: neutral
Explanation: No direct impact

7.8.5 Implication 5: Water use, availability and management:
Positive/neutral/negative Status: neutral
Explanation: No direct impact

7.8.6 Implication 6: Air Pollution.
Positive/neutral/negative Status: neutral
Explanation: No direct impact

7.8.7 Implication 7: Resilience of our services and infrastructure and supporting vulnerable people to cope with climate change.
Positive/neutral/negative Status: neutral
Explanation: No direct impact

Have the resource implications been cleared by Finance? Yes
Name of Financial Officer: Justine Hartley

Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the Head of Procurement? Yes/No (email sent 05.01.22 awaiting confirmation)
Name of Officer: Henry Swan

Has the impact on statutory, legal and risk implications been cleared by the Council's Monitoring Officer or LGSS Law? Yes
Name of Legal Officer: Fiona McMillan

Have the equality and diversity implications been cleared by your Service Contact? Yes
Name of Officer: Charlotte Black

Have any engagement and communication implications been cleared by Communications? Yes/No (email sent 05.01.22 awaiting confirmation)

Name of Officer: Matthew Hall (been part of the Chair & Vice Chair discussions)

Have any localism and Local Member involvement issues been cleared by your Service Contact? Yes
Name of Officer: Charlotte Black

Have any Public Health implications been cleared by Public Health?
Yes
Name of Officer: Jyoti Atri (been part of the Chair & Vice Chair discussions)

If a Key decision, have any Environment and Climate Change implications been cleared by the Climate Change Officer?
Yes
Name of Officer: Sarah Wilkinson

8. Source documents guidance

8.1 Source documents

The King's Fund
https://www.kingsfund.org.uk/publications/integrated-care-systems-explained
https://www.kingsfund.org.uk/publications/health-and-care-bill-key-questions

The British Medical Association
https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/integration/integrated-care-systems-icss

Social Care Institute for Excellence Research for the Better Care Fund
https://www.scie.org.uk/integrated-care/better-care/guides/sharing-risks-benefits/challenges

The Health Foundation
https://www.health.org.uk/news-and-comment/consultation-responses/integrating-care%253A-next-steps-to-building-strong-and-effectiv

NHS Midlands and Lancashire Commissioning Support Unit
https://www.strategyunitwm.nhs.uk/sites/default/files/2018-06/Risk%20and%20Reward%20Sharing%20for%20NHS%20Integrated%20Care%20Systems%20-%20180605_0.pdf

NHS Confederation
https://www.nhsconfed.org/news/considerable-uncertainty-over-ics-accountability-new-report-finds

Royal College of Nursing
https://www.rcn.org.uk/professional-development/accountability-and-delegation

Local Government Association
https://www.local.gov.uk/parliament/briefings-and-responses/lga-response-nhs-england-and-nhs-improvement-consultation

APPENDIX 1:

The following table refers to the CCGs response entitled 'You Said we Did'- the relevant sections have been extracted.

Section	You said	We did
Introduction	Add a reference to a commitment to a user centred health and care system	We have added this reference at paragraph 1.1.4
Introduction	Set out in simple language, what we are trying to fix in the system	We have amended the text at 1.1.4 and 1.1.5 to make this clearer. We have used simple language subject to where legal and statutory requirements are set out
Board size and composition	Suggestion that an additional space on the Board be made available for the Local Authority/Director of Public Health	We have allocated an additional regular participant place on the Board for the Director of Public Health and this was included in our submission to NHSE on the Board size and composition
Board size and composition	Suggestion that an additional space on the Board be made available for Healthwatch to be a regular participant	We are continuing to have discussions internally and with Healthwatch and NHSE on where Healthwatch can add the most value to our ICS decision-making discussions
Appointments process	Confirm that APMS organisations are excluded from being partner members	A new disqualification criteria has been added at 3.2.3, as follows: A person whose involvement with the private healthcare sector or otherwise could reasonably be deemed to risk undermining the independence of the NHS
Appointments process	Suggestion that there should be equal representation from all responsible local authorities	The ICB is a unitary Board - there are no representatives on the Board, each member brings their sector perspective. The local authorities are able to jointly nominate the member drawn from the local authorities. No further changes will be made
Governance	An additional disqualification must apply for anyone with any financial or personal interest in a "for profit" company that provides health, care, or diagnostic services or that	As above, this has been added to the revised constitution for all ICBs

Section	You said	We did
	provides equipment used by the NHS, to avoid any potential conflict of interest	
Governance	The exclusion of private health providers in senior positions or at decision making meetings for the commissioning of services/spending of public money	This is now covered by a new disqualification criteria for the ICB, as above. The ICB Conflicts of Interest policy also provides a robust mechanism to ensure that we use NHS money wisely, providing best value for taxpayers and accountability to our patients for the decisions we take
Accountability and Transparency	The current CCG allows for questions from the public to be submitted and answered. The ICS should at least offer the same level of public scrutiny and provide an option for public participants to speak to their questions. Specify the process.	The Board and its committees will have to make decisions transparently, holding meetings in public and publishing the papers. We consider that the arrangements at 9.1.7 provide this flexibility but we have added an additional reference at Appendix 2 4.3.3 and will provide further detail on the process in the Governance Handbook
Communication and engagement	PPG network should be more widely used for communications and gathering input and feedback from the public	We have added further detail at sections 7 and 9 on how we will work with people and communities
Communication and engagement	Support wider and deeper involvement of local people in decision making and a commitment to specific action to seek and support involvement from those communities experiencing the greatest health inequalities	We have included this in the principles at section 7.2.1 and 9.1.5

Section	You said	We did
Communication and engagement	Provide and publish a mechanism whereby interested members of the public can "sign up" to be notified of consultations	This will be available on the ICS website
Scrutiny and decision-making	Specify that the default provider will always be an NHS provider where one is available or offered and the NHS Provider Selection Regime for competitive tendering will only be actioned if there is no NHS provider available	We cannot commit to defaulting to an NHS provider under the current guidance – only that we will use providers to deliver NHS services in a transparent way, in the best interests of patients, taxpayers and the population. No further changes will be made
ICP	Suggest an addition that the Board will seek to uphold the ICP's integrated care strategy wherever possible. And to merge as far as possible the ICP Committee and Health and Wellbeing Board agendas and develop one plan and one set of priorities	We have amended the text at 1.1.7 to read: 'The terms of reference for the ICP, and the Health and Wellbeing Board will be aligned with this Constitution' The detail on the arrangements to align the ICP Committee and HWB agendas/plans/priorities will be covered in the TOR of reference for the ICP and HWB rather than this constitution
Reporting	Add to the requirement to report on the implementation of the Health and Wellbeing Strategy to also cover the ICP Integrated Care Strategy	This has been added at 7.5.3. We have maintained the reference to the two strategies (HWB strategy and ICP strategy) although we can of course in practice deliver this as a single, aligned strategy
	Add reference to the ICP sub-committee	The ICB Constitution refers to ICB committees and sub committees. The ICP is not a committee of the Board, but rather a statutory committee of the ICS formed jointly with the local authorities. As such, the LA and the ICB are co-owners and equal partners in the ICP

Section	You said	We did
	Suggestion to add; • a commitment to build in the principle of local democratic accountability wherever possible; • an ‘equal partnership model’ being adopted in the ICS, fostering mutual respect between health, local authority and voluntary and community sector partners; • Consideration of a public service ethos and social value focus • building in the need to balance health prevention and social care outcomes	We have highlighted mutual respect and the value that each partner brings at 1.1.2 Social value is embedded as part of our contracting and procurement policies. The ICS will comply with the About Public Services (Social Value) Act 2012 Under which we are required to consider how the services we commission and procure might improve the economic, social and environmental well-being of the area. As the constitution relates specifically to the ICB, and is a high-level document, the points relating to local democratic accountability and social care outcomes will be included within other ISC supporting material where the points can be further expanded on

Adult Market Pressure Payments

To:	Adults & Health Committee
Meeting Date:	13 January 2022
From:	Charlotte Black, Executive Director, People & Communities
Electoral division(s):	All
Key decision:	Yes
Forward Plan ref:	2022/009
Outcome:	Committee are being asked to agree to the proposed approach to managing market pressures. The aim of the proposed scheme is to ensure that we have sustainable provision of Adult Social Care capacity across our independent provider market, ensuring we are able to meet the eligible assessed needs of individuals in line with our statutory responsibilities.
Recommendation:	The Adults and Health Committee is being asked to: a) agree to the implementation of the proposed approach to managing market pressures with budget implications for 2022/23 and beyond to be built into the Business Plan; and b) Agree to the proposed use of the Workforce Development Grant Round 2.

Officer contact:
Name: Charlotte Black
Post: Executive Director, People and Communities
Email: Charlotte.black@cambridgeshire.gov.uk
Tel: 07775 800209

Member contacts:
Names: Councillors Howitt and van de Ven
Post: Chair/Vice-Chair
Email: Richard.Howitt@cambridgeshire.gov.uk, susanvandeven5@gmail.com
Tel: 01223 706398

1. Background

1.1 The Impacts of COVID 19 in Cambridgeshire continue to bring a significant pressure to the provision of care and support in the community, both due to the additional demand on services and the impact of the pandemic, governance guidance on the workforce and mandatory vaccination legislation. In addition, changes to national legislation, including the increased rate of the National Living Wage to £9.50/hr from April 2022, the introduction of the Health and Social Care Levy and the proposed social care reforms, will introduce additional financial pressures to the local authority and wider provider market.

1.2 Whilst there has been government funding to help address some of these pressures, particularly in relation to infection and prevention control, this is one off in nature and is due to end at the end of March 2022. Whilst this goes some way to addressing some of the pressures and financial challenges faced by providers in the short term, it does not address the longer term, sustained pressures that providers are reporting, as a result of:

- Increased staffing costs – costs have increased 15.4% in 2021 and 17% since before COVID. This is due to higher recruitment costs, retention incentives, increased hourly rates, increased agency use, increased training costs, increased staff sickness costs etc.
- Impact on wellbeing and mental health - staff wellbeing is challenged, leading many staff to leave the sector.
- Loss of income - Private occupancy levels have fallen by 28% since pre-Covid, impacting on overall income for providers.
- Increasing insurance costs in Cambridge alone have increased by 80% for a premium for this year, as there are now only 2 insurance providers for the care home market.
- Food costs have increased by over 4.5% in 2021.
- Increased cleaning and PPE costs compared to pre Covid up nearly 300%.
- Repair costs are now rising due to the increase in the price of raw materials, up 14%.
- Brexit and care staff leaving the EU and departing the local area
- Providers having to apply for visas for new workers which impacts on timescales and costs
- Number of workers in the sector is static or diminishing and those who remain transit across providers, thus affecting local demand
- Low remuneration for the responsibility of the roles compared to less skilled work
- Winter pressures bring increased illness of staff (reducing workforce) and service users (increased demand), exacerbated by seasonal competition in warehouse and retail
- Lack of career progression and pay
- Inadequate training to deal with complex and specialist cases
- Less attractive conditions of employment including long and antisocial hours, travelling between homecare calls, poor rural infrastructure, not being paid for travel time
- The impact of mandatory vaccinations on the workforce

2. Main Issues

2.1 Infection Control, Rapid Testing and Vaccine funding, as outlined in the table below, is being passported to providers to support with the costs associated with this for the remainder of this financial year.

