Cambridgeshire & Peterborough Integrated Care System

Cambridgeshire & Peterborough Health and Wellbeing and Integrated Care Strategy



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Welcome

“We are pleased to introduce Cambridgeshire and Peterborough’s Health and Wellbeing and Integrated Care Strategy – our combined plan to tackle some of the most challenging issues faced by people in our area.

Across Cambridgeshire and Peterborough, we face many challenges in improving the health and wellbeing of our local people and communities. The impact of COVID-19, combined with rising living costs, is continuing to impact on people’s lives. More than ever, we need to find new, effective, and sustainable ways to work together making sure our local health and social care system benefits everyone, and that we make it easier to access different types of support for people’s personal health and wellbeing, regardless of where they live or their personal circumstances.

Our strategy is a truly integrated piece of work, developed by working closely with local partners from health, social care, local authorities and the voluntary, community and social enterprise sector along with feedback from local people across Cambridgeshire and Peterborough. It identifies our vision of ‘All Together for Healthier Futures’ via the four priorities which we believe, through working in partnership, will make a difference to people’s lives. These priorities are:

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

Our collective aim is simple – to work together to enable local people across Cambridgeshire and Peterborough to live happier and healthier lives.”



John O’Brien



Cllr Susan van de Ven



Cllr John Howard

Co-Chairs of the Joint Cambridgeshire and Peterborough Health and Wellbeing Board/ Integrated Care Partnership

Contents

1. **Introduction**
   - 1.1 Our approach
   - 1.2 Our population health challenges
   - 1.3 Our Journey so far
2. **Health and Wellbeing Strategy**
   - 2.1 Background
   - 2.2 Health and Wellbeing Strategic Priorities for Cambridgeshire and Peterborough 2022-2030
3. **How we will deliver our strategy**
   - 3.1 North Cambridgeshire & Peterborough Partnership
   - 3.2 Cambridgeshire South Care Partnership
   - 3.3 Mental Health, Learning Disability & Autism Partnership
   - 3.4 Children’s & Maternity Partnership
4. **Engaging with People and Communities**
5. **One System, One Workforce**
6. **Equality, Diversity and Inclusion**
7. **Health Care Delivery and Clinical and Care Leadership**
   - 7.1 Innovation and Improvement in Service Delivery
   - 7.2 Population Health Management
   - 7.3 Health Inequalities
   - 7.4 Prevention of Ill Health
8. **Integrated Health and Social Care**
9. **Our Enablers**
10. **Conclusion**



1. Introduction

This strategy sets out the collective ambitions of our Integrated Care System (ICS), which comprises a range of organisations that have an interest in the health, care, and wellbeing of people across Cambridgeshire and Peterborough. We have joined efforts to plan and deliver health and care services to improve the lives of people who live and work in our area.

Setting the scene: Our Partnership

Cambridgeshire & Peterborough Integrated Care System (ICS) is home to around a million people who live in cities, towns, and rural areas across our area. Our communities include some of the most highly educated and affluent areas in the country, and some of the most deprived and diverse.

To meet the needs of our communities, the ICS brings together a wide range of organisations, including Cambridgeshire County Council, Peterborough City Council, Cambridgeshire and Peterborough Combined Authority, district councils, the NHS (hospitals, community, primary care, and ambulance services), voluntary, and community and social enterprise (VCSE) partners, Healthwatch, education, police, and fire services.

We all want to support people through their lives, helping them to have the best start, to planning for their future care, and ultimately their end of life.

To do this, we have agreed shared priorities and created this strategy setting out how we can improve the health and wellbeing of our communities, with a focus on prevention. It is underpinned by a strategic assessment of our local people and community needs and built on the feedback from our local people and communities.

Our strategy is jointly owned by the Integrated Care Partnership (ICP), a statutory committee formed between NHS and local authorities in Cambridgeshire and Peterborough, and the Health and Wellbeing Board (HWB), which is a formal committee of the council[1].

All partners are equal and have committed to cooperative and supportive working beyond organisational boundaries to focus on improving health and wellbeing for the people and communities they serve.



"I am working with partners to ensure that people with advanced illness or are at the end of their life, get **the best care and support**. We've developed new services like the Palliative Care Hub (111, option 3) together, providing 24/7 telephone support to everyone in Cambridgeshire."
Sharon Allen, CEO Arthur Rank Hospice Charity, Cambridgeshire.

[1] Cambridgeshire County Council and Peterborough City Council have joint working relationships and have agreed to delegate authority to a single Health and Wellbeing Board to act on behalf of both areas.

By pooling our data, understanding, resources, knowledge, and experience, we will deliver better outcomes for local people.

Together we will be able to solve problems and make improvements that we could not do alone.

"Our community is an amazing place to be. Let's grow our strengths and listen to what others' concerns are. Together we can make a difference, alone we can't."

Our priorities

Four key priorities define this strategy. Priorities that our communities, our partners and our data tell us are important:

- Our children are ready to enter education and exit prepared for the next phase of their lives.
- Creating 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 well-being.

All together for healthier futures

Our strategy looks at the medium-to-long term, addressing the significant changes we need to make and sustain to deliver real change. We will review it annually.

"Cambridgeshire and Peterborough NHS Foundation Trust and East of England Ambulance Service NHS Trust colleagues have been working together for over a year now to provide a mental health joint response for people calling the ambulance service during a mental health crisis.

"We have reduced the number of people being taken to A&E by being able to offer them triage and support in their own homes. Reducing the amount of time paramedic crews spend on mental health call outs, allowing them to attend their next emergencies, whilst those in a mental health crisis can have their mental health and physical health needs assessed by the right people, at the right time in the right place."
Mental Health Joint Response Car Team



1.1 Our approach

We have had our shared vision from the start – All Together for Healthier Futures. This strategy puts our vision into action. This strategy has been developed using our **Leadership Compact:**

- **Put people and quality first**
- **Have honest relationships and act with integrity**
- **Be transparent and inclusive when making decisions**
- **Do what we say, celebrating success and learning from failure**
- **Hold each other to account**

Next, our strategy is built using our **shared design principles:**

Think local
Everything should be done as near to where people live their lives as possible.

Keep it simple
For both residents and staff remove all unnecessary layers that add limited value.

Do it together
Partners integrate to get better results. Including voluntary sector and small providers.

Prove it
Use evidence to show the impact of what we are doing.

In 2021, we agreed to have a single strategy based on four priorities, and developed three clear phases:

Phase 1
Data intelligence gathering around priorities.

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

Phase 3
Implementing programmes of activity to address these gaps.

Alongside these phases, we have engaged widely with local people and communities, as well as our stakeholders through our **'Let's Talk: Your Health & Care'** campaign. You'll see the insights we gathered throughout this strategy, and comments from local people about what we need to do to make a real difference to their lives.

Senior responsible officers for each priority were drawn from a wide range of partners. This diversity of leadership is reflective of our partnership and ensures the strategy development is truly integrated across Cambridgeshire and Peterborough, with shared ownership amongst health and wider sectors.

This **'One Plan'** approach is a first for our area and demonstrates the commitment of all partners to work together towards shared goals, whilst retaining organisations' different areas of expertise and statutory responsibilities.

"I lead on health and wellbeing for East Cambridgeshire District Council. It is fantastic to be part of the ICS, working with local organisations to deliver improved health outcomes in our community, and identifying and working on shared priorities and funding opportunities in a joined-up way with excellent partnership collaboration"
Liz Knox, Environmental Services Manager – Health and Wellbeing, East Cambridgeshire District Council





As a starting point for this work, our COVID-19: Evidence of Needs & Impact Report for Cambridgeshire & Peterborough, showed us that:

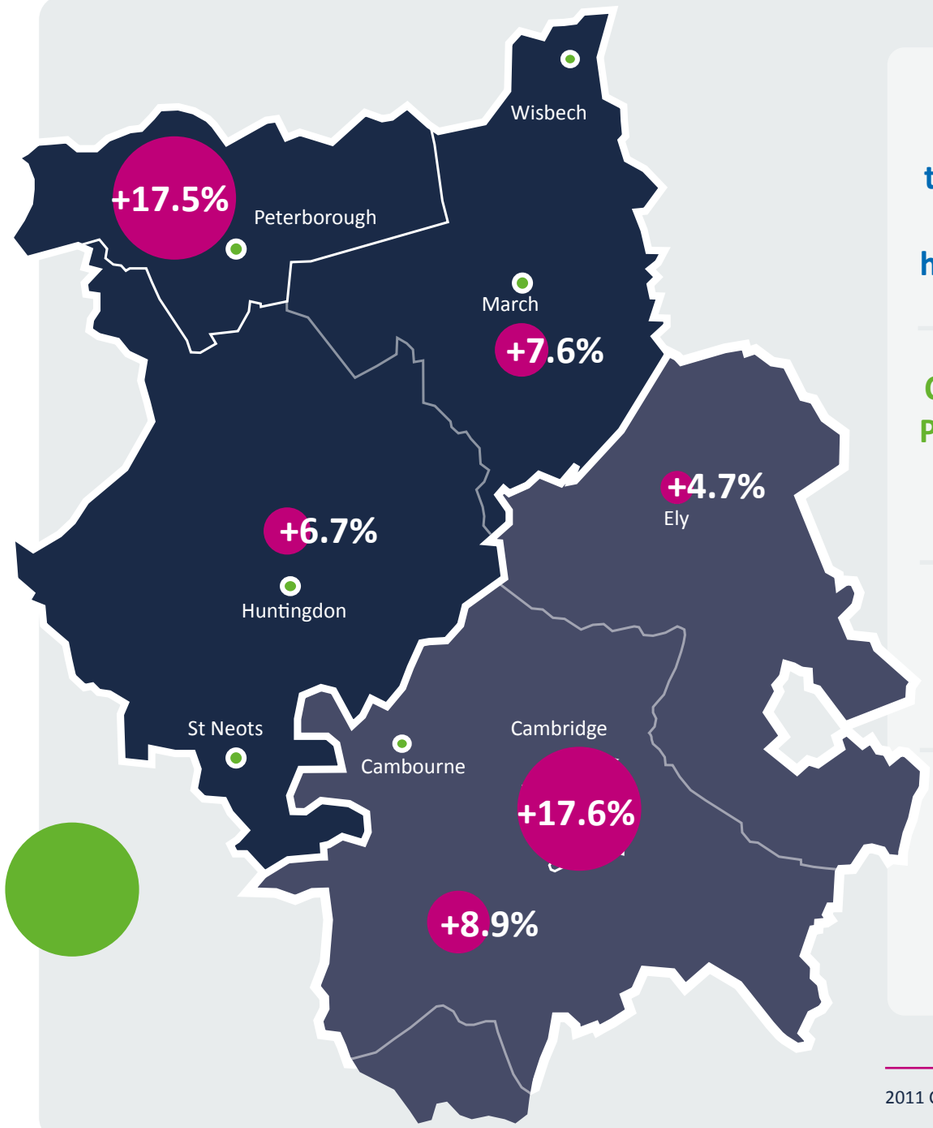
- COVID-19 exposed and exacerbated inequalities, as demonstrated by the differential impact on our Black, Asian, and Minority Ethnic communities and those living in our most deprived areas.
- There are more people in poverty, which has a long-term impact on health.
- The mental health of local people has been impacted by the pandemic, particularly children and young people.
- Obesity has increased and affects around a third of our Year 6 children and up to 60% of adults.
- Our health service is under significant pressure and the way that people access health care and preventative health care has changed.
- There are risks and opportunities to our environment as a result of the pandemic.
- There is also a need to focus on safety and prevention of harm in our service delivery as pressures on services increase.



"I work at The SUN Network, working with older adults who have lived experience of struggles with mental health, either their own or through caring for a loved one. I listen to their feedback about what they have experienced and facilitate their involvement in co-production, which will help shape the services that they use. By working alongside the ICS, the voices of more people are being heard, which is influencing positive changes."
Natasha Davis, Older Adult Mental Health Engagement Facilitator, The Sun Network

1.2 Our population health challenges

As our local people and communities age, there is a greater prevalence of long-term conditions. Together with overall growth, this is expected to lead to increased demand for health and care services.



Over the last ten years the population has grown by:

Cambridge & Peterborough
+17%

England
+6.6%

East of England
+8.3%

2011 Census vs 2021 Census Data

With growing needs



People registered with GP

	Over last ten years	By 2041
Aged 85 or over	+32%	+128%
Under 18	+19%	+11%

Source: GP figures above Cambridgeshire County Council Research Group (CCCRG), mid-2020 based population forecasts

Chronic conditions

26.8% of local people have chronic conditions such as, disabilities, incurable cancer, organ failure, frailty, or dementia.

91,000 local people aged 65+ currently have long-term conditions.

87% of local people aged 85 & over have a chronic condition

31% have five or more.

23% of those aged 18-64 have a chronic condition

1% have five or more.

Source: Chronic Conditions figures above: Population and Person Insight Dashboard (PAPI), June 2021

Key risks associated with ill-health include environmental, social, and behavioural factors, all of which require a joined-up response.

Many of these conditions affecting local people are related to actions people take that affect their health and wider determinants of health. Over 60% of our local adults are overweight or not and obese and childhood obesity is at its highest rate across our area, reflecting poor diet and low levels of physical activity. Obesity and poor diet are linked with type 2 diabetes, high blood pressure, high cholesterol, and increased risk of respiratory, musculoskeletal, and liver diseases.

A growth in these conditions leads to more unpaid carers. In Cambridgeshire and Peterborough, we have over 77,000 unpaid carers, including young and parent carers, and it takes around two to four years for them to be identified for additional support. Local and national evidence shows that carers' health, wellbeing, and overall quality of life (including ability to participate in education or employment) is significantly impacted by their caring responsibilities, particularly if not linked into appropriate support at the earliest opportunity.

> "I am an unpaid carer for my husband and parents... I'm feeling more and more ground down every day, but nothing fixes anything. I don't know how much longer I can do this for."

There is a high level of poor mental health across all parts of Cambridgeshire and Peterborough, which was exacerbated by the pandemic, particularly among children, young people and unpaid carers. We know that poverty is associated with poor health outcomes, and increased costs of living is likely to impact various aspects of our population's health and wellbeing. For example, exacerbation of respiratory conditions due to cold or damp housing conditions and impact on mental health as a result of concerns about household bills and debt.

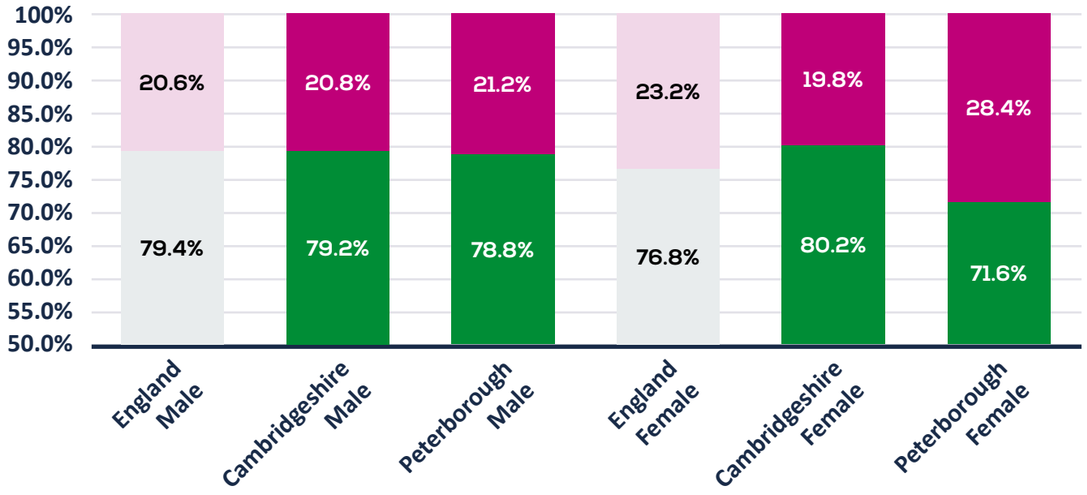
There are stark and unacceptable health inequalities across our communities.