Grant	Allocation (October 21-Mar 22)
Infection Control Fund	£2,367,154
Rapid Testing Fund	£1,255,416
Vaccination Funding	£243,696
Total	**£3,826,266**

2.2 In November, government announced Workforce Development Funding of £1,573,580 until the end of March 2022, which we plan to passport to providers to address workforce pressures over winter. In December, government announced an additional £2.9m of Workforce Development Funding to be utilised by the end of March 2022. It is proposed to utilise some of this funding to offset the approach outlined in this paper for 2021/22.

2.3 Provider pressures are impacting across all elements of care provision, including residential/nursing care, home care and learning disabilities provision, creating additional risks to the health and social care system, at a time when capacity is already stretched by increased demand, winter pressures and financial challenges. These pressures are resulting in provider hand backs - over the last month alone 14 providers have handed contracts back, impacting on 20 service users and over 166 hours of care per week.

2.4 The risk of provider failure has a significant impact on the Local Authority and the provision of care, including:

- Disruption for existing residents who will lose their home, and potentially may need to move to another part of the County with minimal personal choice or preference.
- Clinical and social decline in the residents affected, particularly those with dementia who may struggle to understand the change and disruption.
- Difficulty in sourcing appropriate placements in alternative homes, particular when the same pressures may affect their capacity to accept
- Overall loss of capacity within the care home sector in Cambridgeshire

2.5 Alongside this we have a key opportunity to reshape provision, to move away from the traditional offering of residential home provision to deliver more flexible, local, person centred solutions based around peoples' homes, that deliver on the joint administration priorities, including - Care Together and Independent Living Services.

2.6 We need to work with providers to ensure sufficient, resilient market capacity in the short, medium and long-term. We want to engage with providers through a single conversation, which takes account of addressing pressures in a sustainable way alongside implementation of the joint administration priorities around implementation of real living wage and a social value return on investment. This means we need to address the following areas of market support:

- Short term emergency support to address the immediate challenges of workforce over winter, e.g. recruitment and retention, addressing infection control costs and pressures
- Medium to longer term financial sustainability in recognition of the longer-term pressures faced by providers, recognising increasing inflation rates, the impact of the health and social care levy and national living wage increases and implementation of the real living wage
- Medium to longer term workforce development support, including a local strategy and development of the care workforce as a profession

2.7 In addition to financial provision to manage increasing demand and demography (£10.036m in 2022/23) a number of options to address these pressures for providers have already been identified and currently £12.3m of budgetary investment in 2022/23 is being accounted for via the business planning process, as outlined below.

Pressure / Investment	2022/23 (£000)	2023/24 (£000)	2024/25 (£000)	2025/26 (£000)	2026/27 (£000)
Demand and Demography (Ref: A/R3.002 to A/R.3.007 and A/R.3.017)	10,036	11,539	11,398	11,107	11,267
Inflationary Pressures on Care Costs (Ref: A/R.2.002)	1,866	1,984	2,918	2,918	2,918
Impact of National Living Wage on Adult Social Care Contracts (Ref: A/R.4.009) *	7,172	7,565	4,883	4,883	4,883
Impact of Health and Social Care Levy on Care Providers (Ref: A/R.4.042)	1,000	-	-	-	-
Additional Investments – operational capacity	618	-	-	-	-
Additional Investment – Joint Administration Priorities	1,662	4,358	3,619	409	543
Total	**22,354**	**25,446**	**19,608**	**19,317**	**19,611**

*Incorporates the 6.6% increase to £9.50/hr.

This is against a backdrop of adults identifying c. £10.5m of savings, increased income and budget reductions for 2022/23.

2.8 Whilst this provides a range of financial support, it does not address all of the pressures providers are facing, and there are a number of additional options to consider implementing.

2.9 Option 1 – Do nothing: If we do nothing, in addition to the distribution of government funding and the investment already budgeted in the business planning as outlined above, then there will be no additional upfront cost to the local authority. However the pressures on the market will continue to exacerbate. This will lead to further provider hand-backs and decreased capacity to address statutory care needs. We are already in a position where provider hand backs are increasing, with 14 providers handing back contracts over the past month, impacting on 20 service users and over 166 hours of care per week.

2.10 *Option 2 – Emergency 10% uplift to address winter pressures:* This option would provide additional short term financial support to help address the immediate pressures of workforce and capacity over winter. Whilst this would support capacity over the next few months, this does not offer a sustainable long term financial solution for the market. The upfront cost of this would be significant to the council. There is also a risk that this approach could duplicate the passporting £5.2m of one-off government grant funding to providers between now and the end of March 2022.

2.11 *Option 3 – Implement full uplifts, NLW and RLW proposals and social value now:* NLW and RLW costs have been factored into the business planning budget for 22/23 onwards, with a phased approach to rolling out the RLW. This option would look and bringing these payments forward and implementing them immediately. Whilst this would offer a long-term sustainable solution to providers, there are a number of risks and issues with this approach, including:

- Permanent budgets will not be approved until the business planning process is complete and has full Council sign off in February 2022, so any payments to providers initiated in year would have to be communicated as 'temporary' or 'emergency' in nature, which may present a confusing message to the market.
- The cost of implementing the RLW has been factored into the business planning budget in a phased way over a 2-year period. To implement this in one uplift would present a significant financial pressure to the local authority of c. £10m in 2022/23.

2.12 *Option 4 – Additional investment in targeted areas:* This option would mean we continue to implement the approach to NLW and RLW in a phased way, in line with the business cases. This would result in NLW kicking in from 22/23 and the RLW being phased in over 2 years. In addition to the government grant funding and the business cases already accounted for within business planning, we have identified a number of areas where additional targeted investment would be beneficial, as outlined below:

Investment Area	Description	2021/22 Investment (£000)	2022/23 Investment (£000)
Care Homes – Blanket Uplift	In order to support the market to meet the financial challenges and mitigate the risk to the decline in quality of provision, we propose to: • Uplift all spot's below T1 rates to T1 block bed rates (backdate to April 2021/October 2021 dependent on contract anniversary date) to support providers with low spot rates • Uplift all T1 block beds to T2 block bed rates backdated to October 2021 • Apply no uplifts to T2 block beds or spot placements above the T1 rate There is a current uplift budget of £456k available in year, so this has been offset against the total.	379	NIL

	The cost of this for 2021/22 would be £835k. With the current uplift budget of £456k available, this would require an additional £399k for 2021/22. ***The additional cost in 2022/23 would be £800k but we have sufficient inflationary drag funding in the budget for 2022/23, so no additional funding would be required.***		
Home Care – Blanket Uplift	The main areas of pressures faced by home care providers are: • Fuel and utilities increases • NI increase, as a result of the health and social care levy • NI increase for staff / move to more competitive pay The proposal is to increase the hourly rate by £0.65 per hour, backdated to April 2021, in addition to the business planning investment already outlined. This will cost £985k in 2021/22 and £986k in 2022/23.	985	986
Home Care – Specific Provider Uplift	A 12-month extension was announced to providers of the home care block cars in March 2021, to run from June 2021 to June 2022. An annual uplift was awarded which equates to a pressure of £159,541 for the existing double up cars from 22/23 onwards. This can be offset in 2021-22 against the savings from decommissioning single cars. However, the full saving on the re-tender of £235,853 has been offered as a saving in 2022/23 as part of the business planning process. This means that there will be a pressure that needs funding from 2022/23.	NIL	160
Learning Disabilities – Floating Support	In order to ensure sufficient support is in place for LD providers to support capacity over winter. To support people with Learning Disability and/or Autism across Cambridgeshire, including: • 24 hour support at home • Additional staffing to existing supported living provision	65	NIL

	• Providing emergency support in the community • Flexible support within the community or within the home as an alternative to residential respite • Additional staffing to support in existing residential care provision We would be looking to commission an initial block of support to ensure that there are two floating support staff available to undertake any of these support packages based in the community/people's. We anticipate that the proposed funding for this service at a weekly cost of £2,033 per worker per week = 2 x £2,033 x 16 weeks = £65,056		
Learning Disabilities – uplift	It is requested that additional uplift funding is made available to providers of LD services in particular for LD residential, respite, supported living and day opportunities in order for our financial commitments to meet the demand to support people with higher needs. It is proposed that this is made to contracted LD providers where need is evidenced in recognition of market and inflationary pressures. This would be separate/additional to any future payments which may be made linked to staffing such as recruitment and retention payment which may be targeted at CQC registered providers only. This payment would support providers to continue to operate, particularly given the recent known inflationary increases for non-staffing costs such as accommodation, utilities and fuel. The uplift will equate to investment of £686k (local authority share) in 21/22 and £686k (local authority share) in 22/23.	686	686

Workforce Development	The following areas of investment in workforce development have been identified. • Workforce Strategy Development • Resource to set up and deliver recruitment programme (targeted at schools, colleges, apprenticeships etc)		
	Workforce Strategy Development: Having good quality capacity is predicated on a suitable skilled workforce which can be retained and new skills recruited to meet the ongoing demand for different services. The council will seek to develop a workforce strategy in collaboration with providers to set the strategic direction for this. Due to our own capacity challenges and competing demands it is not possible to undertake this in any reasonable timeframe. Therefore to enable this to happen additional resource is needed for a six-month period. It is anticipated that this will incur a pressure of £67,000 in 2021/22 and £32,000 in 2022/23.	67	32
	Workforce Recruitment Programme: In order to support the homecare market in recruiting new applicants, attracting new people into care industry, we will develop a recruitment programme. This will involve engaging with schools, colleges and working in partnership with the health and care academy, as well as providers to begin changing the narrative around care and careers within care. We are already working in partnership with the health and care academy, and understand there are courses available for free, however not everyone who is completing it goes on to work within care. Understanding where and why this happens will be vital in trying to solve the issue of recruiting and retaining new people into care. Either inhouse or commission an organisation to provide: • 1.5 FTE staff to manage service to work alongside all stakeholders to deliver engagement programmes.	30	120

	• To review and analyse existing support and courses available and understand where in the pipeline people are falling away from working in care. • Marketing campaign to support the strategy, alongside resource support for providers who will be working with us in partnership to successfully run the strategy. Total spend: £120,000/annum for two years (£240,000 over two year contract)		
Total		**2,212**	**1,984***

2.13 Recommended Option: The recommended option is option 4. This is reflective of the budget pressures and risks that have already been accounted for as part of the business planning process, whilst recognising that there are additional interventions needed to stabilise the market.

2.14 This would require additional investment in 2021/22 of £2.2m. The recently announced second round of Workforce Recruitment and Retention funding can be used to fund some of this support, where it falls within the grant criteria and is incurred between December 2021 and March 2022. Further details of this grant are set out at section 2.20 below.It is suggested that the remainder of the support in year be funded by existing ASC budget underspends within the service area. As of October, the adults and safeguarding directorate wee reporting a forecast underspend of £4.6m for 2021/22. In 2022/23 a corporate investment of £2.0m would be required.

2.17 Additional Financial Risks in 2022/23

2.17.1 Market risks: In addition, the following budget risks related to the market have been identified for 2022/23. Whilst we are not asking for additional investment to be made into the 2022/23 budgets at this stage, it is important to highlight that these may present a pressure next financial year, which would need to be addressed in year.

2.17.2 Community Equipment: The community equipment service is heavily dependent on third party suppliers across a variety of sectors. Community equipment costs have significantly increased as a result of the pandemic. There is a risk to the budget in 2022/23 as a result of inflationary cost pressures we may continue to see come through. There is no inflationary provision currently included in budget for the community equipment contract as part of the 2022/23 uplift strategy. The contract was recently re-tendered and a saving of £121k has been offered for 2022/23 as part of business planning. The saving has been modelled on the basis of reduced activity costs, assuming the same pattern of expenditure/mix of products next year.

2.17.3 We know pressures on equipment prices are particularly high at the moment due to shipping container shortages and Brexit. Any further price increases would not be covered within the contract and would be a pressure passed to the Council. Modelling a c. 2% increase across all equipment, which would a prudent, mid-way point in terms of the pressure we could see in reality, would present an additional pressure of c. £20k to the budget in 2022/23.

2.18 Other risks

2.18.1 The following risks which are not directly related to the market pressures are also being worked on / taken forward through separate papers:

- Retention payments for social work staff within Adult Social Care – the subject of a separate paper to January committee.
- Deprivation of Liberty Safeguards / Liberty Protection Safeguards – new guidance was due to have been issued by now in relation to the implementation of Liberty Protection Safeguards during 2022-23. We are still awaiting this guidance before we can assess the impact on staffing / operational costs. But whilst we await the guidance we are looking to clear the backlog of DoLS assessments which are overdue. This is expected to cost £179k over 2 years but is planned to be covered in year by underspends, and next year within the Adults budget or from the ASC risk reserve.
- Reforms to Adult Social Care - the details behind the government's recent announcements on reform of adult social care, including the cap on care costs, are awaited. The reforms will increase costs for the Council but as yet we do not know how much of this will be funded. As further information becomes available work will continue to quantify the financial impact of the changes.

2.19 Workforce Recruitment and Retention Fund Round 2

2.19.1 In December 2021, the government announced a further round of additional funding of £2.9m for Cambridgeshire County Council. The purpose of this funding is to support workforce recruitment and retention for adult social care between 10/12/2021 and 31/03/2022.

2.19.2 Following discussion with local providers and partners, including local NHS partners, it is proposed that the funding be utilised to address the following key areas of known workforce pressures. This approach enables us to target funding appropriately, based on the identified internal and external workforce capacity pressures:

- C. 80% of funding to be passported to the market to address workforce pressures over the winter, including supporting the implementation of the approach outlined in this paper.
- Remaining 20% of funding to be utilised to address identified internal workforce capacity pressures, including:
    - funding of the social worker retention payment scheme for payments made before 31 March 2022, as per the 'Adults Retention Payment' paper being presented to the January 2021 Committee. This will enable us to bring forward these payments into 2021/22, to support retention of staff in key front line social care roles.

- Funding of capacity to address the reviews backlog for costs incurred before 31 March 2022, creating additional internal staffing capacity to address this; and
- Targeted recruitment interventions to drive up recruitment for local authority staffing, reducing vacancy rates across social care roles.

2.19.3 Utilising the funding in this way will support sufficient adult social care workforce capacity throughout the coming winter months. Addressing both identified internal workforce capacity issues, as well as supporting external independent providers who provide care and support to those who are most vulnerable. This includes a focus on both recruitment of additional staff, retention of staffing and training for staff. This will support the aims of:

- Supporting timely and safe discharge from hospital where ongoing care and support is needed
- Support providers to maintain the provision of safe care and bolstering capacity with providers to deliver more hours of care
- Support providers to prevent admission to hospital
- Enable timely new care provision in the community
- Support and boost retention of staff within social care

2.19.4 Due to the late notification of funding, and the need for rapid implementation/distribution of funding needed prior to year-end, we are proposing that the committee agree the approach for utilising this funding.

3. Alignment with corporate priorities

3.1 Communities at the heart of everything we do

There are no significant implications for this priority.

3.2 A good quality of life for everyone

Provider sustainability will help to support sufficient quality adult social care provision is available, enabling people to be supported in the right way, in the right place at the right time, ensuring the best outcomes for people.

3.3 Helping our children learn, develop and live life to the full

There are no significant implications for this priority.

3.4 Cambridgeshire: a well-connected, safe, clean, green environment
There are no significant implications for this priority.

3.5 Protecting and caring for those who need us
There are no significant implications for this priority.

4. Significant Implications

4.1 Resource Implications
The report above sets out details of significant financial implications in paragraph 2.14

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications
Whilst no specific procurement implications are raised within this report, we will continue to work with procurement to ensure compliant processes are developed to deliver the required aims.

4.3 Statutory, Legal and Risk Implications
There are no significant implications for this category.

4.4 Equality and Diversity Implications
There are no significant implications for this category.

4.5 Engagement and Communications Implications
There are no significant implications for this category.

4.6 Localism and Local Member Involvement
There are no significant implications for this category.

4.7 Public Health Implications
There are no significant implications for this category.

4.8 Environment and Climate Change Implications on Priority Areas:
There are no significant implications for this category.

4.8.1 Implication 1: Energy efficient, low carbon buildings.
Positive/neutral/negative Status: Neutral
Explanation: The proposal has no impact on this.

4.8.2 Implication 2: Low carbon transport.
Positive/neutral/negative Status: Neutral
Explanation: The proposal has no impact on this.

4.8.3 Implication 3: Green spaces, peatland, afforestation, habitats and land management.
Positive/neutral/negative Status: Neutral
Explanation: The proposal has no impact on this.

4.8.4 Implication 4: Waste Management and Tackling Plastic Pollution.
Positive/neutral/negative Status: Neutral
Explanation: The proposal has no impact on this.

4.8.5 Implication 5: Water use, availability and management:
Positive/neutral/negative Status: Neutral
Explanation: The proposal has no impact on this.

4.8.6 Implication 6: Air Pollution.
Positive/neutral/negative Status: Neutral

Explanation: The proposal has no impact on this.

4.8.7 Implication 7: Resilience of our services and infrastructure, and supporting vulnerable people to cope with climate change.
Positive/neutral/negative Status: Neutral
Explanation: The proposal has no impact on this.

Have the resource implications been cleared by Finance? Yes
Name of Financial Officer: Justine Hartley

Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the Head of Procurement? Yes
Name of Officer: Henry Swan

Has the impact on statutory, legal and risk implications been cleared by the Council's Monitoring Officer or LGSS Law? Yes
Name of Legal Officer: Amy Brown

Have the equality and diversity implications been cleared by your Service Contact?
Yes
Name of Officer: Will Patten

Have any engagement and communication implications been cleared by Communications?
Yes
Name of Officer: Matthew Hall

Have any localism and Local Member involvement issues been cleared by your Service Contact? Yes
Name of Officer: Will Patten

Have any Public Health implications been cleared by Public Health?
Yes
Name of Officer: Emily Smith

If a Key decision, have any Environment and Climate Change implications been cleared by the Climate Change Officer?
Yes
Name of Officer: Sarah Wilkinson

5. Source documents guidance

5.1 None

Adult Social Care Retention Payments

To:	Adults & Health Committee
Meeting Date:	13 January 2022
From:	Charlotte Black, Executive Director, People & Communities
Electoral division(s):	All
Key decision:	Yes
Forward Plan ref:	2022/027
Outcome:	Committee are being asked to agree to a retention payment scheme for Adult Social Workers, where we are experiencing high turnover and vacancy rates. The aim of the proposed scheme is to retain our current Adult Social Worker capacity and have a positive impact on outcomes, quality, performance, management of demand and prepare to meet the additional requirements resulting from adult social care reform.
Recommendation:	The Adults and Health Committee is being asked to: a) agree to the implementation of a retention payment scheme for Adult Social Workers, with an investment of £302k in 2022/23 and a further £152k in 2023/24.

Officer contact:
Name: Charlotte Black
Post: Executive Director for People and Communities
Email: charlotte.black@cambridgeshire.gov.uk
Tel: 01223 727993

Member contacts:
Names: Councillors Howitt and van de Ven
Post: Chair/Vice-Chair
Email: Richard.Howitt@cambridgeshire.gov.uk, susanvandeven5@gmail.com
Tel: 01223 706398

1. Background

1.1 Over the last 12 months the Adults and Safeguarding directorate have experienced significant difficulties in recruiting to social work roles, as a result we now have a robust vacancy monitoring system in place. This has shown us that we are beginning to experience a recruitment trend similar to that of children's social workers. We would like to take the learning from our Children's Social Care, where a retention payment scheme for Social Workers has already been introduced and get ahead of this issue before it escalates further. Evidence so far is this scheme has been effective in retaining staff.

2. Main Issues

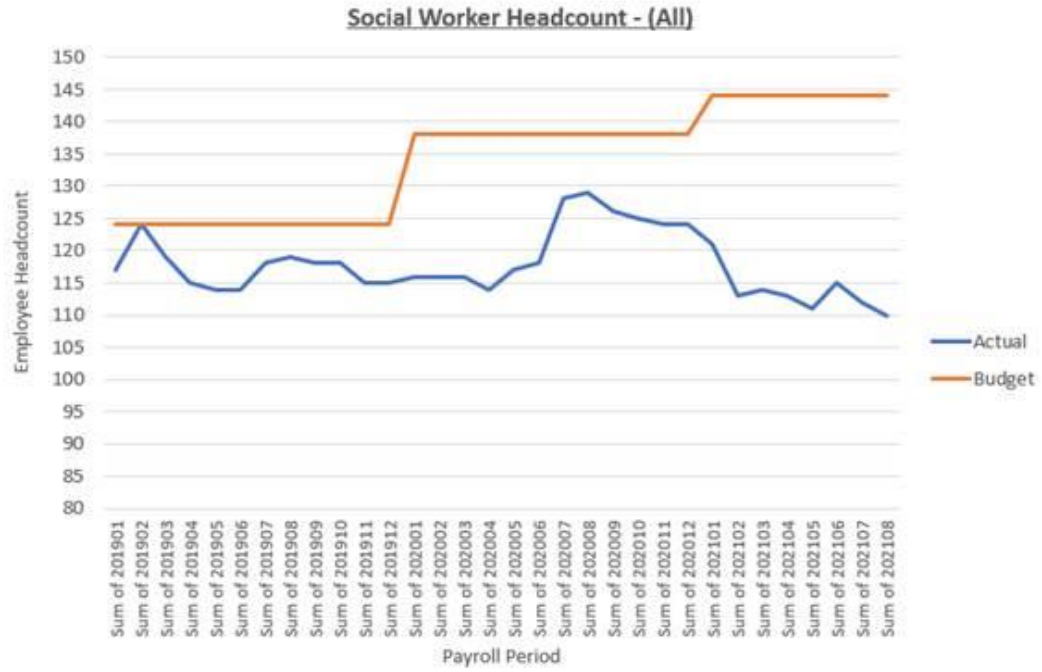
2.1 The Adult Social Care reform set out in the White Paper means that by September 2023 we will need to have completed a social work assessment for all those who currently pay for their own care who may be eligible for financial support as a result of the Social Care reforms. Currently we provide financial support for less than 1 in 25 of over 65s and national estimates are that approximately 14% of over 65s will meet the cap for care costs in the future. It is essential that we are able to retain our current Adult Social Worker capacity to meet our current statutory requirements and be in a position to successfully expand it further to meet these future demands.