People living in our most deprived areas die approximately ten years earlier than those living in our more affluent areas. This life expectancy difference is driven predominantly by early deaths due to cardiovascular disease, cancer, and respiratory conditions. To compound this stark reality, those living in the most deprived areas also live a larger proportion of their lives in poorer health. Inequalities are further worsened by digital exclusion, rurality and homelessness, or home insecurity.

Across Cambridgeshire, the life expectancy of males and females at birth are 81.2 years and 84.3 years respectively, while in Peterborough it is 78.2 years and 82.3 years. As the chart on next page shows, according to most recent data, a female born in Peterborough has a life expectancy of 82.5 years but can only expect to live 59.1 years in good health. This means they will spend more than 28% of their life not in good health. For men in Peterborough and men and women in Cambridgeshire, the percentage of years spent not in good health is around 20%, which is close to or slightly better than the England average.

Cambridgeshire & Peterborough Healthy Life Expectancy

Source: https://fingertips.phe.org.uk











(I work within a) team of three nurses and a paramedic who support and work with nursing homes and domiciliary care providers in Cambridge and Peterborough, to improve the quality of care to local people. Our roles work across multiple partners and organisations, including sourcing, commissioning, and delivering training to providers dependent on service and individual need, and utilising our skill sets as clinicians to offer best practice to support our care sector.

Helen Garfoot, Jane Banks, Fran Goodwin, and Holly Clark, Care Sector, Quality improvement Team, Cambridgeshire & Peterborough ICS

Case study

Central Thistlemoor and Thorpe Primary Care Network addresses complex need

The patients registered with Central Thistlemoor and Thorpe Primary Care Network (PCN) face some of the most difficult circumstances within Cambridgeshire and Peterborough, due to a combination of language barriers, deprivation within the locality, and a high rate of low-paid jobs.

By upskilling existing health care assistants to manage the health coaching needs of the people, the PCN has enabled access to a range of languages to facilitate immediate and ongoing support, promoting fulfilment of treatment plans which has led to better outcomes and self-management.

Results demonstrate a 20% reduction in GP appointments for those patients undergoing health coaching, and a reduction in emergency department attendances by 10%. There has been a 30% increase in the uptake of smoking cessation services, with a 16% decrease in a recorded status of 'smoker'. There has also been a reduction of 11% of people recorded as having a BMI greater than 35. One local person from a Czechian background, said:

"I have been smoking since I was 20 years old. With the help of the smoking clinic, which was run in my language, I have managed to quit. My thanks to the team."



Some groups and communities are much more likely to experience poor health outcomes. For example, LGBTQ+ have higher rates of common mental health problems; life expectancy for the Gypsy, Roma Travellers community is approximately 10-12 years less than that of the non-Traveller community; and men and women who are homeless at or around the time of their death live 31 and 38 years fewer than the average respectively.

NHS Confed Report 'Unequal impact of COVID-19' https://www.nhsconfed.org/news/unequal-impact-covid-19-report-published. The COVID-19 pandemic has had a disproportionate impact on many who already face disadvantage and discrimination. COVID-19 has been particularly detrimental for people living in areas of high deprivation, people from Black, Asian, and Minority Ethnic communities, older people, those with a learning disability and others with protected characteristics. Higher COVID-19 mortality rates in our most deprived areas have contributed to the life expectancy gap between those and the least deprived areas in the county.

We recognise there can be barriers to accessing services for some disadvantaged people and communities who can experience longer wait times for treatment or service support. A central part of responding to these impacts of the pandemic has been focused on restoring services and increasing the scale and pace at which we act on tackling health inequalities and protecting those at greatest risk. The learning and work carried out in response to the pandemic must continue to ensure health inequalities are not widened further, especially in respect of new challenges facing us as the cost-of-living increases.

The current cost of living challenge is being felt across the local area especially for people with a low income; 46% of those who responded to our 'Let's Talk' campaign, said they were already feeling an impact. These financial pressures will result in many households making difficult decisions; reducing heating and the quality or amount of food is likely to have short-term and long-term effects on health, especially if there are underlying health conditions. The stress of these decisions is significant for mental health and relationships, including parenting. More families with children will struggle, and we know that child poverty is strongly associated with health and educational outcomes.



"The Greater Peterborough Network is a GP Federation with a passion for integration and innovation, connecting general practice with the wider health and care system in Greater Peterborough. We work with partner organisations to improve services and outcomes for our local people. One project we recently initiated was a pilot scheme working with the East of England Ambulance Service (EEAST) to assist crews by offering a dedicated number to call, for them to do clinician-to-clinician handover to the GPN's fully governed wraparound service. This enables EEAST to have a quicker handover and allow them to go their next patient."
Mustafa Malik, CEO, Greater Peterborough Network

1.3 Our Journey so far

The formation of our ICS on 1 July 2022 gives us further opportunities to work together as a true partnership, to deliver better health and wellbeing opportunities for our local people and communities. We have been working together in an integrated way for several years and this strategy builds on this work. Throughout our strategy you will find examples of our integrated approach to date and hear from the voices of local people and our staff about what matters most to them.

Our anchor system

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

Together, we employ a significant proportion of local people. One in every 25 employed people in our area works for the NHS. Collectively, across the NHS, local authority, and voluntary sector, we employ more people than any other organisation in Cambridgeshire and Peterborough.

We also have a significant influence on our local communities through our combined purchasing power (£1.3 billion NHS spending alone) and the management of our estates portfolio.



All Together for Healthier Futures

We are an anchor system that intentionally enhances social value for its communities and workforce.

Equity
Reduce inequalities in health outcomes by targeting inequalities and addressing discrimination in all forms.

Opportunity
Create a system of opportunity by increasing educational aspiration and attainment among children and adults and offering local employment opportunities, particularly for vulnerable groups, and setting an example in terms of national and local accreditation programmes.



People
Give people more control over their health and wellbeing by leading the way in supporting the health and wellbeing of our workforce and our residents and increased early intervention and prevention to improve longer term health outcomes for our children and young people.

Sustainable
Be environmental and financially sustainable with a resilient workforce.

Quality
Deliver a world class service enabled by research and innovation by creating the conditions and enacting initiatives to attract innovation, local investment and economic growth.

By considering our collective roles and the long-term impact of our actions in areas such as employment, education, and procurement, we can have significant impact on the health, sustainability, and wellbeing of our local people and communities.

Where are we now

We have made a good start. From employment for people with learning disabilities and support of the green agenda, to supporting sustainability in the local economy. But there is more to do, and we will work together to maximise the positive impact we can have as anchor institutions for the good of our local communities focusing on:

Employers
Developing inclusive and accessible practices starting from outreach, to volunteering, through internships and apprenticeships, in recruitment, personal development, promotion, retention and leadership.

Environment
Delivering an innovative and wide-ranging Green Plan to reduce our carbon impact and become more resilient and sustainable, and align to the UN's Sustainable Development goals and NHS net zero targets.

Purchasers
Ensuring suppliers meet specific standards and assessing their social and environmental impact as part of our contracting process, in line with the Social Value Act.

To get there, we know there are some challenges to address around measuring the impact and real difference we can make with our anchor work; help all organisations, no matter their size, to contribute to these shared aims; and ensure we take a unified approach that shares knowledge and learning as standard.

To overcome these, we will work together to create the tools needed to address all the opportunities being an anchor institution presents. We will also look at how we can achieve standards set by external accreditation bodies to ensure we achieve the best possible outcomes.

In the future we can point to our successes as anchor institutions and understand exactly the positive difference it has had for our local people and communities.

Health & Wellbeing Strategy



2. Health & Wellbeing Strategy

2.1 Background

The health and wellbeing strategy must be informed by the Joint Strategic Needs Assessments (JSNA). For the purpose of this strategy, the COVID-19 Impact Assessment fulfils the function of the JSNA, summarising the joint work we have done across local government, the NHS and partners to understand the emerging impact of COVID-19. The full report can be found in the following link:

Covid-19: Evidence of Needs & Impact Cambridgeshire & Peterborough. In addition, the JSNA core data set provides us with an understanding of health and wellbeing in local people in Cambridgeshire and Peterborough. Cambridgeshire Insight – Joint Strategic Needs Assessment (JSNA) – Published Joint Strategic Needs Assessments.

The COVID-19 pandemic has positively changed the way we work together. All partners in Cambridgeshire and Peterborough have rallied to respond to the pandemic, each partner playing their part and delivering what was required, within very short time scales. We must not lose our collective learning from this.

There are also significant infrastructure changes (including the development of the ICS) which will support system partners to enhance their integrated approach and work more closely together. Whilst the Health and Wellbeing Boards (HWB) and the Integrated Care Partnership (ICP) must remain separate legal entities with their own statutory responsibilities, that cannot be delegated to each other, we have agreed that we will be aligned. This approach has allowed us to bring the HWBs and ICP closer together with common membership and joint meetings with many of the same individuals sitting on the Board and the Partnership.

In July 2022 the Health and Wellbeing Board in Cambridgeshire and Peterborough held their first meeting with the Integrated Care Partnership (ICP), meeting as a committee in common. Since then, further development sessions for the membership and meetings have been undertaken. All partners in the combined HWB/ICP have committed to cooperative and supportive working, collectively focusing on improving health and wellbeing for the people they serve. We believe that by working together across organisations, pooling our data, our understanding, resources, knowledge, and experience will result in better outcomes for local people. When we refer to 'joint' in this strategy, this means jointly with the ICP, across geographies and with partners, local people, and communities. Together we will be able to solve problems and make improvements that we could not do alone.

Case study

Bringing Health and Wellbeing Boards together

The two Health and Wellbeing Boards (HWB) in Cambridgeshire and Peterborough established formal joint working relationships in 2019. The formation of the ICS provided further opportunities to build a greater alignment between different partners. In early 2022, a Joint Cambridgeshire & Peterborough Health and Wellbeing Board was formed. Our approach has been to establish new collaborative working arrangements between the Health and Wellbeing Boards and the developing Integrated Care Partnership (ICP), so there is a commonality of purpose that ensures effective and joined up decision making across multiple organisations.

2.2 Health and Wellbeing Strategic Priorities for Cambridgeshire and Peterborough 2022-2030

What do we want to achieve?

Three overarching ambitions were agreed by consensus across the local authorities, NHS, and other partners, reflecting the issues we know about in our local people and communities and the outcomes that are most important. Whilst these are recognised as ambitious, they are achievable. All partners have committed to delivering these ambitions and in doing so committed to collective and organisation-specific endeavours.

By 2030: We will increase the number of years that people spend in good health

Life expectancy is often used as a measure of societal progress, and although it is important, it does not consider the fact that towards the end of life there is often a period, perhaps many years, which is spent in poor health.

Healthy life expectancy, on the other hand, measures the average time we can expect to live in good health. It is clearly worthwhile to prevent conditions that cause disability and poor health over a long time, to increase the number of years that people spend in good health.

We know that healthy life expectancy is also strongly linked to deprivation, with people living in less well-off areas more likely to experience a long time at the end of life in poor health. **By 2030 we want to see healthy life expectancy increase by at least two years for men and women in Cambridgeshire and Peterborough.**

Case study

East Cambridgeshire Integrated Neighbourhood Winter Wellness Project

East Cambridgeshire Integrated Neighbourhood Winter Wellness Project focuses on over 100 local people over 80, living alone or co-caring, with one or more long-term conditions. The project supports these people to live healthier and safer throughout the winter months.

This project responds to the issue of social isolation, identified as important for both men and women of different age groups, during our people and communities engagement exercise. People told us that they can feel invisible, forgotten, and lonely. Financial pressures mean that people were less likely to go out and socialise.

The project brings together several services in the area to help people better manage their health and wellbeing needs, be more connected and supported to engage in activities they enjoy as well as reducing pressure on system services. One health coach fed back:

"What a worthwhile programme, so person centred and great to hear."

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

Preventable premature mortality are deaths of people under 75, from causes that are largely or entirely preventable. For example, smoking related deaths, or deaths from vaccine-preventable diseases. We know that there is a strong relationship between the wealth of an area and the rate of preventable premature mortality. Our most deprived areas see many more of these deaths than our least deprived areas. We will weaken this relationship between wealth and early preventable deaths so that people in our least well-off areas are less likely to die young.

We will achieve better outcomes for our children

Working with parents and communities, we will achieve better outcomes for our children, by recognising their needs with a holistic view of child development, health and wellbeing. Investing in the health and wellbeing of our children will pay dividends throughout their lives. In addition, investments in the early years are often the most cost effective. Such an achievement would mean that on key measures of health and wellbeing for children, Cambridgeshire and Peterborough will be the best in a group of 'comparator' local authorities (those which are similar in size, wealth and some demographic factors). Further evidence from the COVID-19 Impacts and Needs Assessment Children & Young People has informed this ambition.

Covid-Impacts-and-Needs-Assessments-Pack-2-0722.pptx (live.com)



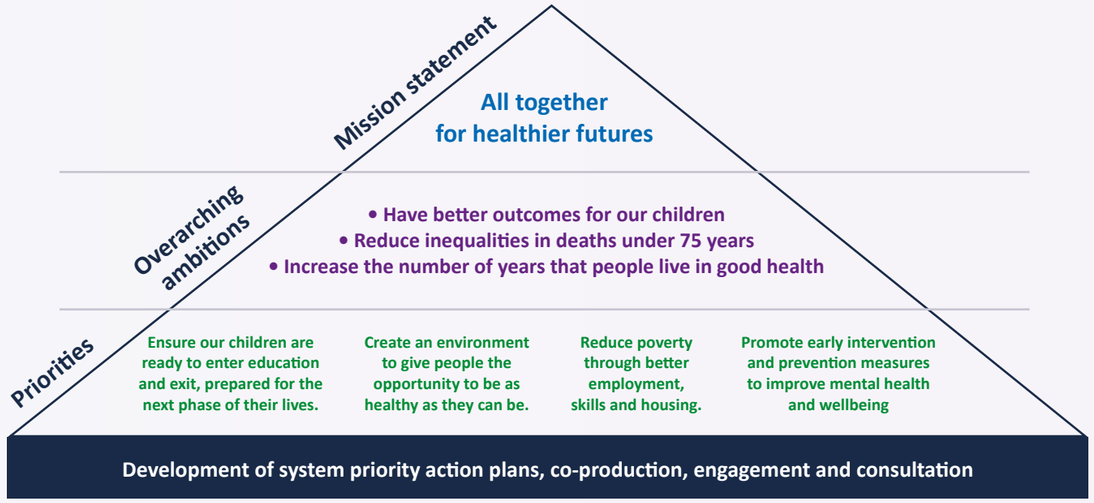
"Here at The Kite Trust, we work across organisations, local authorities and health partners to support the wellbeing and creativity of LGBTQ+ young people in Cambridgeshire, Peterborough and surrounding areas. We support young people directly through our youth work programme, providing youth groups with 1:1 support and family activities, but also seek to change the environments and barriers that prevent them from achieving their full potential. We are proud to work in partnership with other charities, organisations, networks, and local authorities. Some examples of this are the provision of our "Meet and Eat" programme, as well as our LGBTQ+ inclusive sporting opportunities work and through our collaboration with the Fullscope Network we are working to improve access to mental health services for LGBTQ+ young people locally."
Katie Girling-Weeks, Operations Manager, The Kite Trust

As part of our early work on this strategy, there was considerable discussion on how to set appropriate long-term goals for Cambridgeshire and Peterborough that would make a difference to the health of local people. The three overarching goals that were decided upon are intended to be stretching and ambitious, but also plausible and achievable. These goals will add up to a healthier and happier community, where the foundations for a good life are set in childhood, health inequalities are lessened, and wealth is less strongly linked to good health and wellbeing. Technical data presenting the best available evidence on the current situation for the three overarching goals has been used. It is important to note that for some of the indicators used to measure progress towards these goals, the full impact of the COVID-19 pandemic is not yet showing in the data. We may in fact be starting from a lower point than the most recent data suggests.