2.2 The Association of Directors of Adults Services (ADASS) network is reporting similar issues with Social Work recruitment across all LA's following the covid pandemic and many are also considering introducing retention schemes as a result. Therefore, we need to ensure that we remain competitive with other authorities by offering our Adult Social Workers a financial benefit to stay with us.

2.3 High levels of vacancy and instability amongst social workers and team managers have an adverse impact on outcomes, quality, performance and management of demand. In adults this impacts on our ability to meet statutory requirements and means we miss opportunities to take actions that will improve outcomes, manage demand and prevent need from escalating and cost increasing. High vacancy levels lead to other costs such as the need to bring in external agencies to deal with our backlogs in reviews. Vacancy levels have reached 32% in some teams demonstrating that both recruitment and retention is an issue. The full detail of vacancy percentage by team and month is shown:

	Vacancies as a percentage					
	Apr-21	**May-21**	**Jun-21**	**Aug-21**	**Sep-21**	**Oct-21**
Older People/ Physical Disability	**15.84%**	**16.93%**	**13.96%**	**16.16%**	**16.16%**	**19.21%**
Transfer of Care	**12.23%**	**12.57%**	**17.55%**	**13.69%**	**10.71%**	**8.82%**
Learning Disability/ Adults with Autism	**2.63%**	**9.52%**	**7.32%**	**12.20%**	**23.40%**	**32.57%**
Mental Health	**9.76%**	**12.20%**	**16.82%**	**14.29%**	**18.60%**	**18.60%**

The graph below shows the total social worker headcount comparison across all teams suggested to be in scope and the gap between budgeted posts and posts that are filled showing the increase in turnover.



2.4 The impact of turnover in teams is significant, causing backlogs and delays to allocate services to meet need early and prevent escalation. It also puts additional pressure on social workers in the service, with high case- loads, resulting in reduced job satisfaction and stress, on occasion resulting in sickness absences. When a vacancy is created there is often a gap whilst recruitment is undertaken, resulting in delays to casework being undertaken and appropriate and timely support being provided which leads to increased risks and cost.

When considering a retention scheme for Social Workers and which teams this should apply to, we have considered the overall impact that this is likely to have across the directorate. Several teams have been excluded including the MASH, Adult Early Help, Quality and Practice Teams, Care Home Support Team and several other teams where there doesn't appear to be an issue.

The teams that are suggested to be in scope are those that are dealing with complex social work assessments and long term care planning, where the impact of vacancies and turnover create the greatest issues. The Teams in scope would be:

- Older People and Physical Disability
- Mental Health
- Transfer of Care Team
- Learning Disability Partnership
- 0-25 includes Young Adults Team and Children's Disability Services

2.5 The principles of the scheme already introduced to Children's Social Workers would apply to Adult Social Care. The Retention Payment Scheme will see Social Workers and Senior

Social Workers receiving a total of 20% of starting salary of P1 or P2 respectively, paid as three non-consolidated incremental payments over a period of three years, followed by a fixed rate payment thereafter. Team Managers will receive a fixed payment each year following one year's service.

2.6 General Principles:

It will be clear in our pay policy that retention payments are non-contractual discretionary payments, and the Council reserves the right to discontinue payments in the event of significant financial difficulty. Individual teams or roles can be removed from the agreed list of eligible teams/roles in the event that retention and recruitment is no longer an issue. In both situations, 6 months' notice of the withdrawal of payments will be given and those in eligible roles will be made aware of this.

Where an individual voluntarily moves to a role that does not attract a retention reward the eligibility for payment will cease from the date of change of appointment and will not be paid if they are in their notice period and leaving the organisation or subject to formal disciplinary or work performance processes.

Employees who receive a retention reward and subsequently leave the Council's employment are not expected to pay back the reward.

A review of the Adults and Children's retention payment schemes will be led by HR annually to ensure that the scheme is in line with market conditions

2.7 Costs:

The option of doing nothing would be likely to result in increased staff turnover. This would result in ever increasing agency social workers costs and a reduced quality of service and expose the County Council to a considerable level of risk.

To apply the model agreed for Children's Social Care which would see an incremental payment rising to 10%, the direct cost of retention payments would be £650k at the high point (2023/24) and require additional funding of £454k. This would ensure parity between adults and children's and would also future proof the Council as many other neighbouring Councils are developing similar approaches.
The table below shows the modelled annual cost of the scheme and the additional funding that will be requested. It should be noted that no additional funding is requested in 2021/22 as it is proposed that the costs are funded from Workforce Funding for Adult Social Care received from the government. Learning Disability and Young Adults Team costs will be a funded from the pooled budget. The Committee is being asked to agree funding for the cost of retention payments for the remaining Adult social care teams (Older People, Physical Disability, Mental Health, Transfers of Care and Adults and Autism Team). Historic over-achievement against the internal Learning Disability pooled budget vacancy savings target is sufficient to absorb the cost without requiring additional funding. It is assumed that costs for the Children's Disability Team (budget is not part of A&S) will be funded from excess vacancy savings consistent with the Children's scheme.

The impact on in-year Adults & Safeguarding vacancy savings from reducing average social worker and senior social worker vacancy levels has been assessed as £162.5k. It is

proposed that this risk can be absorbed within Adults & Safeguarding without requiring additional funding due to historic over-achievement against in-year vacancy savings.

It should also be noted that DHSC may continue to provide Workforce Funding for Adult Social Care to Local Authorities in future years and it would be reasonable to call on this to meet some of these costs where they meet the criteria.

	2021/22 £000	2022/23 £000	2023/24 £000	2024/25 £000	2025/26 £000	2026/27 £000
Adults & Safeguarding Funding Request	***128***	***302***	***454***	***392***	***402***	***353***
Learning Disability & Young Adults Team - Cost to Pool Budget	35	82	129	119	125	110
Children's Disability - Cost funded by Vacancy Savings	19	43	67	60	62	55
Total Cost	**182**	**427**	**650**	**571**	**589**	**518**

Business Planning Bid	0	302	152	-62	0	0

3. Alignment with corporate priorities

3.1 Communities at the heart of everything we do

There are no significant implications for this priority.

3.2 A good quality of life for everyone
There are no significant implications for this priority.

3.3 Helping our children learn, develop and live life to the full
There are no significant implications for this priority.

3.4 Cambridgeshire: a well-connected, safe, clean, green environment
There are no significant implications for this priority.

3.5 Protecting and caring for those who need us
There are no significant implications for this priority.

4. Significant Implications

4.1 Resource Implications
The report above sets out details of the cost implications in section 2.7.

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications
Whilst no specific procurement implications are raised within this report, we will continue to work with procurement to ensure compliant processes are developed to deliver the required aims.

4.3 Statutory, Legal and Risk Implications
There are no significant implications within this category.

4.4 Equality and Diversity Implications
Payments will be made to all staff in eligible posts. Work will be undertaken to review pay rates of other lower paid staff who play a crucial role in Adult Social Care without a social work qualification.

4.5 Engagement and Communications Implications
There will be engagement with the relevant unions.

4.6 Localism and Local Member Involvement
There are no significant implications within this category.

4.7 Public Health Implications
There are no significant implications within this category.

4.8 Environment and Climate Change Implications on Priority Areas
There are no environment and climate change implications.

4.8.1 Implication 1: Energy efficient, low carbon buildings.
Positive/neutral/negative Status: Neutral
Explanation: The proposal has no impact on this.

4.8.2 Implication 2: Low carbon transport.
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Name of Legal Officer: Amy Brown

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Yes
Name of Officer: Will Patten

Have any engagement and communication implications been cleared by Communications?
Yes
Name of Officer: Matthew Hall

Have any localism and Local Member involvement issues been cleared by your Service Contact? Yes
Name of Officer: Will Patten

Have any Public Health implications been cleared by Public Health?
Yes
Name of Officer: Emily Smith

If a Key decision, have any Environment and Climate Change implications been cleared by the Climate Change Officer?
Yes
Name of Officer: Sarah Wilkinson

5. Source documents guidance

5.1 None

Adults and Health Policy and Service Committee Agenda Plan

Published on 4 January 2022

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 Committee meeting:

- Minutes of previous meeting and Action Log
- Agenda Plan, Training Plan and Appointments to Outside Bodies and Internal Advisory Groups and Panels

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for reports	Agenda despatch date
13/01/22	Integrated Care System (ICS) - Cambridgeshire County Council position paper	C Black and J Atri	Not applicable	04/05/22	05/01/22
	Adult Market Pressures	C Black	2022/009		
	Adults Retention Payments	C Black	2022/027		
	Covid 19 Update	J Atri	Not applicable		
	Scrutiny Items				
	Integrated Care System (ICS) Scrutiny	J Thomas and J O'Brian	Not applicable		
	Neuro-Rehabilitation Consultation	J Thomas and J O'Brian	Not applicable		
17/03/22	Mental Health Employment Service	S Bye	2022/001	04/03/22	09/03/22

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for reports	Agenda despatch date
	Procurement of Older People's Visiting Support Service	L Sparks	2022/006		
	Individual Service Fund Tender	G Hodgson	2022/008		
	Procurement of Countywide Floating Support service	L Sparks	2022/007		
	Provision of Healthwatch Service	S Bye	2022/005		
	Care and support in Extra Care	L O'Brien	2022/019		
	Care Together	J Melvin	Not applicable		
	Finance Monitoring Report	J Hartley	Not applicable		
	Performance Monitoring Report	T Barden	Not applicable		
	CPFT S75 Mental Health annual report	D Mackay	Not applicable		
	Annual Service User's survey	C Black	Not applicable		
	Adults Safeguarding annual report	C Black / J Procter	Not applicable		
	Risk Register	D Revens	Not applicable		
	Covid 19 Update	J Atri	Not applicable		
	Scrutiny Items				
	Delegated authority to respond to NHS Trust Quality Accounts	K Parker			
	Hinchingbrooke Hospital Site Development Proposals	NWAFT TBC			
21/04/22 Reserve date				08/04/22	13/04/22

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for reports	Agenda despatch date
14/07/22	Place Based Homecare Model in East Cambridgeshire (Care Together)	R Miller	2022/016	01/07/22	06/07/22
15/09/22 Reserve Date				02/09/22	07/09/22
05/10/22				23/09/22	27/09/22
15/12/22				02/12/22	07/12/22
12/01/23 Reserve Date				TBC	04/01/23
09/03/23				24/02/21	01/03/23
27/04/23 Reserve Date				14/04/23	19/04/23

Please contact Democratic Services democraticservices@cambridgeshire.gov.uk if you require this information in a more accessible format

To be scheduled: Healthy Weight Update, Decentralisation report.

Adults and Health Committee Training Plan 2021/22

Below is an outline of topics for potential training committee sessions and visits for discussion with the new Adults and Health Committee.

The Adults & Health Committee induction recording can be sent to Members by contacting democraticservices@cambridgeshire.gov.uk

Suggested dates	Timings	Topic	Presenter	Location	Notes
Thursday 28 October 10:00 - 11:00 Virtual Teams meeting	1 hour	Public Health and the COVID-19 pandemic – roles and responsibilities Local Outbreak Management Plan	Deputy Director of Public Health (CCC) and consultant leads Cell leads / Surveillance	This will be an interactive session in relation to Outbreak Management In addition, in this session you have the opportunity to talk to staff involved in outbreak control including the contact centre staff who provide support to those self-isolating	**PH session: Hold in PH & Members' Diary** Minimum attendance of 4 members
Friday 29 October 15:00 - 16:00 Virtual Teams meeting	1 hour	Introduction to Children and Young People's Public Health Commissioning	Public Health Consultant lead – Children and Young People – Raj Lakshman	Virtual	**PH session: Hold in PH & Members' Diary** Children's Committee to be invited
Thursday 11 November 10:00 - 12:00	2 hours	Introduction to Health Improvement and Public Health Commissioning	Deputy Director of Public Health (CCC) Public Health Joint Commissioning Unit (JCU) PH Commissioning Team Leads	Virtual introduction into public health commissioning	**PH session: Hold in PH & Members' Diary**

Suggested dates	Timings	Topic	Presenter	Location	Notes
Virtual Teams meeting					Maximum attendance of 3 Members, can be arranged on request
Thursday 11 November 9.00 – 10.00 Virtual Teams meeting	1 hour	Overview of Transfers of Care, the role of the Transfers of Care Team and an overview of Brokerage: - What is 'discharge to assess'? - How the service works - how many people we support and some case examples?	Head of Transfers of Care, Head of Brokerage, Contracts & Quality Improvement	Virtual	**ASC Session:** Minimum attendance of 4 Members
Wednesday 17 November 13:00 to 14:00	1 hour	Overview of Public Mental Health and Mental Health Services and the role of Social Care including an overview of commissioning related to Mental Health. Some examples of the current people we support	Trust Professional Lead for Social Work, CPFT Senior Commissioner: Prevention, Early Intervention and Mental Health Public Health Consultant lead for Mental Health	Virtual	**PH Session:** Minimum attendance of 4 members
Thursday 18 November **10:00 to 11:00**	1 hour	Introduction of Public Health Intelligence (PHI) – information for Public Health and Public Heath Inequalities	Deputy Director of Public Health (PCC) PHI lead and Team	Virtual Interactive	**Holds in the PH and Members' Diary**

Suggested dates	Timings	Topic	Presenter	Location	Notes
Thursday 18 November 11.00 – 12.00	1 hour	An overview of Adult Social Care Finance to include Charging policy and Direct Payments	Strategic Finance Manager, Head of Adults Operational Finance, Public Health	Virtual	**Finance Session** Minimum attendance of 4 Members
Monday 22 November Amundsen House 9.30 – 12.00 Scott House 13.00 – 16.00 **Thursday 25 November** Amundsen House 9.30 – 12.00 Scott House 1pm – 4.30pm	1 day or 2 half days	Overview of the Adult Social Care Customer Journey including Prevention & Early Intervention Services and Long-Term Complex Services. At this session you will start the day at Amundsen House and be introduced to our Prevention & Early Intervention services, where many of our customers start their journey. You will have the opportunity to listen into live calls and get to know more about Adult Early Help, Reablement and Technology. In the afternoon, you will visit our Social Work Teams for Older People and the Learning Disability partnership in Scott House	Head of Prevention & Early intervention, Head of Assessment & Care Management, Social Work Teams	Amundsen House & Scott House	**ASC Session:** Maximum attendance of 4 Members & can be arranged on request

Suggested dates	Timings	Topic	Presenter	Location	Notes
****New date**** **Tuesday 15 February** **Virtual** **2.00pm – 4.00pm**		and have the opportunity to experience case work.		Virtual	
Thursday 25 November 10:00 - 11:00	1 hour	Introduction Public Health and Prevention Primary Prevention Healthy Aging and Falls Prevention Mental Health	Deputy Director of Public Health (CCC) Public Health Consultant leads Adults & Social Care, Mental Health. Team Manager (Health in All Policies) Senior Public Health Manager Partnerships	Virtual	**PH Session:** Hold in PH & Members' Diary
Thursday 25 November 14.30 – 16.00 Cancelled	1 ½ hours	Introduction to Health Protection and Emergency Planning	Deputy Director of Public Health (PCC) Public Health Consultant lead TBC Senior Public Health Manager (Emergency Planning and Health Protection)	Virtual Interactive	**PH session:** Emmeline Watkins With Tiya Balaji Minimum attendance of 4 members
Tuesday 30 November	1 hour	Introduction to Integrated Care Systems	Jan Thomas (CCG appointed to CEO ICS)	Virtual	**PH session:**

Suggested dates	Timings	Topic	Presenter	Location	Notes
On request **November**	2 hours	Introduction to Health Improvement and Public Health Commissioning	Deputy Director of Public Health (CCC) Public Health Joint Commissioning Unit (JCU) PH Commissioning Team Leads	In this session, you will start at Scott House prior to visiting the Drug and Alcohol Service or Lifestyle services	**PH Session:** Maximum of 4 members to be arranged on request
November Date to be confirmed External session	**TBC**	Introduction to Scrutiny	Director of Public Health Head of Public Health Business Programmes	Virtual	**Dem services** Minimum attendance of 4 members
November Date to be confirmed External Session	**TBC**	Introduction to the Integrated Care System	Partners from the ICS /NHS will be leading this session for members of scrutiny committees across Cambridgeshire & Peterborough	Virtual	**Externally Lead** Minimum attendance of 4 members
On request	1 hour + visit	Adult Safeguarding and Making Safeguarding Personal. An overview of how Safeguarding works and the role of the Multi Agency Safeguarding Hub (MASH)	Assistant Director of Safeguarding, Quality & Practice	Virtual or Stanton House and could include a visit to the MASH in God-Manchester	**ASC Session:** Maximum attendance of 4 Members, to be arranged on request

Suggested dates	Timings	Topic	Presenter	Location	Notes
On request **Monday 1 November** 11.00 – 13.00	90 mins	Overview of the Learning Disability Partnership (LDP) including an overview of commissioning related to Learning Disability including: - Adults & Autism - 0-25 Young Adults Team - Preparation for Adulthood - Housing and Accommodation - Day Opportunities- in house provision and external - Carers Direct Payments and Personal Health Budgets	Head of Learning Disability Partnership, Head of Commissioning Adults Social Care, Mental Health and Learning Disabilities, Senior Commissioner LDP	Scott House or Virtual, this could also include a visit to one of our In-House Provider settings	**ASC Session:** Maximum attendance of 4 Members, to be arranged on request

GLOSSARY OF TERMS / TEAMS ACROSS ADULTS & COMMISSIONING

More information on these services can be found on the Cambridgeshire County Council Website:
https://www.cambridgeshire.gov.uk/residents/adults/

ABBREVIATION/TERM	NAME	DESCRIPTION
COMMON TERMS USED IN ADULTS SERVICES		
Care Plan	Care and Support Plan	A Care and Support plans are agreements that are made between service users, their family, carers and the health professionals that are responsible for the service user's care.
Care Package	Care Package	A care package is a combination of services put together to meet a service user's assessed needs as part of a care plan arising from a single assessment or a review.
DTOC	Delayed Transfer of Care	These are when service users have a delay with transferring them into their most appropriate care (ie; this could be from hospital back home with a care plan or to a care home perhaps)
KEY TEAMS		
AEH	Adults Early Help Services	This service triages requests for help for vulnerable adults to determine the most appropriate support which may be required
TEC	Technology Enabled Care	TEC team help service users to use technology to assist them with living as independently as possible
OT	Occupational Therapy	
ASC	Adults Social Care	This service assesses the needs for the most vulnerable adults and provides the necessary services required
Commissioning	Commissioning Services	This service provides a framework to procure, contract and monitor services the Council contract with to provide services such as care homes etc.
TOCT	Transfer of Care Team (sometimes Discharge Planning)	This team works with hospital staff to help determine the best care package / care plan for individuals being discharged from hospital back home or an appropriate placement elsewhere
LDP	Learning Disability Partnership	The LDP supports adults with learning disabilities to live as independently as possible
MASH	Multi-agency Safeguarding Hub	This is a team of multi-agency professionals (i.e. health, Social Care, Police etc) who work together to assess the safeguarding concerns which have been reported

ABBREVIATION/TERM	NAME	DESCRIPTION
MCA DOLs Team	Mental Capacity Act Deprivation of Liberty Safeguards (DOLS)	When people are unable to make decisions for themselves, due to their mental capacity, they may be seen as being 'deprived of their liberty'. In these situations, the person deprived of their liberty must have their human rights safeguarded like anyone else in society. This is when the DOLS team gets involved to run some independent checks to provide protection for vulnerable people who are accommodated in hospitals or care homes who are unable to no longer consent to their care or treatment.
PD	Physical Disabilities	PD team helps to support adults with physical disabilities to live as independently as possible
OP	Older People	OP team helps to support older adults to live as independently as possible
Provider Services	Provider Services	Provider Services are key providers of care which might include residential homes, care homes, day services etc
Reablement	Reablement	The reablement team works together with service-users, usually after a health set-back and over a short-period of time (6 weeks) to help with everyday activities and encourages service users to develop the confidence and skills to carry out these activities themselves and to continue to live at home
Sensory Services	Sensory Services	Sensory Services provides services to service users who are visually impaired, deaf, hard of hearing and those who have combined hearing and sight loss
FAT	Financial Assessment Team	The Financial Assessment Team undertakes assessments to determine a person's personal contribution towards a personal budget/care
AFT	Adult Finance Team	The Adult Finance Team are responsible for loading services and managing invoices and payments
D2A	Discharge to Assess	This is the current COVID guidance to support the transfer of people out of hospital.
Carers Triage	Carers Triage	A carers discussion to capture views and determine outcomes and interventions such as progress to a carers assessment, what if plan, information, and/or changes to cared for support
DP	Direct Payment	An alternative way of providing a person's personal budget
DPMO	Direct Payment Monitoring Officer	An Officer who audits and monitors Direct Payments
Community Navigators	Community Navigators	Volunteers who provide community-based advice and solutions

GLOSSARY OF TERMS / TEAMS ACROSS PUBLIC HEALTH

ABBERVIATION/TERM	DESCRIPTION
Common Terms Used in Public Health	
Accreditation	The development of a set of standards, a process to measure health department performance against those standards, and some form of reward or recognition for those agencies meeting the standards.
Assessment	One of public health's three core functions. The regular collection, analysis and sharing of information about health conditions, risks, and resources in a community. Assessment is needed to identify health problems and priorities and the resources available to address the priorities.
Assurance	One of the three core functions in public health. Making sure that all populations have access to appropriate and cost-effective care, including health promotion and disease prevention services. The services are assured by encouraging actions by others, by collaboration with other organisations, by requiring action through regulation, or by direct provision of services.
Bioterrorism	The intentional use of any microorganism, virus, infectious substance, or biological product that may be engineered as a result of biotechnology, or any naturally occurring or bio-engineered component of any such microorganism, virus, infectious substance, or biological product, to cause death disease, or other biological malfunction in a human, an animal, a plant, or another living organism in order to influence the conduct of government or to intimidate or coerce a civilian population
Capacity	The ability to perform the core public health functions of assessment, policy development and assurance on a continuous, consistent basis, made possible by maintenance of the basic infrastructure of the public health system, including human, capital and technology resources.
Chronic Disease	A disease that has one or more of the following characteristics: it is permanent, leaves residual disability, is caused by a non-reversible pathological alteration, requires special training of the patient for rehabilitation, or may be expected to require a long period of supervision, observation or care.
Clinical Services/Medical Services/Personal Medical Services	Care administered to an individual to treat an illness or injury.