How we will achieve these ambitions

Discussion at our system-wide workshops identified four priority areas where we know we need to do things differently to achieve our overarching ambitions.

The four priorities for the HWB and the ICS focus on children, our environment and opportunities for health, poverty, and mental health and wellbeing. Each of these priority areas will be developed into a chapter of the Health and Wellbeing Strategy. The four priorities are listed below. Measurable outcomes for each of these priorities are also provided, and further work is being done on these ensuring we can track our progress effectively.



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

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

Measurable changes we aim to deliver for our local people in this area:

- Increase the number of children who show a good level of development (GLD/school readiness) when they enter education.
- Reduce the number of young people aged 16-17yrs who are not in Education, Employment or Training (NEET).
- Reduce inequalities in both these outcomes.

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

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

Measurable changes we aim to deliver for our local people in this area:

- Achieve a 5% decrease in childhood overweight/obesity by 2030.
- Reduce childhood overweight/obesity to pre-pandemic levels by 2026.
- Reduce adult overweight/obesity levels in pre-COVID-19 times by 2030.
- Every child in school will meet the physical activity recommendations.
- Achieve a 10% increase in the number of adults who undertake 150 minutes of physical activity per week by 2030.
- Reduce inequalities in overweight / obesity

Reduce poverty through better employment, skills, and better housing

- This especially recognises that the Health and Wellbeing Board/ICP partners are large employers within our local economy. The way we employ and treat our staff and commission services can have a significant impact, as well as capturing work with wider partner organisations on the economy, employment, and health. This links to the anchors approach that is set out earlier in the strategy.
- Local and combined authorities have a key role to play in impacting the health of local people by improving housing across Cambridgeshire and Peterborough.
- Better physical and mental health will improve employment opportunities for our local people.

Measurable changes we aim to deliver for our local people in this area:

- Reduce relative poverty, for example the proportion of children living in relative poverty.
- Deliver improved quality and availability of housing that meets health and wellbeing needs, for example increasing the supply of affordable housing for key workers and the proportion of local people in safe and secure accommodation.
- Achieve improved employment opportunities and outcomes, for example through better jobs and employability skills provision.





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

- Work to improve wellbeing across the area, as well as intervening early when people experience mental ill-health, will have huge benefits for all our local people.
- Emerging research into the risk factors for the development of mental health problems will enable us to develop targeted preventative measures.

Measurable changes we aim to deliver for our local people in this area:

- Increase the proportion of children and young people who score a high mental wellbeing score on the annual school survey.
- Increase the proportion of adults who report a 'good' or 'very good' score for their life being worthwhile in 2030 compared with 2021/22.
- Reduce the proportion of children and young people who need to be referred to mental health services.
- Increase understanding of what people can do, and what choices they can make, to best support their wellbeing and the wellbeing of those they care about.
- Improve awareness of where and how people can access help and information to prevent mental health problems escalating.

Senior staff from across the local public sector are working with partners and communities to take on development and leadership of the four strategy priorities, supported by evidence, data about and conversations with our local people. Further work on these system-wide priorities, agreeing what will change, what will cease and what new approaches are necessary, will take place over the next six months.

The longer timescale for developing this work is necessary to include and summarise much of the work that is already being done in these areas. It is also important to allow sufficient time for meaningful co-production, engagement, and consultation to take place with local people and communities, as well as ensuring relevance and support from partner organisations.

The Health & Wellbeing Board, NHS and voluntary sector partners will have different roles to play in each of these priorities. For example, the health system does not provide housing, and the local authority does not commission most mental health interventions. However, each of the four areas has scope for action for all key partners, along with additional benefits that should come from working on these agreed priorities together as a system.

All four priorities have been considered to see what needs to be done around the cross-cutting themes and ambitions of improving children's outcomes, reducing health inequalities, and improving years of life lived in good health.

We intend these strategic priorities to shape work across the NHS and Cambridgeshire and Peterborough local authorities over the next eight years. We are starting from a challenging position given the impact of COVID-19 across our area, but we have set stretching yet achievable ambitions.

By working more closely across the NHS, the public sector including schools, partners, local communities, and local people than we ever have before, we can achieve these ambitions and make a meaningful difference to the lives of our local people and communities; happier and healthier children and young people, fewer early deaths in our more deprived areas, and more years spent in good health.

Case study

Using Innovation Funds to keep people warm and well in winter

We work closely with district council partners across Cambridgeshire and Peterborough and have created an Innovation Fund to target projects that support our strategic priorities. One example developed by Cambridgeshire South partners includes delivering Warm Hubs for our communities to provide a safe, warm place for people to go to in their local areas and provide opportunities to share and maximise access for people to get the help and support they need. This includes supporting vulnerable families and individuals to access benefits they are entitled to, accessing Citizens Advice appointments and provision of food bank vouchers.

This project starts to respond to the findings from our strategy engagement work that indicated that due to the increased cost of living, **34%** of respondents required financial help, **30%** required advice from services such as Citizens Advice and **19%** required support from foodbanks with **22%** indicating they would use warm hubs.

3. How we will deliver our strategy

Becoming an ICS brings local organisations closer together than ever before. It sees our local health and care organisations, local councils, and voluntary, community and social enterprise organisations working collaboratively to improve population health and tackle health inequalities.

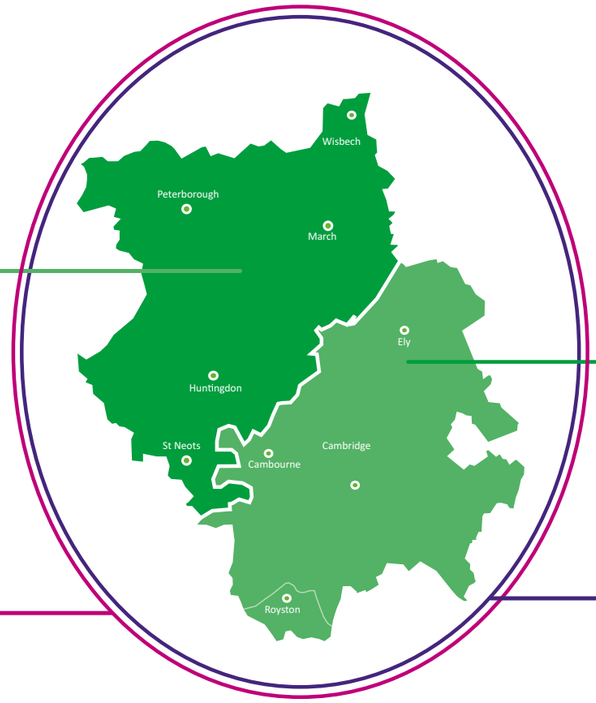
As part of the ICS development our care and support providers come together to form new partnerships that will ensure people receive care that is integrated, delivers the experiences and outcomes that matter to our people and communities, and is delivered as close as possible to where they live their lives.

North Cambridgeshire & Peterborough Partnership

Population 582,710

Partnerships:

- Cambridgeshire and Peterborough ICS
- Healthwatch Cambridgeshire and Peterborough
- Cambridgeshire and Peterborough Health and Wellbeing Board
- Cambridgeshire County Council, Peterborough City Council, Fenland District Council, Huntingdonshire District Council
- 49 GP practices, 13 PCNS, Greater Peterborough Network (GPN), West Cambs Federation (WCF)
- Cambridgeshire and Peterborough wide Local Medical Committee,
- North West Anglia NHS Foundation Trust (NWAngliaFT)
- Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
- Cambridgeshire Community Services NHS Trust (CCS)
- East of England Ambulance Service NHS Trust (EEAST)
- Other partners including schools, community pharmacists, dentists and opticians, parish councils as well as local voluntary, community and faith organisations.



Cambridgeshire South Partnership

Population 440,371

Partnerships:

- Cambridgeshire and Peterborough ICS
- Healthwatch Cambridgeshire and Peterborough
- Cambridgeshire and Peterborough Health and Wellbeing Board
- Cambridgeshire County Council, Cambridge City District Council, East Cambridgeshire District Council and South Cambridgeshire District Council
- 39 GP practices, 9 Primary Care Networks (PCNs) and Cambs GP Network
- Cambridgeshire & Peterborough Local Medical Committee
- Cambridge University Hospitals (CUH)
- Royal Papworth Hospital (RPH)
- Cambridgeshire and Peterborough Foundation Trust (CPFT)
- Cambridgeshire Community Services (CCS)
- East of England Ambulance Service NHS Trust (EEAST)
- Other partners including schools, community pharmacists, dentists and opticians, parish councils as well as local voluntary, community and faith organisations.

Children's & Maternity Partnership

Population 582,710

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

Mental Health, Learning Disabilities & Autism Partnership

Population 582,710

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

The partnerships include:

- Two partnerships are based on geographical 'places' – North Cambridgeshire and Peterborough (focusing on care for people living in Peterborough, Fenland and Huntingdonshire), and Cambridgeshire South Partnership (focusing on care for people living in East and South Cambridgeshire and Cambridge City).
- Two further partnerships are based on people experiencing conditions – Mental Health, Learning Disability and Autism Partnership (focusing on care for people experiencing those conditions), and Children's and Maternity Partnership (focusing on care related to pregnancy and for children and young people).

The partnerships have a role to understand local patient needs, drive service improvement and provide strategic plans that will deliver ICS and locally agreed priorities within the funding available.

They will work collaboratively to ensure alignment and avoid duplication of effort to ensure joined up services and support for all our local people and communities.

Together, they are working together on the development of the new system structures, governance and taking a lead on the cultural changes needed to embed the new ways of working.

They are also collaborating on planning and delivery of new models of care that address the needs of our joint priorities for local people, such as mental health and children's care models within the Integrated Neighbourhood Teams, care models for long-term conditions across North Cambridgeshire, Peterborough and Cambridgeshire South, or mental health services for children and young people.

Case study

Menopause Wellness Event – East Cambridgeshire Integrated Neighbourhood

Over 350 local women from East Cambridgeshire attended the Menopause Wellness event at the Lighthouse Centre, Ely in October 2022, which was organised and facilitated by partners within East Cambridgeshire's Integrated Neighbourhood (IN). The aim was to raise awareness of menopause and provide expertise, information, and informal opportunities to women on how they could support their health and wellbeing in mid-life and beyond.

Women were invited by their GP practice(s) and the event was fully booked within 48 hours. The programme included taster exercise and wellbeing activities sessions, talks from experts, and health checks. One attendee reflected:

"I love this event, because we're all in the same boat, no-one's embarrassed; we're in it together."

The next section describes the vision and future strategy for each of these partnerships.

"In my role as clinical mental health lead, true partnership working has been fundamental to achieving a new community mental health model in Peterborough. It was truly a joint effort between the local PCNs, CCG, CPFT, local authority, Mind, and our Service User Network (SUN). Together, we developed our vision which we have made a reality and we know that our patients, carers and staff are all reaping the benefits."
Dr Emma Tiffin, local GP



3.1 North Cambridgeshire & Peterborough Partnership

Our vision is to support people to stay well, be independent and live longer ensuring every person matters and every contact counts.

We serve a diverse community of 568,000 people who experience significant health inequalities. We have higher levels of deprivation with male and female life expectancies statistically lower than the ICS average. People living in our area have higher recorded prevalence of obesity, chronic heart disease, hypertension, stroke, COPD and diabetes and we have higher rates of secondary care (hospital) use and children's and adult social care compared with the ICS average. The birth rate is significantly higher, and our population is expected to increase by 11.0% between 2019 and 2031.

Across the North Cambridgeshire & Peterborough Partnership, we will work in partnership with our local people and local partner stakeholder organisations to provide an integrated health and care system fit for the future. This means people receiving and having access to seamless, holistic services that meet physical and mental health needs at the earliest possible opportunity.

Through focusing on people and communities, we place an increased priority on prevention and proactive care, rather than reactive treatment. Over time, we expect to deliver most of an individual's care needs in their local community, thereby reducing the need for hospital-based care.

Community of 568,000

Population is expected to increase by 11.0% between 2019 and 2031

Based on an understanding of our local people and communities, the North Cambridgeshire & Peterborough Partnership aims to:

- Meet the needs better of our local people – understand outcomes and better align resources to need.
- Address health inequalities in our population outcomes and focus on prevention.
- Address the specific challenges affecting North Cambridgeshire & Peterborough.
- Know and engage our local people and communities.
- Increase integration, reduce duplication and work across partners.
- Build practical and trusting relationships with North Cambridgeshire & Peterborough partner organisations.
- Support our neighbourhoods and communities.
- Build a partnership that can collectively manage a capitated budget for all health and care of the local people.

Case study

Wildflower Project tackles inequalities for sex workers

BMC Paston Primary Care Network, alongside Peterborough City Council and Cambridgeshire County Council, Peterborough, and South Lincolnshire Mind, developed the Wildflowers Project - an integrated sexual, mental, and general health service for sex workers in Peterborough who experience barriers to accessing health care. Since starting the project, the cervical smear uptake in this group has increased from 19% to 89%.

The team has recently been involved in a joint syphilis screening project with iCash and Public Health England, resulting in detection and treatment of a number of cases. The service continues to support these women to move forward and to access and appropriately use primary care services and therefore reduce pressure on secondary care. The project was shortlisted for the HSJ Awards in 2021 for Innovation in Primary Care.

Where are we now?

We have established a partnership built on delivery that works across organisations, making significant progress on our key work programmes including Integrated Neighbourhoods, outpatients, and diabetes.

We have agreed hosting arrangements with North West Anglia NHS Foundation Trust, an operating plan and budget for 2022/23 and continue to build the team and structures to support delivery.

We continue to bring care and provision of services together, closer to people's homes. We have established 13 Primary Care Networks (PCNs), which will develop into Integrated Neighbourhoods in time bringing together people working in physical and mental health, social care, and voluntary organisations. They are teams who work with general practices, within a small area to provide more local opportunities for local people and communities, to receive care.



Our plan

By working together, we can better meet the needs of our local people, understand outcomes, and align resources to need. We have three overarching clinical priorities:

- Frailty and long-term conditions.
- Emergency and ambulatory Care.
- Stronger role in prevention and wellbeing.

We will create a 'One Team' approach to service delivery that will help to break down boundaries to ensure and enable North Cambridgeshire & Peterborough Partnership to provide:

- Integrated Care - develop Integrated Neighbourhoods as critical infrastructure which will improve coordination and integration in primary, community and care services through dedicated Integrated Neighbourhood Teams and multi-disciplinary working.
- Service Delivery – lead transformation changes in outpatients and diagnostics and integrate or distribute these into primary care to reduce acute demand and improve access for local people.
- Clinical Pathways - create proactive population health management of long-term conditions and high-risk users to improve disease outcome measures and reduce admissions, using our population health management strategy.
- Integrated Care Models from community hubs – planned development for Fenland/Doddington Hospital with rollout to further sites that will implement integrated care models that maximise the use of assets increasing efficiency, utilisation, and access to care for our local people.
- Urgent and Emergency Care – work in partnership to deliver Virtual Wards, improved patient experience and better coordination of discharge and flow for patients through the acute hospital sites.
- Developing the infrastructure of North Cambridgeshire and Peterborough Partnership - further develop the governance structure and processes to be able to receive delegated functions and funding and increase staff capability to sustain delivery.



"I am a General Practitioner and I work with people who have a high level of challenge. The majority of people I care for speak little English and are in physical jobs with poor terms and working conditions. I love working with partners to think about how we can tailor services to our local people. An example of this relates to the council's health trainer and lifestyle services who help support our patients in their own language to stop smoking, reduce alcohol consumption and support them from coming off drugs (both prescription and street)."

Dr Neil Modha, GP in Peterborough

As a GP in South Cambridgeshire, I have a large number of elderly people where physical, psychological and social needs often overlap. The increased emphasis within the Integrated Care System of joined-up partnership working focused on the individual's needs, rather than organisational boundaries, is a major step forward in providing better and more efficient care.

Dr James Morrow, GP & Managing Partner, Granta Medical Practices



3.2 Cambridgeshire South Care Partnership

Our vision is that we want people living in Cambridgeshire South to enjoy healthy lives in strong, connected communities.

We have a diverse local community of approximately 430,000 people living in Cambridgeshire South (Cambridge City, East and South Cambridgeshire). Some people experience better than average outcomes, but some experience significant health inequalities that are likely to worsen because of the current cost-of-living challenge. Our local community is growing and ageing, with several new housing developments and there is increasing demand for unplanned care, requiring a more proactive approach to ensure greater focus on prevention and early intervention.

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

As a partnership we have agreed a broad ambition, which we intend to develop further alongside our partners, and have made a commitment to how we will work together in the interests of the local people and communities we serve.

Based on an understanding of our people, the Cambridgeshire South Care Partnership aims to:

- Lead the integration of health and care in the South Place on behalf of our people and communities and the system.
- Produce a new model of care for communities and local people helping to reduce inequalities in health and wellbeing outcomes.
- Describe how care is delivered in relation to key elements in people's lives like housing, finance, food, energy, education, leisure, and transport.
- Start to implement more coordinated care that reduces the number of people being admitted to hospital and ensures people get discharged as soon as they are ready.
- Look at ways to make sure people leaving hospital retain their independence and return home with support as often as possible.
- Involve partners to agree how care services can work better together for people, joining up care in neighbourhoods and improving efficiency and effectiveness in our use of our collective resources.
- Develop specific plans that invest in a sustainable primary care and ensure new ways of working have the required primary care clinical leadership.
- Establish better co-ordination of care for people who have long- term health conditions
- Develop ways of working that help people manage their own health needs to lead the healthiest independent lives possible.
- Support sustainability of care, health and wider services required to meet local people's and communities' needs.

Where are we now?

We have been building a strong partnership across Cambridgeshire South for several years and are already having a positive impact on people's experience and outcomes.

Our Integrated Neighbourhoods have engaged with their communities to improve confidence in management of diabetes and menopause wellbeing, we have partnered with Healthwatch to develop 12 health champion roles locally, and we are leading a pilot across the county to improve experience and timeliness of discharge processes for patients. We're exploring and implementing new digital tools to facilitate integration and information sharing and developing a system-wide Transfer of Care Hub with enhanced patient tracking processes, to enable improved patient experience and better coordination of discharge and flow within Cambridgeshire and Peterborough.

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



The Cambridgeshire South Joint Strategic Board was established in August 2022 and is co-chaired by representatives from the local authority, primary care and the hospital and has begun to lead six key work streams:

- Partner engagement to ensure effective partnership working is in place to enable integrated neighbourhoods to thrive.
- Further development and implementation of an Operating Framework for Cambridgeshire South, informed by the best available evidence, to drive forward integrated care delivery and population health management.
- Co-produce a two-year strategy by March 2023 and a long-term strategy in 2023/24 that best fits the needs of local people and communities and sets out implementation plans and a supporting investment and redesign plan.
- Overseeing a 'here and now' implementation plan on priority improvement work for the next 6-12 months.
- Lead and steer the development of Cambridgeshire South Care Partnership to ensure it has the functions, capacity, and capability to be successful.
- Have oversight of the Cambridgeshire South health and care system and the sustainability of all partners, leading where required to address the challenges faced.

We have also agreed a working draft Integrated Care Operating Framework which aims to drive the delivery of integrated care, informed by the best available evidence.

Our plan

Our partnership is committed to transforming the ways we organise and deliver care so that our local people and communities can enjoy healthy lives in strong, connected communities.

We will do this by developing person-centred care models, informed by our people, data, and best practice evidence. We will collaborate with the Integrated Care Board teams, and our colleagues in the other partnerships and collaboratives to ensure alignment, avoid duplication of focus or effort, and minimise unwarranted variation.

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

- Build integrated neighbourhood partnerships that can make decisions with their people and communities about health and care priorities.
- Identify people who are at higher risk of experiencing poorer health and wellbeing and who would benefit most from more proactive and personalised care, delivered by neighbourhood-based multidisciplinary care teams.
- Support people to receive care that would usually be provided in an emergency department or hospital ward in their own home or primary care practice or return home as soon as possible after a hospital admission.
- Learn by doing through co-development of new integrated care models, learning from local experience and national/international evidence.
- Put in place a practical plan to ensure the primary care and voluntary providers within our neighbourhoods are resilient, sustainable, and great places to work
- Drive the delivery of integrated care, informed by the best available evidence through an Integrated Care Operating Framework.

There are a number of enablers that are key to the design and delivery of our approach. These include a shift in culture to ensure that people who are already, or may in the future, use our care pathways, are partners in the redesign of them. This is so that the care provides outcomes that matter to the people using them.

It is important that we have access to Population Health Management intelligence, linked datasets and timely analysis of data so this information can be used to drive change. We want to utilise digital tools and enablers that are aligned with the system, place and neighbourhood priorities that make it easier to collaborate on the care for individuals and communities and we will focus on the alignment of our resources, both workforce and funding.

3.3 Mental Health, Learning Disability & Autism Partnership

Our Partnership brings together partners from across the area to work together to improve care for people living with mental illness, learning disabilities and autism.

There is no health without mental health. We must continue to prevent and treat mental health problems with the same commitment, passion and drive as we do with physical health problems. This is why one of the four ICS strategic priorities looks to promote early intervention and prevention measures to improve mental health and wellbeing.

Mental health has never been more important, both nationally and locally. Our Let's Talk results show that 49% of respondents **said they expected to need access to mental health support over the coming months** due to the increased costs of living. Through our engagement with local people and communities, mental health support was flagged as a key issue, with people telling us they wanted quick and easy access to services at an early stage for themselves, those they care for and children and young people.

"Family mental health sessions would be great. Children are being taught many things that their parents could also benefit from."

"More mental health service provision and increase of capacity and a significant reduction in waiting times to receive help."

As we emerge from the pandemic, the demand for mental health services has increased significantly and is compounded by increased levels of acuity. As a result, more needs to be done to ensure that our local people have timely access to high quality services both to improve mental health and well-being and to treat serious mental illness. We recognise the need to ensure that carers of people with mental health challenges, including young carers and parent carers are properly recognised, involved, and supported.

The health inequalities for those with a serious mental illness and/or a learning disability is evident, and the creation of a Mental Health, Learning Disability & Autism Partnership will provide a focus on improving outcomes and reducing these inequalities.



"In my role, I work closely with Cambridgeshire County Council, health partners and voluntary sector organisations across the ICS to improve access and services for people with mental health needs and those in crisis.

"I oversee the Mental Health Joint Response Car from an EEAST perspective and educate ambulance crews to engage effectively with people who are struggling with their mental health and improve pathways so their needs are cared for in the most appropriate way. I work with Cambridgeshire police linking the role of EEAST with the police when attending mental health calls and being on hand to offer knowledge and advice when needed."
Tamara Beeken, Mental Health Advanced Practitioner

The Mental Health, Learning Disability & Autism Partnership (MHLDAP) will:

- Develop strong collaborative leadership where mental health, learning disability and autism feature throughout the ICS to support holistic population health management by making mental health everyone's business.
- Develop a clear all age system-wide Mental Health, Learning Disability and Autism strategy.
- Drive the transformation of the design and delivery of care to improve mental health, learning disabilities and autism provision across local communities.
- Support reductions in health inequalities which are caused by a complex mix of societal factors through localised approaches which address the wider determinants of health.
- Support improving early identification and support for carers of people with mental health challenges, a learning disability and autism.
- Support improvements of local people's and carer's experience and recovery through outcome measures, promoting shared decision making and personalised care.
- Utilise data from acute, community, primary and social care to accurately assess the activity of the partnership aligned provision and how these services can be improved.
- Work closely with other partnerships to deliver services locally and support key transitions of services and support required throughout people's lives.





"I am in charge of Section 117 aftercare services provided by Cambridgeshire and Peterborough Integrated Care Board in collaboration with the local authority; these services are designed to meet a need arising from or related to a person's mental health condition. The aftercare provisions are intended to reduce the likelihood of a person's mental health condition deteriorating and, as a result, the likelihood of them requiring another hospital admission."
Samuel Nkala Head of Complex Cases - S117, MH, LD & Autism.

Where are we now

Partners across the health and care system, including the NHS, local authority, voluntary and community sector with patient and carer involvement, have worked together collaboratively for many years and have driven significant improvements in both mental health, learning disability and autism services and pathway transformations for our local people.

Key developments include:

- ✔ Development of a First Response Mental Health Crisis Service (111 Option 2), which is now being rolled out nationally.
- ✔ Development of Eating Disorder Pathway - responding to the increasing need for eating disorder services NHS and voluntary sector services have worked together to expand pathways, interventions, and medical monitoring for eating disorder patients.
- ✔ Roll out of a programme of transformation of Community Mental Health services - including Peterborough Exemplar project that has invested in additional services and roles to join up local services.
- ✔ Improving access to perinatal and maternal mental health services through developing pathways and investment in voluntary sector support.
- ✔ Implementation of a coproduced provider collaborative model YOUnited across Children and Young people's emotional and mental health. CPFT is the lead provider of this outcomes-based model with Centre 33 and Ormiston Families from the voluntary sector and Cambridge Community Services, using a whole system approach.
- ✔ Development of CASUS, a countywide young people's substance misuse service that provides information, support and specialist treatment in Cambridgeshire and Peterborough to young people under 18 years old experiencing drug and alcohol problems.

The development of the Mental Health, Learning Disability & Autism Partnership has enabled partners from across the system to come together to identify further areas for development and transformation, including commissioning a 'Needs Assessment' for Mental Health and Learning Disabilities to inform MHLDAP strategic decision making.



"We are lead learning disability nurses who work within the learning disability partnership, which is an integrated health and social care team.

"We support clients with a learning disability to access primary and secondary health care, ensuring reasonable adjustments are in place and breaking down barriers to access. We work collaboratively with GP surgeries, providing a link worker role to support people to access learning disability health checks."
Rebecca Ford and Marianne Attwood, Lead Nurses Learning Disabilities Cambridgeshire County Council

Our plan

The Partnership seeks to develop collaborative leadership where mental health, learning disabilities and autism feature throughout the ICS by making mental health everybody's business. It will also enable us to improve the experience of service users and their carers by promoting shared decision making and personalised care to ensure better mental and physical health outcomes.

Working together, we will improve the quality of life and life expectancy for people, improve access to care and the experiences of people using the service and carers, and ensure fewer people with learning disability or autism will need to go into hospital to receive care.

The Partnership will achieve this by:

- Driving transformation in line with the NHS Long Term Plan and embedded clinical leadership. By 2023/24 we expect performance to be in line with the Long-Term Plan expectations.
- Supporting reductions in health inequalities through place-based approaches which address the wider determinants of health.
- Working with people using the service and carers to improve their experience of services, ensuring they are involved, engaged, and supported to co-produce our system solutions.
- Supporting improvement in the use of system data to inform decision making and service transformation.
- Supporting the development of the future Mental Health, Learning Disabilities and Autism workforce, through creating new roles and opportunities to achieve workforce growth, recruitment, and retention.

Our strategy will also enable the Partnership to focus on specific areas of challenge including:

- Workforce retention and recruitment - by developing a mental health workforce plan with providers, Health Education England, and partners in the local authorities and voluntary, community and social enterprise sectors.
- Acuity and complexity of needs - through expansion and transformation of targeted areas, such as crisis care provision and ensuring that health inequalities exacerbated by the pandemic - most notably among people with a learning disability and autistic people - are addressed.
- Rise in demand expected to continue - by taking a partnership approach to the development of mental health and learning disabilities services, ensuring there is information and support available for carers where people are on waiting lists.

"I work with our partners in the NHS, local charities, police, universities and more to deliver our suicide prevention strategy. The work I am most passionate about is supporting CPSL Mind with the STOP Suicide campaign, encouraging people to have the confidence to talk about suicide with someone they are worried about.

"My hope for Cambridgeshire and Peterborough is that everyone has access to the right help and support for whatever emotional pain they may be facing."
Joe Davis, Suicide Prevention Manager, Public Health Team, Cambridgeshire County Council



3.4 Children's & Maternity Partnership

The Children's & Maternity Partnership brings together organisations across physical and mental health, education, social care and the voluntary, community and social enterprise sector, to plan care that is joined up and focused on the needs of our local people and communities.

Our provider landscape is multifaceted and complex, and parents and carers, children, young people and families, interface with many different service providers.

By working in partnership, the Children's & Maternity Partnership will champion the health and wellbeing needs of children and young people locally. It will work together with people who rely on public services and support, those who have struggled to access help, as well as wider stakeholders, to ensure that improvements are led by communities and their needs.

Where are we now?

The Children's & Maternity Partnership will continue to support integrated working in relation to existing and emerging strategies, including Best Start in Life (pre-birth to 5); Strong Families, Strong Communities (focusing on Early Help); joint SEND strategy; All Age Autism strategy; All Age Carers Strategy and Mental Health Strategy for Children and Young People.