ABBERVIATION/TERM	DESCRIPTION
Determinants of health	The range of personal, social, economic and environmental factors that determine the health status of individuals or populations
Disease	A state of dysfunction of organs or organ systems that can result in diminished quality of life. Disease is largely socially defined and may be attributed to a multitude of factors. Thus, drug dependence is presently seen by some as a disease, when it previous was considered to be a moral or legal problem.
Disease management	To assist an individual to reach his or her optimum level of wellness and functional capability as a way to improve quality of health care and lower health care costs.
Endemic	Prevalent in or peculiar to a particular locality or people.
Entomologist	An expert on insects
Epidemic	A group of cases of a specific disease or illness clearly in excess of what one would normally expect in a particular geographic area. There is no absolute criterion for using the term epidemic; as standards and expectations change, so might the definition of an epidemic, such as an epidemic of violence.
Epidemiology	The study of the distribution and determinants of diseases and injuries in human populations. Epidemiology is concerned with the frequencies and types of illnesses and injuries in groups of people and with the factors that influence their distribution.
Foodborne Illness	Illness caused by the transfer of disease organisms or toxins from food to humans.
Health	The state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity. Health has many dimensions-anatomical, physiological and mental-and is largely culturally defined. Most attempts at measurement have been assessed in terms of morbidity and mortality
Health disparities	Differences in morbidity and mortality due to various causes experience by specific sub-populations.
Health education	Any combination of learning opportunities designed to facilitate voluntary adaptations of behaviour (in individuals, groups, or communities) conducive to health.
Health promotion	Any combination of health education and related organizational, political and economic interventions designed to facilitate behavioural and environmental adaptations that will improve or protect health.
Health status indicators	Measurements of the state of health of a specific individual, group or population.
Incidence	The number of cases of disease that have their onset during a prescribed period of time. It is often expressed as a rate. Incidence is a measure of morbidity or other events that occur within a specified period of time. See related prevalence
Infant Mortality Rate	The number of live-born infants who die before their first birthday per 1,000 live births.

ABBERVIATION/TERM	DESCRIPTION
Infectious	Capable of causing infection or disease by entrance of organisms (e.g., bacteria, viruses, protozoan, fungi) into the body, which then grow and multiply. Often used synonymously with “communicable
Intervention	A term used in public health to describe a program or policy designed to have an effect on a health problem. Health interventions include health promotion, specific protection, early case finding and prompt treatment, disability limitation and rehabilitation.
Infrastructure	The human, organizational, information and fiscal resources of the public health system that provide the capacity for the system to carry out its functions.
Isolation	The separation, or the period of communicability, of known infected people in such places and under such condition as to prevent or limit the transmission of the infectious agent.
Morbidity	A measure of disease incidence or prevalence in a given population, location or other grouping of interest
Mortality	A measure of deaths in a given population, location or other grouping of interest
Non-infectious	Not spread by infectious agents. Often used synonymously with “non-communicable”.
Outcomes	Sometimes referred to as results of the health system. These are indicators of health status, risk reduction and quality of life enhancement.
Outcome standards	Long-term objectives that define optimal, measurable future levels of health status; maximum acceptable levels of disease, injury or dysfunction; or prevalence of risk factors.
Pathogen	Any agent that causes disease, especially a microorganism such as bacterium or fungus.
Police Power	A basic power of government that allows restriction of individual rights in order to protect the safety and interests of the entire population
Population-based	Pertaining to the entire population in a particular area. Population-based public health services extend beyond medical treatment by targeting underlying risks, such as tobacco, drug and alcohol use; diet and sedentary lifestyles; and environmental factors.
Prevalence	The number of cases of a disease, infected people or peoplewith some other attribute present during a particular interval of time. It often is expressed as a rate.
Prevention	Actions taken to reduce susceptibility or exposure to health problems (primary prevention), detect and treat disease in early stages (secondary prevention), or alleviate the effects of disease and injury (tertiary prevention).

ABBERVIATION/TERM	DESCRIPTION
Primary Medical Care	Clinical preventive services, first contact treatment services and ongoing care for commonly encountered medical conditions.
Protection	Elimination or reduction of exposure to injuries and occupational or environmental hazards.
Protective factor	An aspect of life that reduces the likelihood of negative outcomes, either directly or by reducing the effects of risk factors.
Public Health	Activities that society does collectively to assure the conditions in which people can be healthy. This includes organized community efforts to prevent, identify, pre-empt and counter threats to the public's health.
Public Health Department	Local (county, combined city-county or multi- county) healthy agency, operated by local government, with oversight and direction from a local board of health, which provides public health services throughout a defined geographic area.
Public Health Practice	Organisational practices or processes that are necessary and sufficient to assure that the core functions of public health are being carried out effectively.
Quality assurance	Monitoring and maintaining the quality of public health services through licensing and discipline of health professionals, licensing of health facilities and the enforcement of standards and regulations.
Quarantine	The restriction of the activities of healthy people who have been exposed to a communicable disease, during its period of communicability, to prevent disease transmission during the incubation period should infection occur.
Rate	A measure of the intensity of the occurrence of an event. For example, the mortality rate equals the number who die in one year divided by the number at risk of dying. Rates usually are expressed using a standard denominator such 1,000 or 100,000 people.
Risk Assessment	Identifying and measuring the presence of direct causes and risk factors that, based on scientific evidence or theory, are thought to directly influence the level of a specific health problem.
Risk Factor	Personal qualities or societal conditions that lead to the increased probability of a problem or problems developing.
Screening	The use of technology and procedures to differentiate those individuals with signs or symptoms of disease from those less likely to have the disease.
Social Marketing	A process for influencing human behaviour on a large scale, using marketing principles for the purpose of societal benefit rather than for commercial profit.
Social Norm	Expectations about behaviour, thoughts or feelings that are appropriate and sanctioned within a particular society. Social norms can play a powerful role in the health status of individuals.

ABBERVIATION/TERM	DESCRIPTION
Standards	Accepted measure of comparison that have quantitative or qualitative value.
State Health Agency	The unit of state government that has leading responsibility for identifying and meeting the health needs of the state's citizens. State health agencies can be free standing or units of multipurpose health and human service agencies.
Surveillance	Systematic monitoring of the health status of a population.
Threshold Standards	Rate or level of illness or injury in a community or population that, if exceeded, call for closer attention and may signal the need for renewed or redoubled action.
Years of Potential Life lost	A measure of the effects of disease or injury in a population that calculates years of life lost before a specific age (often ages 64 or 75). This approach places additional value on deaths that occur at earlier ages.
Health and Care Organisations in Cambridgeshire & Peterborough	
CAMHS	Community Child and Adolescent Mental Health Services https://www.mind.org.uk/information-support/for-children-and-young-people/understanding-camhs/?gclid=EAIaIQobChMIr_P53PKW8QIV_4FQBh1GmgBYEAAYASAAEgI2Q_D_BwE
CAPCCG	Cambridgeshire and Peterborough Clinical Commissioning Group https://www.cambridgeshireandpeterboroughccg.nhs.uk
CCC	Cambridgeshire County Council https://www.cambridgeshire.gov.uk
CCS	Cambridgeshire Community Services NHS Trust http://www.cambscommunityservices.nhs.uk/
CHUMS	Mental Health & Emotional Wellbeing Service for Children and Young People http://chums.uk.com/
CPFT	Cambridgeshire and Peterborough NHS Foundation Trust (Mental health, learning disability, adult community services and older people's services) http://www.cpft.nhs.uk/
CQC	Care Quality Commission (The independent regulator of health and social care in England) http://www.cqc.org.uk/
CUH	Cambridge University Hospitals NHS Foundation Trust (Addenbrooke's and the Rosie) https://www.cuh.nhs.uk
EEAST	East of England Ambulance Service NHS Trust http://www.eastamb.nhs.uk

ABBERVIATION/TERM	DESCRIPTION
HH	Hinchingbrooke Hospital (Provided by North West Anglia NHS Foundation Trust – NWAFT) https://www.nwangliaft.nhs.uk
HUC	Herts Urgent Care (provide NHS 111 and Out of Hours) https://hucweb.co.uk/
ICS	Integrated Care Systems
Helpful NHS Terminology Links	
https://www.nhsconfed.org/acronym-buster	The NHS uses a number of acronyms when describing services this acronym buster may be of some help.
https://www.kingsfund.org.uk/audio-video/how-does-nhs-in-england-work	The Kings Fund have produced a good video explaining how the NHS in England works. The Kings Fund website in general contains many resources which you may find helpful.
https://www.england.nhs.uk/learning-disabilities/	NHS terms used in the field of disabilities
https://www.thinklocalactpersonal.org.uk/Browse/Informationandadvice/CareandSupportJargonBuster/	Think Local Act Personal jargon buster search engine for health and social care.

Integrated Care System for Cambridgeshire and Peterborough

To:	Adults and Health Committee
Meeting Date:	13 January 2022
From:	Jan Thomas Chief Executive Officer, Cambridgeshire and Peterborough Clinical Commissioning Group
Electoral division(s):	All
Key decision:	N/A
Forward Plan ref:	N/A
Outcome:	Information for the purposes of scrutiny
Recommendation:	It is recommended that the Adults and Health Committee note the progress of the developing Integrated Care System (ICS).

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1. Background

1.1 **Integrated Care Systems**, or ICSs, are partnerships working together to improve health and care for all, through shared leadership, integration and collaborative action.

There are 42 Integrated Care Systems in England, with our ICS covering all of Cambridgeshire & Peterborough, a population of around one million people.

By working together as an ICS different parts of the health, care sector and wider system (e.g. voluntary orgs) are better able to improve the health and wellbeing of local communities, reducing health inequalities and putting citizen at the heart of everything we do. The NHS Long Term Plan committed to delivering ICS's across England by April 2021, to build on the lessons learnt and good work carried out by Sustainability and Transformation Partnerships (STPs), Clinical Commissioning Groups (CCGs) and by vanguard areas.

An ICS for Cambridgeshire and Peterborough was confirmed in April 2021 and is due to operate in shadow form in this financial year before becoming fully operational from April 2022, subject to Parliament confirming the current plans.