A collaborative network has been established with representatives from local authority, NHS, education, voluntary, community and social enterprise organisations, parent and carer networks and other key stakeholders. Together, this group can share intelligence about emerging areas of concern and opportunity and support a partnership approach to helping to address them.

The partnership will maintain a collective effort to tackle key challenges that our area is facing including:

- Demographic growth and planning for new towns.
- Increase in identified need, especially for emotional wellbeing, mental health and safeguarding support.
- Impact of the cost of living on families.
- Significant health inequalities across the local communities.

Our plan

Our Partnership model offers a new approach to meeting the needs of children, young people, and families by supporting a partnership response which prioritises:

- Co-producing solutions with children, young people, parents, and carers
- Planning care around the places and communities where children, young people and families live
- Targeting inequalities of health and opportunity
- Addressing the wider determinants of care needs to proactively promote health and wellbeing
- Working together as an integrated system to safeguard children, young people and families
- Supporting young people to transition smoothly and successfully to adulthood

Our shared priorities and supporting strategies are summarised in the diagram below:

ABU Workgroups	Perinatal & Early Years		Emotional Wellbeing & Mental Health		Social Educational Needs, Disabilities & Neurodiversity		Physical Health	
Current system strategies	Better Births & Ockenden Review	Family Hubs & Best start in Life	CYP Mental Health Strategy	Strong Families, Strong Communities	SEND Strategy	All Age Autism Strategy	The Fuller Stocktake	Facing the Future Standards
Cross cutting principles	Participation and coproduction							
	Developing a place-based approach to care							
	Addressing inequalities of health and opportunity							
	Prevention through targeting wider determinants of health							
	Safeguarding is everyone's business							
	Supporting transitions to adulthood							

The Children's & Maternity Partnership has sought to reduce duplication and improve outcomes by supporting a multiagency, whole-system approach to transformation work, whether the individual strategy is NHS-led (in blue) or local authority-led (in green).

"When you are working on the ground with partners in East Cambridgeshire, there is an open door which dramatically reduces bureaucracy. The flexible funding which ensures we find the right solutions that are determined by children and families themselves."
Matt Edge, CEO and Therapeutic Practitioner of The Cambridge Acorn Project



A key priority for the partnership is to respond effectively to safeguarding needs as a system, working together, with a shared commitment to safeguarding being everybody's business. This means taking a proactive approach to providing early support which builds on the existing resources and resilience of families and communities. Examples of this approach include:

- The Best Start in Life is a 2.5 year old developmental review pilot, where health visitors work in partnership with those who know families best, in nurseries and children's centres, to provide early support targeted to need

- The Family Hub programme, sees multiagency teams take a coordinated approach to support with infant feeding, developing a positive home learning environment, providing parent support, improving parent-infant relationships and addressing perinatal mental health. Our Let's Talk engagement work told us that local people miss the local community support that Sure Start Centres offered – the Family Hub Programme will help to address this

- The Supporting Families and Reducing Parental Conflict programmes, which advocate a multiagency approach to improving safety for children and families. The following outlines emerging priorities and projects for 2023/24

Children's & Maternity Priorities for 2023/24				
ABU workshops	Perinatal & Early Years	Emotional Wellbeing & Mental Health	Social Educational Needs, Disabilities & Neurodiversity	Physical Health
Health Promotion Projects	Family hubs programme in partnership with Barnardo's Raham project for Muslim and ethnic minority parents	Mental health prevention pilots System response for complex cases with high risk and high cost	Keyworker collaborative in partnership with Edmund Trust and Circles Whole system offer for neurodiverse young people and their families	Paediatric asthma pilot Community continence service pilot Pilots for hospital reviews in community settings



"Violet and Rachel are both designated safeguarding leads at the Wisbech Adventure Playground. Their role is to ensure all children and young people are safe and to make referrals as appropriate through community, early help and social care partners, to ensure we are meeting the needs of the children we work with."
Violet Loveridge & Rachel Conroy, Wisbech Adventure Playground



Case study

The Raham Project

The Raham project works to reduce health inequalities within maternity for Black and Asian women. Two passionate mothers from within a local community in Peterborough joined forces with the local maternity and neonatal service and the Head of Midwifery and Maternity Voice Partnerships to provide an opportunity initially to support women with perinatal mental health. This project has now widened to cover all aspects of pregnancy and birth RIGHT across Peterborough and Cambridgeshire.

Through simple applicable messaging (mainly through short videos with subtitles) the team ensure topical messages are available to a wide group of women and their families, for whom English is a second language. Work is underway to have the information available in a wider range of languages. One of the key channels the project uses is its dedicated Facebook group, which is run and managed by women from ethnic minority groups who have the trust and respect of their communities.

4. Engaging with People and Communities

To deliver on our vision and priorities, we will follow approaches set out in a number of other Integrated Care System strategies, including the People & Communities Strategy, and the Voluntary, Community and Social Enterprise (VCSE) Strategy.

What is engagement

Engagement can mean different things to different people. In this context, it is about how individuals or organisations, as members of the local communities in Cambridgeshire and Peterborough, can become and are involved in decisions about the health, care and wellbeing of themselves, their families or staff, and the local community.

These opportunities are fundamental to make sure people's voices, experiences and ideas are heard, as we have pledged to in our People & Communities Strategy. At its core, it's about making sure the right people are heard and listened to, on matters that affect them, in the right way and at the right time.

Of equal importance is our work with our Voluntary, Community and Social Enterprise (VCSE) partners. We co-produced a strategy with VCSE partners and the National Association for Voluntary and Community Action (NAVCA) earlier this year to set out our shared vision and ambitions for partnership and together with the steps we will take to achieve our goal of embedding the VCSE sector fully as equal and respected partners within the ICS.

Our VCSE sector brings diversity, specialism, local knowledge and reach which both complements and supports the work of the ICS. They have many strengths and play an important role in the health, wellbeing, and care of local people in a range of ways including offering information, advice, and guidance, providing advocacy, promoting health and wellbeing in its widest sense, focusing on early intervention and prevention, and connecting with local people and communities that are seldom heard. We have welcomed the opportunity to discuss with our VCSE partners - through 'Let's Talk' and direct conversations - the priorities within this strategy.

Our approach to engagement

Our People & Communities Strategy sets out our approach to engaging with local people and communities, and how we will use those insights to shape our plans and the services we commission (buy) or deliver in the future.

Our vision of 'working together to improve the health and care of our local people throughout their lives' aligns to our commitment to include local people when we are making decisions about what services and support is needed locally. Life experiences and views can help us to make better choices.

We have an incredibly diverse local community, and this diversity can bring challenges, but also opportunity to improve services to meet the needs of our entire community, particularly those whose voices we hear from less frequently.



"My role is to coordinate the Adult Social Care Partnership Boards. These are groups of people with lived experience of using services who meet regularly with commissioners and providers to help them think about improvements. The boards include people with physical and/or learning disabilities, older people, carers, people with sensory impairment and people who use wheelchairs."
Graham Lewis, Partnership Development Manager, Healthwatch Health Champion Volunteer Team

Let's Talk: Your health & care

The **'Let's Talk: Your health & care'** campaign was launched on 7 October 2022 to inform this strategy and wider ICS work. Our aim was to reach a wide cross section of our community with a focus on hearing from communities whose voices we hear less often.

We are committed to listening to and acting on the experience and aspirations of local people and communities to:

- help them to sustain and improve their health and wellbeing
- involve them in developing our plans and priorities for the future
- listen to their view on how we can continually improve our services to improve experience and outcomes.

The campaign gained insight and feedback from across our communities. We heard from local people what they thought of current services and the impact of increased costs of living, as well as how we can improve for the future.

Engaging with our local people and communities to gather their insights and feedback in advance of drafting our Strategy and Joint Forward Plan (JFP) is a critical part of this work. It enables our strategy to be uniquely relevant to our local communities and wider area.

Our plans need to be driven by lived experience, insights, and knowledge to meet the needs of our local people and communities via a combination of hard data (for example via JSNAs) and soft intelligence, via Let's Talk.



"We worked collaboratively with community connectors, local authority colleagues and health partners to identify barriers to the COVID-19 vaccine uptake and build vaccine confidence in our communities. This partnership working led to increased trust and engagement by the community which has made a huge difference in the uptake of health support services. Working alongside such a diverse and passionate group of people, we witnessed how the barriers to engagement were overcome which has been hugely rewarding."
Nneka Ikejiani & Maxine Bain Programme Managers Enduring Transmissions Plus Cambridgeshire County Council

Working together

Let's Talk was developed collectively with leads from all four priority areas from across a range of partner organisations within the ICS and supported by the wider partnership including Healthwatch.

Acknowledging the insights people have been telling us and Healthwatch over the past few months was important to us through the Let's Talk questionnaire. The first part was developed to further understand the issues facing people in our communities here and now.

The second part was developed to gain insights into what services people feel they might need in the future, as well as starting to understand what is important to people around the four priority areas. We deliberately kept the questions broad to ensure the questionnaire wasn't too long and was relevant to everyone.

How we reached people

Prior to the launch of the Let's Talk campaign, extensive research was carried out to create a directory of groups and people to contact to ask them for their support and views/experiences. In particular, we sought to find hard to reach groups, or those whose voices are seldom heard.

Over 400 groups were contacted with information about Let's Talk, encouraging them to share the information with people who they were in contact with.

We contacted all our known partners such as NHS trusts, local councillors and MPs, local authorities, Healthwatch, Voluntary, Community and Social Enterprise (VCSE) partners and other emergency service providers to encourage them to complete the questionnaire themselves and share with their networks.

As well as speaking to a wide range of people either one to one or at meetings, at hospitals and other sites and at locally run partner events the campaign had a strong digital presence. There was a dedicated space on the ICS website, which included an explainer video and easi read version about the campaign.

We worked together to talk about what really mattered to people. We spoke to faith groups, the Gypsy and Traveller community, our Parks Partnership, Voluntary, Community and Social Enterprise groups, Youth Council, education leads and many, many more.

Throughout the Let's Talk campaign we used the ICS' social media platforms to encourage the public and staff to take part. We also had extensive support from our ICS partner organisations.

We want to specifically highlight the work with Facebook groups. We have an established link to the network of hyperlocal Facebook groups across our area. These groups are based around estates, villages, postcodes, town, and cities where people discuss issues local to them. We posted into nearly 300 groups, reaching right into these communities, and went on to target specific groups in areas of lower response rates, which enabled us to gather more feedback from these areas.



"I am currently working on a project to improve health inequalities for Gypsies, Travellers, and Roma people. This year I have coordinated training for 357 health and care staff educating people on the cultural barriers faced by these communities. I am now recruiting community volunteers to help Gypsy, Traveller and Roma people get the information and support they need."
Sarah Beckett, Gypsy, Roma and Traveller Project Manager, Healthwatch Health Champion Volunteer Team

Key themes

After reviewing all the feedback received, several themes were identified. The main ones can be grouped as follows using the four pillars:

1 **Our children are ready to enter education and exit prepared for the next stage of their lives**

Parents need to be seen as experts and heard in decisions that affect their children. The loss of Sure Start centres is still seen as detrimental and a loss to the community, alongside requests for improved childcare.

2 **Reducing poverty through better employment and better housing**

Many affordability/cost of living issues were cited. These range from bills, cost of food and heating, and worry over housing alongside a reduction in health and wellbeing activities owing to cost.

3 **Creating an environment to give people the opportunities to be as healthy as they can be**

One of the main issues raised was access to health services, including dentistry and GP practices alongside wait times. Access to transport was also raised, as this has negative impacts on reaching appointments.

4 **Promoting early intervention and prevention measures to improve mental health and wellbeing**

This was seen as a key issue for people, particularly as we emerge from the pandemic. Issues around accessing and provision along with social isolation - across all ages - was flagged. Concerns about feeling invisible and forgotten, as well as people going out less owing to cost.

Outside of the four pillars the other key issue raised was around workforce shortages and concern over how this would impact standards and personalisation in the future for people.

A full post engagement report is available via www.cpics.org.uk.

Let's Talk: final thoughts

What is important is although this initial piece of engagement, Let's Talk: Your health & care has concluded, it is not the end of our work. It will be a continuous conversation with our communities. Our planning approach will mean we will continue to ask you what you think before we make big decisions. We will also be clear about how the insights shared with us have influenced our plans and the actions we take both now and in the future.

5. One System, One Workforce

Working to our shared vision of 'All Together for Healthier Futures' we will meet the needs of our people and communities, shaping an integrated workforce that is inclusive, healthy, flexible, adaptable, skilled, right sized and resilient. This will be achieved by working collaboratively to find areas where joint working adds real and measurable value and where we are able to make use of our collective skills and learned experience, and where services and models are working well, sharing them across our system.

Our workforce will have the right skills to provide the right solutions in the most appropriate setting to improve outcomes for our communities, using resources as effectively and efficiently as possible. We will plan for a future where strategy and people planning are aligned with the ever-changing needs of our community's health and wellbeing.

Let's Talk told us that our people and communities are worried about workforce shortages with comments around experiences of reduced personalised care and lower standards of care as a result.

"NHS shortages - it puts me off consulting them. There's always someone worse off."

Our Workforce Strategy is aligned with our four strategic priorities:

1 Create an environment to give people the opportunity to be as healthy as they can be

By 2030 we plan to:

- Enable our partnerships and integrated neighbourhoods to maximise preventative care and health and embed healthy lifestyle practices, aligning our workforce with prevention not just treatment.
- Align workforce planning with population health need to ensure our workforce has the right skills in the right place and at the right time by the right people to meet our people's needs to remain healthy for as long as possible.
- Embed the future workforce plans at the heart of planning for new places and the development of existing places with a focus on keeping our people healthy to prevent ill health from occurring.
- Develop a digitally enabled workforce to utilise the power of technology and give our local communities the tools required for them to manage their own health and wellbeing.

"Improve resources, staff are stretched to the limit, underpaid, and overworked. This is impacting patient experience and standards of service"

"There really needs to be so much more available, properly funded with adequately trained individuals that are genuinely able to help people."

We will achieve this by:

- Maximising our workforce supply pipelines with a strong focus on wellbeing and health in the context of healthy sustainable career progression, ensuring all of our workforce find the Cambridgeshire and Peterborough area an interesting, supportive, sustainable and rewarding place to work.
- Plan our workforce based on skills required to build a future ready, adaptable workforce including further exploration of the additional roles in the community.
- Work with Education and Training providers to deliver a sustainable supply pipeline into our workforce.
- Provide flexible career opportunities, considering less linear career progression, opportunities and career breaks to ensure we retain the skills and dedication of our workforce, whilst supporting their work life balance.
- Fund well defined roles for sustainable periods in the voluntary sector, supporting people in their local community by their local community.

"I work in specialist community services and support service users with learning disabilities and complex needs to have a voice and involvement in their care. We work closely with colleagues in adult social care as well as families and carers to support people to remain in the community. This approach supports service users to have positive behaviour support plans to help enable them to have a meaningful life."
Sallyanne Broughton, Intensive Support Team



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

By 2030 we plan to:

- Strengthen our community and maternity teams, to be ambitious in ensuring that our children have the best start possible to their life, setting them up for a healthy and happy life.
- Work with our training and educational providers to ensure that our workforce is skilled in the provision of both mental and physical health and wellbeing for our children and young people.
- Work with our local authority and voluntary teams to provide skilled people for services that make a real difference to our children's lives within the community that they live.

We will achieve this by:

- Working with our voluntary and primary care colleagues, listening to the challenges, and supporting sustainable, longer term funded solutions.
- Working with key stakeholders to address skills shortages across our system.
- Work alongside commissioners to ensure sustainable services are planned alongside the workforce that is critical in the running of them.
- Working with commissioners to ensure funding for our workforce is sustainable, providing attractive roles for people.

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

By 2030 we plan to:

- Align our workforce's skills to deliver early, constructive interventions to support and maintain good mental health and wellbeing for our local community.
- Maximise the awareness of the importance of mental health with and for our workforce.
- Address the causes of mental ill health within our workforce and provide tools and resources to reduce or prevent these.

We will achieve this by:

- Strengthening and supporting the adoption of lifestyle choices and practices that create the conditions for positive mental health and wellbeing and averting mental health crises.
- Supporting Staff Mental Health Services and the ICS Health and Wellbeing Hub that deliver rapid access to multi-disciplinary mental health support for our workforce.
- Support services and organisations to address these causes putting the health and wellbeing of our workforce at the heart of our strategy.

4 Reduce poverty through better employment, skills, and housing

This especially recognises that the Health and Wellbeing Board/ICP partners are large employers within our local economy and the way we employ, treat our staff and commission services can have a big impact, as well as capturing work with wider partner organisations on the economy, employment, and health.

Local and combined authorities have a key role to play in improving housing across Cambridgeshire and Peterborough impacting the health of local people.

Better physical and mental health will improve employment for our local people.

By 2030 we plan to:

- Position our anchor institutions as employers of choice; inclusively providing local people with the right skills to work within their local community by commissioning services aligned to local community needs. These roles will deliver rewarding and sustainable careers to local people by local people investing in the local economy.
- Work across Cambridgeshire and Peterborough with all our stakeholders to understand the challenges and work together to find solutions for suitable, affordable, and good quality accommodation for our workforce.

We will achieve this by:

- Aligning workforce planning with population health needs. Proactively engaging with our stakeholders looking at the skills required for the future and inclusively providing opportunities to reduce poverty.
- Work with the local authorities and training providers to reach local communities to improve employment opportunities.
- Extend and adopt successful accommodation models across our Cambridgeshire and Peterborough area, learning from best practice and finding joint solutions.

To achieve our overarching aims, we will focus on three priority areas:



Driven by five enablers



Our vision

One System, One Workforce. We are inclusive and person-centred, committed to the highest standards of wellbeing and health for both communities within our system and the people who are part of our workforce. We offer a broad range of flexible, attractive, varied, and successful careers and roles across our care, voluntary and health sectors throughout our system. Through successful collaboration we will deliver real improvements and opportunities in wellbeing and health while reducing health inequalities.



Through our health inequalities project as community connectors, we work with a wide range of communities and aim to hear from people who are often harder to reach in our society. One of our main outreach projects has been to work with our health partners to promote the uptake of the COVID-19 vaccine across these communities. It took us a long time to build relationships and we found that one to one engagement showed positive results in uptake figures and our health and wellbeing coffee mornings, which often invited GPs for informal conversations, allowed people to discuss, ask questions and air their views."

Yasmin Ilahi, Manager, Gladca Gladstone District Community Association

How are we going to get there and who's leading?

Delivery of our system workforce strategy will be supported by the Local People Board, which is led by the Chief People Officer, as well as the ICS workforce team, stakeholders and enabling groups that drive projects across the ICS. We are also committed to strengthening the use of data and community listening to ensure clarity and focus on our current and future community's needs.

The formation of the ICS in Cambridgeshire and Peterborough provides a unique opportunity for a fresh look at what we do as a system. In the future we will focus on planning our workforce aligned to our community's needs and working in a more integrated way.



"There has been an obvious and deliberate movement to work more collaboratively across partners since the COVID-19 pandemic. My work within the district council has had a much wider impact as a result of working jointly with health colleagues and directly with community groups. Being able to consider the problems we are all facing across the services and support we offer, has meant we are really starting to build strategic, sustainable solutions that help everyone."

Liz Smith, Chief Delivery Officer, Huntingdonshire District Council

6. Equality, Diversity, and Inclusion (EDI)

We are committed to the people and communities we serve. One key element of this commitment is to improve and promote equality for our staff and local people, and to value the diversity of our people. The COVID-19 pandemic brought to the forefront what people affected by inequality already knew: That poverty and deprivation lead to poorer health outcomes. People who live in the most deprived areas of England and Wales were around twice as likely to die after contracting COVID-19.

Other data on the impact of COVID-19 also shows stark inequalities. A disproportionate number of all COVID-19 cases were within BAME communities (who represent 13% of the national population) and people with learning disabilities were significantly more likely to contract COVID-19 than those without learning disabilities. To help us reduce health inequalities and get better outcomes for everyone in our area, we are working together with all partners and stakeholders in a broader way, to consider every person, visitor, family member, volunteer and member of staff as their whole self.

Where are we now?

We have purposefully developed our organisational structures to ensure health inequalities are at the heart of everything we do. Our Equality, Diversity, and Inclusion (EDI) programmes focus primarily on our workforce outcomes, giving responsibility for people and community outcomes to our health inequalities programmes. We know that better workforce outcomes with regards to EDI translate to improved health outcomes for our communities from all backgrounds. This approach provides a data-led and more comprehensive approach to equality issues facing our communities.

The work we do to support our staff is important in ensuring our services run effectively and fairly, whilst equipping ourselves to work in ways that reduce the inequalities in health outcomes for our local people.



How are we going to get there and who is leading?

Our EDI programmes were established in early 2020 as a collective of organisational leads seeking to learn and improve together, sharing and developing best practice and innovative ideas at organisation and system level. The principles of EDI are guided by three overarching objectives:

1 To support our organisational culture to meet the goals set out in the NHS People Promise of 2020.

Whilst acknowledging that not all organisations within the Cambridgeshire and Peterborough ICS are NHS organisations, we will create a culture that supports our people to be Compassionate and Inclusive, Recognised and Rewarded, to have a Voice that Counts, to ensure we are Safe and Healthy, that we are Always Learning, that we can Work Flexibly and that we are a Team.



"In my role as Head of EDI at Royal Papworth Hospital, I can see the vast benefits of working collaboratively within the ICS. Firstly we have built important relationships which allows us to be able to collectively deal with and prioritise areas for improvement, and also understand each other as people in our roles. Also recognising that having input from different organisations within the care profession allows a more holistic view on any decisions being made for staff and patients."
Onika Patrick-Redhead, Head of Equality, Diversity and Inclusion, Royal Papworth Hospital NHS Foundation Trust

2 To provide a comprehensive service, available to all.

This strategy makes significant progress towards ensuring that our services continue to improve, prevent, diagnose, and treat the health and care needs of our people and communities from all backgrounds.

3 To meet the objectives of the Public Sector Equality Duty.

All public sector organisations within our ICS are subject to the public sector equality duty. Throughout our work, we must have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

This involves:

- Removing or minimising disadvantages suffered by people due to their background or circumstances.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people who do not share the same characteristics.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

Key challenges

We want to deliver services which are inclusive and accessible to all our people within an environment in which our staff can thrive. We recognise we have a long way to go, and that the road to equality has no end, but to achieve the progress we want to make we need to be honest, positive, and courageous in our ambition.

There are several cases for the robust implementation of EDI programmes:

- **Legal Case:** Considering equality and human rights is a legal requirement, and in evolving ways, has been for over a century. Evolving case law provides clarity for a wider range of support to be offered to a more diverse group of people but also poses challenges to the partnership in identifying the most effective means of delivery.
- **Ethical Case:** It has been clear for years that morally, the right thing to do is to support and value people from all backgrounds, but simply giving tacit endorsement of EDI objectives has not proven enough. The COVID-19 pandemic has highlighted glaring inconsistencies in society, and this means it is time to combat these across the ICS.
- **Business Case:** Well-delivered EDI programmes enhance organisation and system reputations, provide more positive organisational cultures which in turn support recruitment, retention, and staff experience. Developing a positive culture and a safe environment for all staff drives a positive culture and safe environment for our local people, improving the quality of care delivered.
- **Economic Case:** Preventing ill health, or deterioration in people's health, by tackling health inequalities or barriers to accessing health and social care services improves the health of local people, reducing the rates of admissions and thereby reducing pressures on services.



"Working across the Integrated Care System is key to ensuring we collectively deliver the right service to the right people at the right time. I am passionate about our work with health partners and strive to jointly support good mental health. When Partnerships work together, we can achieve far more for our communities across Cambridgeshire and Peterborough."
ACC Vicki Evans, Cambridgeshire Constabulary

Where do we want to be in the future, by when?

There is no end date in the pursuit of equality. All the actions we take need to be long lasting and will require constant review. Our overall goal is to create consistent experiences for staff across all ICS organisations, with comprehensive and consistent responses to discrimination when experienced.

We want to work widely and consistently on equality issues, to provide data and qualitative feedback that supports all our staff and drives programmes that meet the needs of everyone. To build effective programmes, we must first fully understand those we serve, our communities, our staff, and our local people.

To achieve these objectives, we must:

- Invest in our data described within our population health and digital areas of the strategy.
- Widen our view of equality metrics.
- Invest in innovative programmes of delivery.
- Acknowledge and accept risk in trying new and innovative solutions.
- Work as a collective of organisations.
- Support smaller organisations and those without the capacity of large employers.

7. Health Care Delivery and Clinical and Care Leadership

Care Professional and Clinical Leadership

What

Forum for clinical and care professional decision making, providing recommendations on new clinical strategies and plans, and for new clinical and care professional issues

Responsible for Healthcare Deliver Strategy

Who

Professional and Clinical Leadership Assembly

(Care professionals and clinical leaders)

Why

To enable engagement of health and care professionals across the ICS, help turn research into local practice and share learning from other areas to ensure we deliver the best health and care services and research we can.

It is also an ICS decision-making route for care and health professionals across our system.

Current focus

1 Working together as one team (addressing interface issues across health and care).

2 Identifying and implementing research and technological advances which provide better care more efficiently and effectively.

3 Prevention of ill health, in particular obesity across the life course, which aligns strongly to our four overarching strategic priorities.

4 Reducing health inequalities.

5 Rebalancing the place of care so that people only have the shortest possible hospital admission and receive most care as close to home as possible.

This Healthcare Delivery Strategy will describe how, as a partnership, we work together, involving clinical and care professional teams across the ICS, partnerships, Primary Care Networks, neighbourhoods and through individual conversations with local people and communities to deliver improvements in the areas above.

As set out within our health inequalities area of the strategy, despite significant progress and a collective response to the impact of COVID-19, there are communities across Cambridgeshire and Peterborough who experience unacceptably poorer access, outcomes and life expectancy than the rest of the local people. The creation of a Healthcare Delivery Strategy is a key part of the overall ICS approach. In turn, this work will support the wider strategic priorities, by creating an environment to give people the opportunity to be as healthy as they can be and by promoting early intervention and prevention measures.

Where are we now?

We've already made good progress, with a range of projects underway including primary prevention of cardiovascular disease, exercise and weight management referral schemes, and alcohol screening and treatment services in acute trusts, virtual consultations and patient initiated follow up services, which help people to be managed closer to home and in a more resource-efficient way.

Key challenges

Having sufficient workforce and capacity in place throughout the ICS and ensuring they have the skills and capabilities to provide the right service and support to local people is always key. The focus on transformation, redesign and new ways of working will enable the planned aims and objectives of the Healthcare Delivery Strategy to be delivered. These new approaches and new ways of working will enable the system to work more efficiently and effectively, leveraging the benefits of scale, integration, technology and data. However, a risk remains that key strands of the strategy will not be delivered, or the beneficial impacts will be reduced, due to workforce challenges and constraints.

A thriving primary care sector is key for delivery. We know that most interactions people have with our health services are in their local community, with their local General Practice and wider Primary Care teams. Workforce and workload pressures are currently having a detrimental impact on both patient and clinician experience and on patient outcomes.

Our general practice teams are becoming more multi-disciplinary in their nature, in part to counter a reduction in the number of fully qualified general practitioners in the workforce, but also in recognition of the important contribution other professionals can offer to help address the diverse needs of our local people. The range of skills and services that can be offered through our General Practice teams is expanding, including access to non-medical solutions to local people's life challenges. Health coaches, social prescribers and care co-ordinators are now working effectively alongside pharmacists, physiotherapists, paramedics and advanced practitioners, to name but a few, embedded at the heart of our General Practice teams.



"I am working as a Health Inequalities Engagement Officer supporting Latvian and other Eastern European communities in Peterborough. Our aim is to work and help people with English language barriers.

"We produce a radio show every week in Latvian to improve the understanding of what health services are available in Peterborough. We also produce films which are translated into Latvian and have received over 300 views on each of our four films."
Iveta Suna, Coordinator Latvian Community Association in the UK

The diversity of our General Practice teams will continue to grow, and we will invest additional resources to develop a stable, sustainable and general practice offer, which will work in closer collaboration with the wider primary care team, to offer proactive preventative, and reactive treatment services, to patients closer to home. The skills of community pharmacists in optimising medicine usage and understanding, to increase compliance, to reduce medicine wastage and to contribute to acute and long-term condition management must be recognised and supported.

We must encourage a paradigm shift from an acute-focused sickness service to adding value to individual patients and local people through core GP services. First contact access, coordination, comprehensiveness, and continuity have always been and remain very relevant and important to local people and clinicians alike. Innovations and strategy must focus on not losing these key aspects of traditional primary care models, whilst recognising services must transform and adapt to new challenges and expectations of the communities we are in service of. As we layout our strategic priorities clearly, we remain optimistic in the face of future challenges.

Case study

Post COVID Syndrome Assessment Service

Post COVID syndrome is a new condition that has complex, multiple and variable presentations where patients require access to assessment and support from multiple different services.

An integrated service was developed to respond to the complexity of the syndrome, with a multi and inter-disciplinary approach best delivered as a one-stop service, driven by strong clinical leadership. The clinicians working in this service come from a wide range of professional groups and providers across the system, demonstrating how collaborative and integrated working can support our local people as they deal with complex symptoms associated with this condition.

Where do we want to be in the future, by when?

To reduce inequalities in health outcomes, give people more control over their health and wellbeing, and deliver the right health and care services in the right place at the right time, backed up by research and innovation.



"I'm working on the ICB prevention agenda, offering the blood pressure case finding service to my local community."
Maria Wakerley, Pharmacist, York Street, Cambridge

How are we going to get there and who's leading?

The Healthcare Delivery Strategy, when fully developed, will aim to improve outcomes for local people through measurable changes that directly impact how people manage their lifestyle, are managed and supported by health and care providers and through a reduction in the current levels of health inequalities. Key examples may include:

- Increasing the number of referrals to behaviour change programmes and measuring the access to primary care and preventative services, including measures of inequalities of access.
- Redesigning planned care pathways, allied with increased medical optimisation, digital access and community involvement, to reduce waiting times and improve the clinical management of patients while waiting for treatment, leading to improved clinical outcomes.
- Improved access to primary care and urgent and emergency care responsiveness, measured via integrated performance reports, to ensure that people receive the right care at the right time to deliver improved outcomes.
- Increasing the early identification of unpaid carers, including young carers and parent carers measured by reports on referrals to carer support organisations.