ICSs are placed on a statutory footing and are made up of NHS Integrated Care Board (ICB) and the Integrated Care Partnership (ICP) Committee.

The ICB develops the Health Plan to meet the health needs of the population, having regard to the Partnership's strategy. The plan should cover service restoration, national operational planning requirements and Long-Term Plan commitments.

The ICP Committee develops the Integrated Care Strategy that covers health, public health and social care. It should have regard to the NHSE Mandate and Department of Health and Social Care (DHSC) guidance. It should also address the use of Section 75 to support integration.

2. Main Issues

2.1 Organisations that form part of the ICS include all NHS Trusts and organisations, Local Authorities and key voluntary sector partners.

In our area this includes:

- **Two upper tier local authorities:** Cambridgeshire County Council and Peterborough City Council
- **Six district councils:** Cambridge City Council, East Cambridgeshire District Council, South Cambridgeshire District Council, Fenland District Council, Huntingdonshire District Council and North Hertfordshire District Council (covering Royston and the surrounding area)
- **Three hospital providers:** North West Anglia NHS Foundation Trust (NWAngliaFT), Cambridge University Hospitals NHS Foundation Trust (CUH) and Royal Papworth Hospital NHS Foundation Trust (RPH)
- **Two community providers:** Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) and Cambridgeshire Community Services NHS Foundation Trust (CCS)

- **A mental Health provider:** Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
- East of England Ambulance Service NHS Foundation Trust (EEAST)
- 85 GP practices
- Cambridgeshire Local Medial Committee
- Healthwatch Cambridgeshire and Peterborough
- The Cambridgeshire and Peterborough Health and Wellbeing Board

Other partners including parish councils as well as voluntary, hospices, community, and faith organisations.

2.2 Our Priorities

The mission statement of our ICS is *working together to improve the health and wellbeing of our local people throughout their lives*

The outcomes we want for our population are to:

1. **Reduce inequalities in health outcomes**
   - Doing all we can to equalise opportunities for a healthy long life
   - Vulnerable groups
   - Bringing care close to people and their communities
   - Working together to develop healthy and thriving communities
2. **Create a system of opportunity**
   - Helping local people to start, live and age well within their local community
   - Improving outcomes for key health conditions including respiratory, diseases and cardiovascular disease
   - Tackling obesity
   - Using digital to help all local people readily access care closer to home
3. **Give people more control over their health and wellbeing**
   - Engaging with communities to co-create health and care services
   - Ensuring people have access to appropriate support and services, at the right time and place, for both physical and mental health and wellbeing
   - Improving patients and their families in developing services and in decisions about their own care
   - People having the right support and flexibility about their choices at the end of their life
   - Developing accessible and responsive urgent and emergency care services
4. **Deliver world-class services**
   - Translating cutting edge research into practice for the benefit of all our local people
   - Transforming the way we organise our care learning from local, national and international best practice
5. **Be environmentally and financially sustainable with a resilient workforce**
   - Efficient delivery and evidence-based health and care, organised with the person and their family at the centre
   - Delivering initiatives that will improve the environmental sustainability of our services through a 'green plan'
   - Using our resources wisely for the best health outcomes
   - Supporting the health and wellbeing of our workforce and plan effectively for our future workforce needs

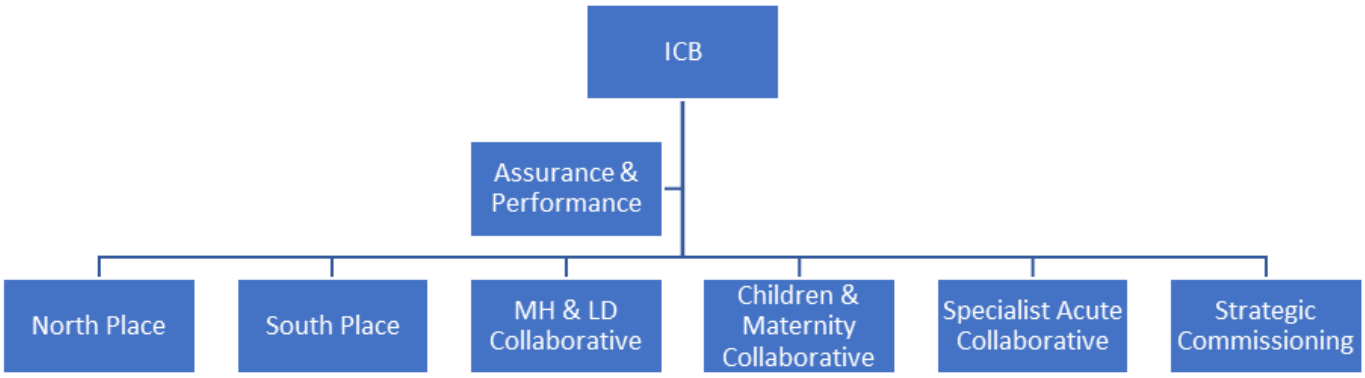
2.3 Development Plans

2.3.1 To facilitate the integration of care and provision of services closer to home, we have established:

Six Accountable Business Units (ABUs), that will have full accountability for budgets and outcomes. There will be master agreements from the ICB to delegate its statutory responsibilities. Each ABU will report to the System Oversight and Assurance Group (SOAG) then up to the ICB.
Our ICB will consist of the following ABUs:

- **Two-placed based partnerships**, North and South Place, which will further integrate health and care services, and build on the success of the two Alliances. These are based on the footprints of our two acute providers in the North and South, co-led by primary and secondary care.
- **Three collaboratives** across the Cambridgeshire and Peterborough system:
  - Mental health (MH) and Learning Disabilities (LD)
  - Children's and Maternity
  - Specialist Acute
- Our **Strategic Commissioning** ABU will absorb most of our functions to begin with, until delegation decisions are confirmed at 'place' level. As we move over the next 18-24 months and start the transition to 'place' functions, it will get leaner as we go through the 'most capable provider' process.

21 Primary Care Networks (PCNs), which will require additional support to progress into **21 Integrated Neighbourhoods (INs).**



2.3.2 Developing Place and Locality

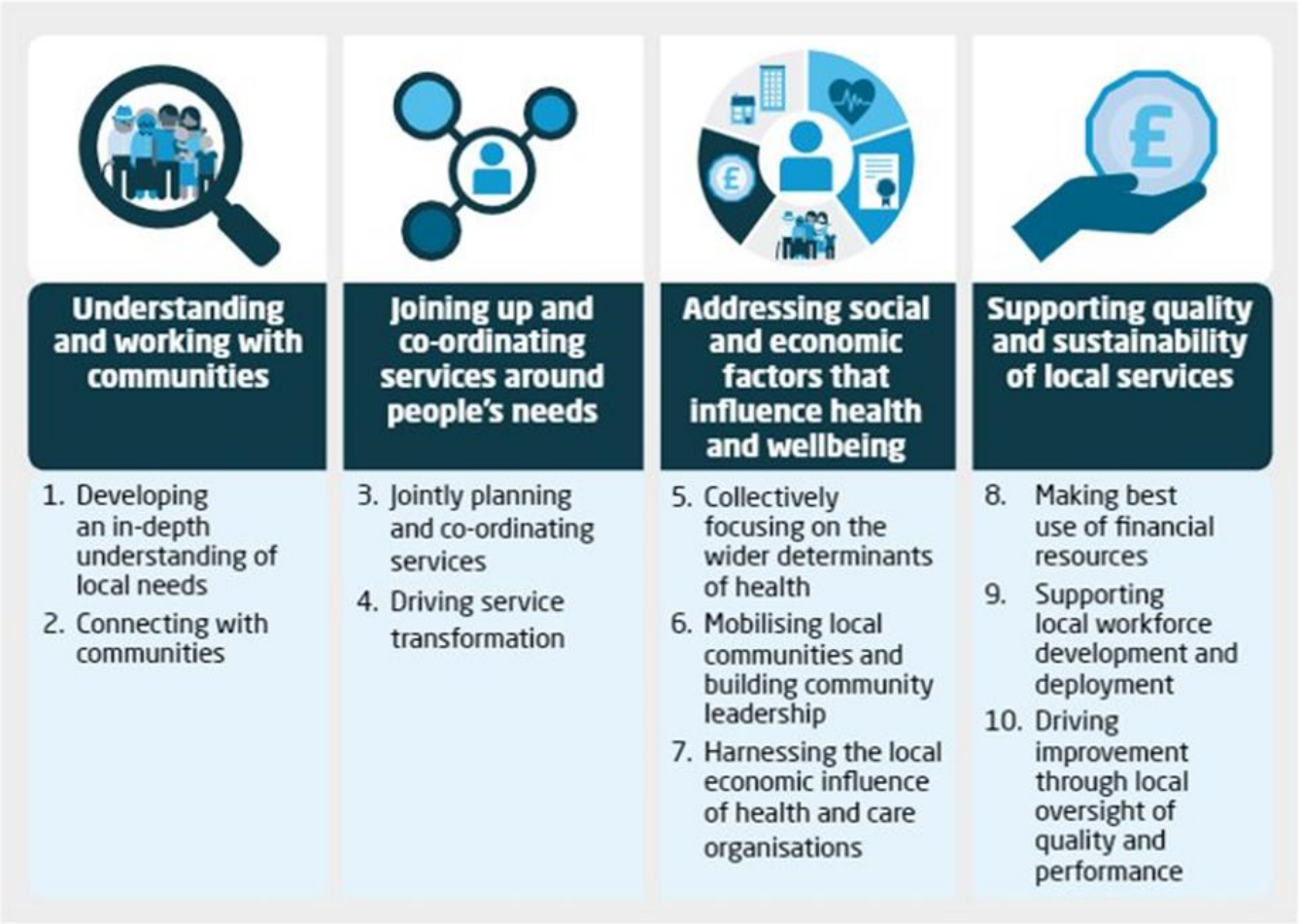
We are developing two place-based partnerships in Cambridgeshire and Peterborough, building on existing work in the Alliances (North & South) and informed by local priorities and using successful practice to guide this work.

There are eight principles to guide the development of our place-based partnerships:

1. Start from purpose, with a shared local vision
2. Build a new relationship with communities
3. Invest in building multi-agency partnerships

4. Build up from what already exists locally
5. Focus on relationships between systems, places and neighbourhoods
6. Nurture joined-up resource management
7. Strengthen the role of providers at place
8. Embed effective place-based leadership

2.3.3 Key functions of place-based partnerships



Source: The King's Fund

What will this mean for our local people and communities?

- Creating a **seamless patient journey** and improving **patient experience**
- Greater working between the NHS, local authorities, and voluntary sector leaders will enable more opportunities to make shared decisions about how to best use resources collectively to improve the wider determinants of health in C&P and **improve outcomes for disadvantaged groups**
- Working together to redesign care around the needs of **communities** to improve **mental health**, building on our previous collaborations as an early implementor of community mental health services in Peterborough for example.
- Working together from beginning to end of patient pathways and standardise approaches to safeguarding, complaints, and infection prevention to **ensure patients receive high quality services regardless of where they are treated.**

- Our work towards a shared patient record means our patients will no longer need to repeat their story to different teams and will improve the quality of their care, because their full **needs will be better understood**
- As ill health has significant impacts on economic productivity, improvements in **health outcomes will translate to greater contributions to the local economy.**

2.4 ICB Recruitment

2.4.1 John O'Brien has been appointed as Independent Chair Designate of Integrated Care Board (ICB).

The proposed Cambridgeshire & Peterborough Integrated Care Board (ICB) will oversee the commissioning, performance, financial management and transformation of the local NHS, as part of Cambridgeshire & Peterborough Integrated Care System (ICS).