Within the five proposed areas of our strategy the organisations and clinical and non-clinical leaders will collaborate through structures, reporting and the use of system-wide metrics and data. Additionally, we are developing a shared care record and enhancing our population health management data as enablers to support delivery of key elements of the strategy.

7.1 Innovation and Improvement in Service Delivery

We are committed to making our services better every day by empowering our teams to identify and implement service improvements. Innovation and continuous improvement support our strategic priorities by enabling us to deliver safe, modern, efficient and effective services.

Our vision is that all members of staff, at all levels and across all partners will see innovation and continuous quality improvement as a key component of their work. That all staff colleagues will each day try to make things better for those who use our services.

There is a great deal of continuous improvement work taking place across our system, supported by quality improvement resources and tools such as the Quality Service Improvement and Redesign Toolkit, as well as other methodologies. We are also in the early stages of introducing Continuous Quality Improvement to health sectors where to date it has had limited uptake.

The Health Innovation's Adopting Innovation Fund programme is supporting our ICS to implement proven innovations, particularly to address health inequalities. The programme is funded until February 2024 and provides upskilling, project co-ordination, funding advice and co-production support for adopting innovations.

Key challenges:

- Stakeholder engagement work has highlighted that staff are often unaware of what is meant by innovation or where to turn for support. We are working with the Adopting Innovation Hub to promote a positive organisational culture for innovation across our ICS.

- Organisational processes are not yet well established to support development and deployment of innovation. To address this, Cambridge University Health Partners are working with its provider members and primary care to develop innovation landing zones where innovations at proof-of-concept stage developed in the region or from outside can be demonstrated, tested and validated in healthcare practice. The ambitions are that this provides our ICS with early visibility into future innovations and allows patients and staff early access and an opportunity to use the expertise in the system for meaningful evaluation. We will also take on board the forthcoming recommendations of the Adopting Innovation Hub to improve system readiness and best innovation practice.



"The Wisbech Primary Care Network, led by the Clinical Director, Dr Mandeep Sira, are working with community pharmacies in Wisbech which enables true integrated working with various system partners to deliver the best possible care to our local community. An example of this, is the General Practice Community Pharmacist Consultation Service, which supports improving patient access to healthcare for minor ailments. To improve patient outcomes, we are also collaboratively exploring innovative ways for community pharmacies to provide more clinical services via Patient Group Directions (PGDs)."
Hina Patel, Community Pharmacist for Wisbech PCN



Areas of focus for the future:

- Ensuring local people are meaningfully involved in the selection and development of innovations and improvements to address local needs. This shift in mindset and culture will need to be modelled and led by our leaders at all levels

- We aim to have an agreed Improvement methodology for the system by the end of March 2023, with a strategy and delivery plan in place by December 2022

- Embedding innovation and continuous improvement as part of organisational culture and development across all parts of our system

The work will be led by the System Clinical Improvement Officer, with system engagement and collaboration through the Quality Improvement and Transformation Group, and the Improvement and Reform Committee.

Case study

Working together for better palliative care

We all want to support people through their lives, including at the very end of their life. Our Palliative Care Hub Advice Line, accessed via 111 option 3, provides dedicated support for people who need palliative care, and their families. This voluntary sector-led initiative brings together the experience of the Arthur Rank and Sue Ryder hospices, the wider voluntary sector and health and care services and in its first 18 months responded to 3,543 calls and supported 2,101 patients. One person who used the service said:

"I just wanted to take the time to personally thank you and your colleagues for the excellent palliative care you provided to my mother who has end stage cholangiocarcinoma. We were having a family get together in Cambridge and my mother's rocket drain for her refractory ascites was leaking and she was in a lot of discomfort. We followed the instructions on the phone for palliative care and were put through to Hannah, a very informed and qualified colleague who despatched a nurse to the hotel. Kirsty was very professional and skilled, she arrived within 30 minutes and was able to drain my mother's ascites and change her dressing. It meant my mother did not need to call an ambulance nor attend A&E and we were able to continue our overnight stay in Cambridge."

7.2 Population Health Management

Population Health Management (PHM) is a key tool to support our goals on prevention of ill-health, reduced inequalities, improved outcomes and quality of care.

PHM is an approach that enables local areas to deliver the most appropriate services for local people. It uses linked datasets from health, care and other services to plan and deliver proactive and preventative care.

Using a PHM approach drives a change in culture towards more integration, more prevention and more provision, based on need rather than service use.

Our long-term vision is that all organisations within the ICS have the skills, resource and information they need to use PHM approaches. All partners will use the same database to align priorities and operationalise PHM. Most operational PHM will happen at Place and Integrated Neighbourhood level, but we will also use a PHM approach at system-level to allocate resource, manage risk and identify system priorities. PHM data can be further enhanced by qualitative information incorporating voluntary sector and public feedback to ensure it reflects community insight and knowledge. We will develop a PHM platform and will also support provider partnerships and Integrated Neighbourhoods in using high-quality PHM approaches.

We have strengthened our population management approach through collaborative working and participation in the National Population Health Management Programme. This has resulted in targeted services for specific groups, including people on opioids and people with co-morbidities from younger age groups.

Some key challenges and how we plan to overcome them:

- PHM relies on a complex linked dataset to produce the most actionable insights. The complexity of Information Governance will always be a challenge for a programme of this type as we need to ensure we use data appropriately i.e., how local people would expect us to use it. A transparent and open process is the only way forward with this, working with data controllers and patients to understand their concerns and desired outcomes.

- Resource is needed at all levels of our system to understand and use the insights created through PHM. This involves engagement from all partners including VCSE and our communities, so it is important to focus on our ICS priority areas and deliver on them.

- VCSE partners have a key role to play both in contributing rich data and intelligence and in working as part of local partnerships to respond to the insights provided.

Looking ahead, we aim to provide a single Population Health Management portal so that all partners use the data to understand how patients use services from a data perspective, and build on the qualitative feedback from local people. It will also help us to understand the other factors that our local people are dealing with on a day-to-day basis e.g. housing quality, cost of living, and long-term conditions.

Critically the data will be used to look ahead to the next 5-10 years to understand what pressures we will be facing as a system and agree the actions we can take now to mitigate them.

A PHM Strategy has been developed and is being shared across the ICS to gather feedback and ensure it meets the needs of our partners and local communities. It will be used by our analytics community and aligned to our priorities to make sure we target our analytical resources in the right place for the right outcome.



"I am a Warden for Age UK. I work with older people in my local community. One of our aims is to provide support and information to maintain health and wellbeing.

"The Social Navigators and Age UK advice line have been invaluable in this. I have been able to sign-post to people accessing lifeline alarms, handrails, key-safes, transport and promoting social events.

It is encouraging to think that health, social care and the charity sector are communicating and working together."
Juliet Hawksworth, Stapleford Community Warden, Cambridgeshire and Peterborough

7.3 Health Inequalities

We will use integrated, local approaches to work together to tackle inequalities, drawing upon the assets and organisations within local communities, and using the widest range of partner opportunities available to address the wider determinants of health, as set out in our strategic priorities.

We will focus on those community groups who experience poorer-than-average health access, experience and/or outcomes who may not necessarily be identified. This includes our ethnic minority communities; inclusion health groups (such as people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery); people with a learning disability; unpaid carers; those people with multi-morbidities; and other protected characteristic groups, amongst others.

We will prioritise targeted action on inequalities in the following clinical areas:

- Maternity: ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups, taking into consideration the requirement for appropriate staffing levels.

- Severe Mental Illness (SMI): ensuring annual health checks for 60% of those living with SMI.

- Chronic respiratory disease: with a clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving uptake of COVID-19, flu and pneumonia vaccines to reduce ineffective exacerbations and emergency hospital admissions due to those exacerbations.

- Early cancer diagnosis: ensuring 75% of cases are diagnosed at stage 1 or 2 by 2028.

- Targeted action on hypertension and diabetes to address inequalities in cardiovascular disease.

- Smoking cessation, through the Treating Tobacco Dependency programme, is an important priority which will positively impact on all five clinical areas.

A key objective is to ensure NHS services are restored equitably following the pandemic, through inclusive recovery plans and monitoring of waiting lists by deprivation, ethnicity and other protected characteristics.

Finally, we need to have greater collaboration in sharing and using data to inform priorities, as well as investing more innovation and prevention to support our goals in tackling inequalities.



"Working closely with Wintercomfort is key to providing good care to our patients. It is not just the healthcare we provide that matters, but the wrap around support and activities that Wintercomfort delivers that makes a difference to a person's health. We look forward to further developing our partnership in the months and years ahead communicating and working together."
Dr Damita Abayaratne, Cambridge Access Surgery

7.4 Prevention of Ill Health

Evidence-based prevention programmes on smoking, obesity and alcohol provide an important way to tackle avoidable illnesses earlier and help reduce the demand on health and care services. They directly support our priorities.

Smoking is the greatest modifiable risk factor responsible for health inequalities and is a significant contributing factor to the ten-year difference in life expectancy that we see between the most and least disadvantaged in society.

Joint action on smoking is co-ordinated through the Cambridgeshire and Peterborough Tobacco Control Alliance. Within this, the Treating Tobacco Dependency Programme has implemented smokefree pathways with particular focus on inpatients, maternity and mental health. The programme is aligned to public health-commissioned services in the community that offer stop smoking support, including a targeted incentives scheme for pregnant smokers and manual and routine workers who have the highest rates of smoking.

Alcohol misuse is also the biggest risk factor for death, ill-health and disability among 15–49-year-olds in the UK, and the fifth biggest risk factor across all ages. However, this is intermittently captured within care records, or shared with their GP and people are not consistently offered support. The impact of harmful drinking and alcohol dependence is much greater for those in the lowest income bracket and those experiencing the highest levels of deprivation.

Both Cambridgeshire and Peterborough have higher than average levels of unsafe alcohol use locally.

Adults who drink over 14 units of alcohol per week	**28.7%** Cambridgeshire	**24.9%** Peterborough	**22.8%** Nationally
Those who abstain from drinking alcohol	**9.3%** Cambridgeshire	**13.2%** Peterborough	**16.2%** Nationally

We've launched an area wide project to provide a seven-day service to identify and treat alcohol dependence related admissions through the emergency department at Cambridge University Hospitals NHS Trust. The aim is to reduce avoidable alcohol-related hospital readmissions as well as reduce the length of stay in hospital.

In Cambridgeshire, although the rate of drug-related deaths is lower than the national average and has decreased in recent years, the number of substance-related emergency department attendances, has risen by 59% from 2018/19 to 2021/22. In Peterborough, although the rate of drug-related deaths is slightly lower than the national average, the number of admissions to Peterborough hospitals for drug poisonings in 2021 being considerably higher than the national rate.

Following publication of the Government's 10-year drug strategy 'From Harm to Hope' in December 2021, a local drugs strategy partnership has been formed across Cambridgeshire and Peterborough with strategic oversight being given by the 'Countywide High Harms Board'.

The NHS Digital Weight Management Programme supports adults living with obesity to manage their weight and improve their health via the comfort of their home using their digital device. It is available for adults living with obesity and who also have a diagnosis of diabetes, hypertension or both. The Digital Weight Management Programme is part of a range of prevention and weight management services commissioned by Public Health, along with the physical activity schemes provided by district local authorities. Our weight management services are jointly funded by health and care and form part of integrated weight management services across our area.

Almost 1 in 4 of local people die from cardiovascular disease (CVD) and between 2016-18 it accounted for 24.9% of all deaths in our ICS. People living in more deprived areas of England are almost four times more likely to die prematurely from CVD. There are various behavioural and clinical risk factors that contribute to the development of CVD, including living with excess weight, smoking, raised blood pressure (hypertension), raised cholesterol, chronic kidney disease, a history of gestational diabetes, living with pre-diabetes or diabetes. Many of the risk

factors that cause CVD can be avoided altogether or once identified, managed successfully with lifestyle change and pharmaceutical intervention. Such interventions are incredibly cost-effective but have not been previously systematically addressed. Taking a population health management approach to better identify, diagnose and manage these risk factors will reduce the premature morbidity and mortality of CVD.

Our CVD Prevention Strategy is in development. It focuses on primary care identification of risk and management of treatment to target through re-shaping the system to use resources currently in the system including Local Authority Public Health behaviour change. As part of the CVD prevention strategy, there is additional focus on primary care identification of risk and management of treatment to best practice standards.

The Local Authority Public Health team commissioned behaviour change services that address all the key high risk health behaviours amongst local people and communities. Public Health is commissioning behaviour insights research across Cambridgeshire and Peterborough to identify what interventions would best elicit positive behaviour changes.

All of these programmes are complemented by wider place-based approaches and local initiatives led by local councils and the community and voluntary sector to promote health and wellbeing in our local communities.

A key challenge for us is the continued prioritisation and funding for prevention programmes in the context of operational and financial challenges, as well as recruitment and workforce challenges to deliver. We aim to integrate prevention within primary and secondary care pathways and to work collaboratively across health, local authority, VCSE and other agencies to maximise our collective impact on prevention for our communities.

Antimicrobial Resistance

About 700,000 people globally die each year due to resistant infections and that figure could rise to ten million by 2050, if action is not taken to slow resistance and remove the unnecessary use of antibiotics. In Cambridgeshire and Peterborough, it is estimated that 1,250 patients could die from antibiotic resistance each year by 2050 if no action is taken.

Antibiotic resistance is accelerated by inappropriate use of antibiotics, especially the overuse of broad-spectrum antibiotic agents. When infections can no longer be treated by first-line antibiotics, patients may suffer a longer duration of illness and treatment, often in hospitals, increasing healthcare costs as well as the economic burden on families and societies. Organ transplants, chemotherapy for cancer and surgeries such as caesarean sections become more dangerous, increasing the risk of mortality.

We will work with partners through our Systemwide Antimicrobial Stewardship Network to reduce antimicrobial resistance by reducing the need for unintentional exposure to antimicrobials as well as optimising the use of antimicrobials across all healthcare sectors.



"CPFT and Cambridgeshire constabulary have been working together since December 2021, turning out a police/mental health nurse car on late shifts. The car responds to people in a mental health crisis that the police meet. The aim is to ensure S136 detentions are used only when there is no other option for providing assessment and care for people, and to ensure that those in a mental health crisis are able to quickly access health support. The staff in the car work closely with the ambulance service and several voluntary agencies, to ensure patients are signposted to the most appropriate avenues to get care and support."
Jamie Secker – Service Manager – First Response Service & Integrated Mental Health Team

Emergency preparedness, resilience and response

Health emergency preparedness and response is coordinated through the Local Health Resilience Partnership (LHRP), which is a sub-group of the Cambridgeshire & Peterborough Local Resilience Forum (CPLRF). LHRP is a strategic forum, authorised to commit resources and direct emergency preparedness in our area.

The group is chaired by the Integrated Care Board Chief of Staff and the Director of Public Health, with membership from executive leads in the ICB, East of England Ambulance Service NHS Trust, local authority (adult social care and public health), NHS trusts, UK Health Security Agency (UKHSA) and the Local Resilience Forum.