Well-equipped to take on this new role, John brings with him a wealth of experience of working in both the public and private sector. This includes time spent as Director of Local Government Performance and Practice at the Department of Communities and Local Government (formerly Office of the Deputy Prime Minister) and most recently as Chief Executive of London Councils, a role he held until earlier this year.

John will take up his post as Chair of the Integrated Care Board formally from April 2022, subject to Parliament confirming the current plans.

2.4.2 Jan Thomas has been appointed as the Chief Executive Officer Designate (CEO) of Integrated Care Board (ICB).

Following an open and competitive recruitment process, Jan will be responsible for overseeing the commissioning, performance, financial management and transformation of the local NHS, as part of Cambridgeshire & Peterborough Integrated Care System (ICS).

At present Jan is the Accountable Officer of Cambridgeshire and Peterborough Clinical Commissioning Group (CCG).

Jan has over 25 years' experience of working in and with the NHS. Starting her career as a nurse, she worked in acute NHS hospitals and has had senior roles in private sector healthcare organisations and the NHS. She is committed to ensuring local people receive the best possible care, putting patients and communities at the heart of commissioning decisions and tackling inequalities.

Jan will take up the CEO designate role prior to statutory accountability changing on 1 April 2022, subject to Parliament confirming the current plans.

2.4.3 The recruitment process for executive roles has been designed to take account of equality, diversity and inclusion at each stage of the process. It is also in line with the principles of the Cabinet Office Governance Code for Public Appointments to ensure that appointments are made on merit after a fair and open process so that the best people, from the widest possible pool of candidates, are appointed.

We engaged with three companies to get quotes to support us with the recruitment of four Non-Executive Members (NEM), three Statutory Executive Directors and the Chief People Officer. Following the mini competition, the panel agreed to split the roles between Cadence Partners, a specialist diversity recruitment agency and Hunter Healthcare Resourcing Ltd, to support this process.

The consultation with senior CCG staff (including Directors, Governing Body and Lay Members) on the proposed top level ICB structure concluded on 3 December and we will shortly commence the process for the recruitment of the three statutory ICB roles plus the Chief People Officer, with interviews planned for February 2022. Each of these roles will be advertised. However, the respective CCG current post holders for the mandated roles will have automatic interview rights if they choose to apply.

For the NEM roles, there is a national portal, role outline and a which will take 12 weeks, with the aim to make appointments in mid-February, subject to Parliament confirming the current plans.

2.5 **ICB Constitution Progress**

2.5.1 We have made good progress on the draft ICB Composition. We submitted a return regarding the Board size and composition to NHSE on 16 November 2021 and have now received approval for this. We are also considering further feedback submitted during our second engagement phase. We continue to make progress on the development of the ICB Constitution and thank all partners for their feedback. The second phase of engagement was completed on 30 November 2021.

2.5.2 The Constitution Task and Finish Group considered the analysis of the feedback received and agreed at its meeting on 1 December 2021 to a number of amendments to the draft constitution as well as noting further areas for development within the Governance Handbook. The updates to the draft constitution included adding detail on engagement around changes to the constitution and additional detail to make it clear that meetings held in public may include time on the agenda for questions from the public, as well as other changes relating to updates to the model constitution issued by NHSE.

2.5.3 We will continue to engage and seek comments on our draft constitution and an updated version reflecting NHSE feedback will published on our website by 31 December. A number of drafting notes will remain visible in this document as we wish to make it clear to stakeholders where we are still waiting for further information and/or national guidance.

2.5.4 We expect further updates to the model constitution following the 3rd session in the House of Lords. The final constitution is due to be submitted to NHSE for approval in March 2022.

2.6 Integrated Care Partnerships (ICPs)

2.6.1 As a statutory committee of the ICS, ICPs will be tasked with producing an integrated care strategy for their area and for securing the four key aims of Integrated Care Systems. It will be the ICP that needs to articulate the high-level ambitions for the System. The Integrated Care Board is responsible for developing a plan to meet the strategy agreed by the ICP and

for allocating resources against that plan.

The ICP is a statutory committee of the ICS, not a statutory body. As such, its members can come together to take decisions on an integrated care strategy, but it does not take on functions from other parts of the system.

2.6.2 Relationship between the ICP and HWB

The expectation is that ICPs will play a critical role in ICSs, facilitating joint action to improve health and care outcomes and influencing the wider determinants of health. It will act as a forum to enhance relationships between the leaders across the health and care system with wider statutory and non-statutory stakeholders. The ICP is expected to highlight where co-ordination is needed on health and care issues and challenge partners to deliver the action required.

These include, but are not limited to:

- helping people live more independent, healthier lives for longer.
- taking a holistic view of people's interactions with services across the system and the different pathways within it.
- addressing inequalities in health and wellbeing outcomes, experiences and access to health services.
- improving the wider social determinants that drive these inequalities, including employment, housing, education, environment and reducing offending; and
- improving the life chances

HWBs will continue under current proposals to play an important role in assessing local needs and developing joint HWB strategies that the ICS should pay close regard to. The guidance makes it clear that ICSs are expected to work closely with the HWBs in their localities.

In Cambridgeshire & Peterborough the two UTLAs, work together as one HWB through a Whole System HWB sub-committee. This committee is therefore co-terminus with the Cambridgeshire & Peterborough ICP, except for Royston, which is supported through Hertfordshire.

2.6.3 Over the course of the last three months, productive discussions have been held between the HWB Chairs, and ICS Chair, supported by the executive. At a joint ICS /HWB Development session held on 6th October 2021, participants agreed to a single health and well-being strategy. This one plan approach enables both the Cambridgeshire & Peterborough ICP and HWB to reflect the priorities of all partners with a particular focus on the wider determinants of health.

At the same meeting, there was also agreement in principle that we would have a single set of strategic health and wellbeing priorities and an aligned approach to facilitate the progression of these priorities:

- Our children are ready to enter education and exit, prepared for the next phase of their lives.
- Create an environment to give people the opportunities to be as healthy as they can be.
- Reducing poverty through better employment and better housing.

- Promoting early intervention and prevention measures to improve mental health and wellbeing.

2.6.5 Next Steps for ICP and HWBs

There is a particular responsibility for local government partners and the designate ICS Chair and CEO to lead a process that engages all partners. This will build on the previous system work that commenced in October and further develop the initial set of ambitions for the ICP, as well as agreeing precise membership, governance and ways of working.

It is proposed that a joint initial paper be developed by local government and ICS designate partners for consideration at the meeting of partners scheduled for 17th January. This would include commentary on the alignment of the ICP and HWBB.

In addition, in order to progress detailed governance issues, it is proposed to establish a system working group hosted by the Directors of Governance, to agree the principles of joint arrangements that support the establishment of an aligned ICP and HWB.

In order to ensure that our ICP is fully representative and has parity of representation across partner organisations and stakeholders, we need to work with our current System Partnership Board members to discuss membership of this group and also consider with each partner organisation on how their remit fits with the priorities of the ICS.

3.0 Early Successes

3.1 The 2021 Health Service Journal Awards recognised a number of projects and initiatives across our area that showed how truly collaborative working can benefit patients:

- **NHS 111 Option 3's Palliative Care Hub, was announced as the winner of the 'Primary Care Innovation of the Year Award'.**
  This service aims to be a single point of access via 111 and reach areas of deprivation. To achieve this meant working in partnership with Integrated Care System (ICS) colleagues. The service is commissioned by Cambridgeshire and Peterborough Clinical Commissioning Group (CCG), operated by Arthur Rank Hospice Charity in partnership with HUC (Herts Urgent Care) who provide the local NHS 111 service and the East of England Ambulance Service NHS Trust (EEAST).
  It is a single point of access, so patients and carers only need to make one call and then we take care of the rest, by collaborating and coordinating with other services, to ensure the outcome for the patient.
- **Herts Urgent Care's Virtual Waiting Room were announced as the winners of the 'Driving Efficiency Through Technology Award'.** The Virtual Waiting Room is a video consultation pilot that brought together local organisations across Cambridgeshire & Peterborough, to introduce an alternative pathway for patients directed to Emergency Departments (ED) following a 111 Clinical Advisory Service (CAS) assessment. The objective was to ensure that patients were seen in the correct part of the system. The impact of the Virtual Waiting Room has been felt across the Cambridgeshire and Peterborough health economy with an improved patient journey across the system.

3.2 **The Health Inequalities Challenge Prize 2022** has been created by Cambridgeshire & Peterborough Integrated Care System with the aim to tackle the digital divide in our communities and support the most vulnerable people in our community.

Digital health and care innovation is beginning to transform health services, and the COVID-19 pandemic has increased the use of digital healthcare support. However, it has also shone a light on the inequalities of digital access to health and care services, as people who do not have access to information and services online are likely to be more at risk of poorer health and social care outcomes.

The Health Inequalities Challenge Prize encourages local innovators to help tackle health and social care inequalities caused by digital exclusion. The prize has been launched in partnership with Cambridgeshire Community Foundation and Healthwatch Cambridgeshire and Peterborough.

3.3 **The ICS Anti-Racism Programme** is under development using the foundations laid out in the NHS England and Improvement, East of England Anti-Racism Strategy.
The vision of the strategy is to deliver improvements in the following areas:

- Everyone sees equality and inclusion as their responsibility and adopt a proactive approach
- To ensure our people have the opportunity to co-design a long-term strategy - “Nothing about me without me”
- To develop a plan of action in collaboration with key partners that will deliver sustainable and measurable change
- To focus on high priority areas that will make a difference to the lives of our people
- To deliver better health outcomes for our people by focusing on health and wellbeing
- To tackle health inequalities within our workforce and local communities
- To commit and invest in an ongoing programme of work focused on improving the experience and wellbeing of our Black, Asian and Minority Ethnic people

4. LEGAL IMPLICATIONS

4.1 Health and Care Bill 2021-22

First and second reading in the House of Commons have been completed.
Focus on collaboration, confirmation of a wider Integrated Care Partnership that brings together local NHS and local government to deliver joined up care for local populations.

The Health and Social Care Bill will:

- Make the legal framework easier to work together.
- Reduce unnecessary bureaucracy; and
- Ensure the system is able to respond to changing needs in the years to come.

Key measures from the Bill include:

- Health and care services planned around patients’ needs.
- Quick implementation of innovative solutions to problems which would normally take years to fix e.g., moving services out of hospitals and into the community, focusing on preventative healthcare.

- A loosened procurement regime for the NHS and public health procurement to reduce bureaucracy and reduce the need for competitive tendering where it adds limited or no value.
- Measures to address health inequalities, such as obesity and improving oral health with new public health requirements on food and drink packaging and advertising of junk food pre-9pm watershed.
- Increased Department of Health and Social Care oversight.