The LHRP meets quarterly and oversees sector-wide health plans, discusses horizon scanning, risks, and sets priorities for health preparedness in the local area. LHRP is supported by a working group who deliver the strategic priorities set by LHRP in a joint workplan. The group ensures that we maximise opportunities of working in an integrated way to prepare for emergencies for our local people.



"Working with
Community Groups,
and partners to ensure that people have their housing, income and employment arrangement supported, has energised us all, and we are clear the contribution it makes to good physical and mental health.

In the same way that civil engineers rightly point to the fact that they save more lives than surgeons, through providing clean water and sanitation, these social engineers are delivering enduring good health, supporting our health colleagues as they respond to bouts of ill health."
Oliver Morley, Corporate Director (People) Huntingdonshire District Council

Health protection

There is a Cambridgeshire and Peterborough Health Protection Partnership that reviews and ensures that appropriate health protection mechanisms are in place to protect public health as well as identifying gaps and issues that require input and action from multiple partners in the system. This Partnership covers the Health Protection areas of communicable disease, environmental hazards, immunisation, screening and sexual health. There is considerable ongoing partnership working on prevention and effective treatment of tuberculosis, blood borne viruses and other infectious diseases.

8. Integrated Health and Social Care

Integrated health and social care plays a fundamental role in delivering our vision across all of the priorities of our strategy, in particular through:

- Early intervention and prevention – supporting people with targeted information and advice, and low-level and community support and reablement services, to prevent or delay the need for long-term care and support.
- Long-term care and support when needed, which is personalised and keeps people connected to their communities.
- Effective transfers between health and social care services.

Early intervention and prevention services include a range of services designed to improve or maintain people's independence and to support their recovery from illness. This may be using technology enabled care, or reablement and rehabilitation support services with the intention of enabling people to receive care in their home environment.

For people with complex needs who require long-term support and care services, social work teams and health care providers undertake statutory assessment and care management to enable people to have better outcomes by being supported to remain as independent as possible in their communities.

Local Authority Transfer of Care Teams, aligned to three of our hospitals, work collaboratively with NHS partners to ensure safe and timely discharges from hospital with a 'Home First' focus.

All partners work closely with Primary Care Networks, social prescribers and community navigators to link into wider community assets and organisations at a place-based level as part of the developing Care Together model.

Case study

Changing the conversation

"Changing the Conversation", led by adult social care services, focuses on delivering better outcomes by more personalised strengths-based practice. It moves conversations away from services to services that meet the needs of what really matters to a person. Impact logs used by frontline workers record outcomes and development opportunities, while huddles provide a safe, collaborative space for teams to discuss, and problem solve together. Voluntary sector community navigators facilitate connections with a wide range of community resources, from grants and funds to groups, clubs and home maintenance services. Moving the focus from drawing people into services to maximising their independence helps to successfully manage the rising demand for adult social care services whilst evidencing better experiences for people.



"We are the keyworker collaborative - we work collaboratively with local authority partners and healthcare professionals to support children, young people and adults aged up to 25 years old who have ASC or learning disabilities with complex behaviour to stay at home and not require admission to a mental health unit. We have supported 11 young people out of hospital, none of which have needed readmission in the last 6 months."
Abbey Rowley, Keyworker Network Lead, Learning Disability and Autism programme, NHS Cambridgeshire & Peterborough

Key challenges

Eligible people are given funding to arrange their own care (also known as direct payments). However, take up is poor in Cambridgeshire and whilst in Peterborough Direct Payments take up is good, a substantial proportion of Peterborough activity are payments to allow a person to use a home care provider that is not on the list of those which the council contracts with, rather than to purchase more flexible types of care and support. Individual Service Funds are being developed across both councils to expand the range of self-directed support options available to individuals to meet their needs.

Information and advice to support prevention and early intervention is not always accessible when it is needed and this reflects in a poor experience for the person and missed opportunities, particularly for some local people. Work is underway through the Place Partnership Boards and the Adult Social Care Forum to understand the barriers and further improve the offer.

Areas of focus for the future:

- Continue to support frontline staff to embed a strengths-based and personalised approach.
- Maximise the opportunities and take up of technology enabled care.
- Promote innovation from VCSE groups around early intervention and prevention. For example, pump priming pilot projects through the Innovate and Cultivate Fund and working with Community Catalyst to build micro enterprises to try to find innovative personalised alternatives to domiciliary care.
- Develop a place-based approach to planning and delivering home care, providing a more holistic offer and ensuring people are able to remain independent for as long as possible.
- Strengthen our focus on co-production of services alongside involvement with local people and communities.

Multi Agency Safeguarding

In Cambridgeshire and Peterborough there is a strong Multi Agency Safeguarding Hub (MASH) team who act as a single point of triage for all incoming safeguarding referrals. A Practice Governance Board has oversight of practice improvements required and tracks progress.

Integrated working arrangements in mental health

A Section 75 Agreement delegates the responsibility for Mental Health Social Work to the Cambridgeshire and Peterborough NHS Foundation Trust (CPFT). This enables a close working relationship between the council and the trust for health and social care needs to be considered jointly. The Agreement is managed through an annual development plan, with oversight governance arrangements in place to ensure compliance with The Care Act. There is strong engagement with the VCSE sector and joint service commissioning across local authorities and health where appropriate. The Good Life Service is commissioned by local authorities and the NHS and provides a recovery and community inclusion service accommodating needs across the whole mental health pathway.

Key challenges and mitigations:

- Meeting the rise in demand for Approved Mental Health Professional assessments and associated services. Partnership work is taking place to assess this pressure and how it can be addressed.
- Addressing the training needs across homecare providers to support people with mental health needs. The councils are working with the Social Care Academy to provide access to training and career pathways.
- Preventing placement breakdown and out of area residential education placements through close engagement and involvement of Child and Adolescent Mental Health Services (CAMHS).
- Improving the experiences of unpaid carers in relation to hospital discharge.

Areas of focus for the future:

- Development of a specialist Adult Social Care Accommodation Needs Assessment which will look to project immediate, medium and long-term accommodation needs and engage the market in developing innovative solutions to meeting needs both now and in the future.
- Reviewing and improving the supported accommodation offer for people with mental health needs.
- Progressing the Mental Health, Learning Disability and Autism Partnership development with strong partnership working collaboration and involvement with local people and communities.

Integrated working arrangements for people with learning disability and autism

Support to people with a learning disability continues to be delivered through a fully integrated arrangement and pooled budget in Cambridgeshire, and a Section 75 Agreement without a pooled budget in Peterborough. This ensures a joined-up approach to meeting the needs of individuals which is focused on their outcomes.

The Section 75 Agreements which govern this arrangement are currently being reviewed to strengthen the governance and performance management metrics and to update the specification and annual work plan.

More recently work has been undertaken with local partnership boards to develop a vision for people with learning disabilities. This was supported by a wider survey and will be used to develop a clear set of commissioning intentions. **Key areas of focus as part of this:**

- Review of respite services to increase capacity and retender provision in a way which meets best practice.
- Review and transform day opportunities and employment pathways. This is being led through a co-production methodology and will look to draw upon the learning taken from the pandemic.
- Expand the number of providers across local supplier markets for accommodation-based services through the Mental Health and Autism Supported Living and Residential Framework.

Other joint commissioning models

In addition to Learning Disability and Mental Health there are a number of other Section 75 Agreements in place which govern integrated service delivery models across health and social care, including Occupational Therapy and Community Equipment. Whilst development within each area is ongoing as new evidence and best practice emerges, these models have proven successful in reducing duplication, improving experience for local people and communities and service performance.

Carers, advocacy, floating support, Lifeline and Healthwatch contracts are jointly commissioned/ delivered across Cambridge County Council and Peterborough City Council. System partners have a shared commitment to embedding user experience and co-production into all service developments, supported by tools, training and best practice guidance in partnership with the SUN Network.



"It is a privilege to work on adult trans-formational projects that deliver better quality service to adults in Cambridgeshire and Peterborough. I work with brilliant minds from various teams across these councils and health and care partners. We work seamless-ly together to deliver quality projects that improve the daily lives of adult communities within our district with the support of my programme and projects delivery team and of course my amazing manager." **Jeremiah Olunloyo Project Manager, Cambridgeshire County Council.**

Better Care Fund

Investment through the Better Care Fund (BCF) has supported collaborative working on managing flow and pressures in the system. Operational data across health and social care is monitored through shared capacity and escalation tools and there has been significant focus on discharge support. There are some challenges around delivery of the 91-day reablement/rehabilitation target, which is largely due to increasing complexity of need of hospital discharges and the need to bridge domiciliary care where mainstream care is not available. The implementation of a centralised discharge hub will enable more coordinated triage, to ensure the right referrals are going into the right pathways. Further work is underway to develop domiciliary care capacity.

BCF finance and performance indicators are reviewed regularly and overseen by the system-wide Integrated Commissioning Board, which has delegated authority from the Health and Wellbeing Board for local BCF plans. The board has cross-system representation from health and social care leaders.

Key challenges for the sector

A number of significant legislative changes affecting adult social care come into effect from October 2023. Many of these, such as the introduction of a cap on care costs, have significant financial implications for social care budgets, but the reforms bring wider changes including Care Quality Commission (CQC) Assurance, carers' support, new models for housing and care and a focus on digitalisation and technology.

The most critical risk is the pressures around workforce capacity, recruitment and retention across the local Authority and care providers, which will likely be exacerbated by the upcoming care reforms unless there is significant investment and innovation. There are specific recruitment challenges for learning disability staff, presenting a significant risk for delivering outcomes for local learning-disabled people.

Strong system leadership across health and social care implemented jointly commissioned additional services to jointly implement and redeploy resources as part of the response to the demands of the pandemic. The system works to support providers, ensuring we have consistent messaging and a central coordination point for management of system-wide issues. As well as the work on the pandemic, this has included development of a Care Home Cell providing support by Public Health, Infection control and Quality Team providing training and guidance.



"I am a Learning Disability Specialist Nurse in an acute trust. My role is to provide extra support to adults with learning disabilities and their supporters when they are in contact with the hospital. I am a clinical resource for our staff and facilitate the trust's improvement plan to continue to improve services/experiences and outcomes."
Cheryl Exley, Learning Disability Specialist Nurse

Future priorities:

- Strategic understanding of current and future needs for different types of support, working collaboratively across wider system.
- Development of effective delivery models, with engagement and co-production, to be able to meet identified needs now and in the future, including personalised and place-based approaches.
- Ensure value for money by working with partners to explore more joined up commissioning, share intelligence and identify opportunities for more streamlined and efficient service delivery.

Personalised care

Personalised care means people have choice and control over the way their care is planned and delivered, based on 'what matters' to them and their individual strengths and needs. We want to deliver person-centred, personalised care for all our local people that respects personal choice, addresses inequalities and increases independence and wellbeing. By embedding shared decision making at an organisational level, we will deliver a fundamental shift in how all health and care services work alongside the individual, families and communities. We will do this by:

- Engaging people in the integration of health and care services.
- Enabling people to stay independent and have increased control over their own lives.
- Empowering people to build knowledge, skills and confidence and to live well with their health conditions.
- Enabling people to stay well and building community resilience, enabling people to make informed decisions and choices when their health changes.

Personalised care has a positive impact on health inequalities, taking account of different backgrounds and preferences, with people from lower socioeconomic groups able to benefit the most from personalised care. It is also a key enabler to managing demand for urgent and unplanned care services through individuals, families and carers taking a more proactive, preventative approach to managing their health and wellbeing.

Specific objectives are that people:

- Are more involved in decisions about their health and care, with the voice of the individual, or of their representative, at the centre, co-producing plans.
- Who live with long-term conditions feel supported to develop the knowledge, skills and confidence to manage their own health, care and wellbeing as independently as is possible.
- Are aware of their choice and control rights and have the information in accessible formats they need to make informed decisions about their care and how it is delivered.
- Are given options, guidance and support to inform their own care plan and how to access help when they need it.
- Have individual assets, needs and preferences are personalised in a way that matters to them
- Have care that is personalised through decisions based on individual strengths and needs.

Key benefits of personalised care:

Currently, across the 22 Primary Care Networks (PCNs) in our area there are 150 Personalised Care roles, funded through the Additional Role Reimbursement Scheme (ARRS), which support local people to focus time on 'what matters to me' and taking a holistic approach to people's health and wellbeing.

There is a well-established personalised care working group, with over 60 members from health and care sectors, VCSE sector and people with lived experience, and a number of initiatives completed or underway, including:

- Implementation of personalised care support plans for people with severe mental illness and for women receiving maternity services, with a focus on deprived areas and women from Black, Asian and Minority Ethnicity backgrounds.
- JOY app, a piece of digital personalised care software, that enables health and social care professionals to link clients to local services and demonstrate outcomes.
- Waiting list pilots for trauma and orthopaedics (hip and knees) and mental health patients.
- Discharge support budget pilot aimed to support people who are medically fit and do not need to stay in hospital.
- Roadshows, training and awareness raising on personalised care for frontline health and care staff.



"When health and care professionals take a moment to ask people "what matters to you", it changes the conversation. This is what personalised care is about; supporting people to be confident to manage their own health, helping them to address social and environmental issues which are impacting on their wellbeing and sharing decisions about health and care so that people make decisions which are right for them."
Dr Mark Brookes, local GP and personalised care lead

Looking ahead, some of our main challenges are maintaining pace in workforce skills development and in the roll out of personalised models of care in the wider context of capacity and workforce fatigue; securing sustainability for initiatives and link worker roles which have been funded through time limited pilots; raising public awareness and engagement in order to maximise impact.

Areas of focus for the future:

- Continue to engage and develop the skills and capabilities of staff to deliver personalised care and support.
- Embed shared decision-making through training, public awareness, and decision support tools.
- Ensure there is development and access to personalised support care plans, with a focus on disadvantaged groups.
- Promote access to social prescribing across all communities.
- Support a shared understanding of personalised care through integrated neighbourhood working.
- Shared training and MDTs and targeted asset-based community development work.
- Provide targeted support for self-management and meet non-medical needs of people waiting for treatment or in the recovery phase of their illness.
- Embed the use of appropriate outcome measures and meaningful metrics across services to report on the impact of our interventions.
- Promote holistic wellbeing assessments as part of care pathways.
- Support wider uptake of Direct Payments and Individual Service Funds for social care clients.
- Share learning and best practice through peer support and system networks.

Safeguarding

Safeguarding remains a priority for us. Chief Officers from across the system meet as partners at the Cambridgeshire and Peterborough Safeguarding Executive Partnership (where the three statutory partners meet; health, police and local authority). Safeguarding remains a golden thread throughout the ICS – and protecting a person's health, wellbeing and human rights, enabling them to live free from harm, abuse and neglect is integral to all we do.

We will strengthen our commitment to safeguarding by working collectively to increase momentum and by standardising our policies, training and audit process. Reporting for safeguarding has already been standardised with agreed metrics and a dashboard for visibility on where we are doing well and areas where we need further development.

Our partners and stakeholders have told us that health is complex, and this can lead to our voice being dispersed and unheard.

We have therefore created a Head of Safeguarding Meeting across our NHS trusts to enable us to speak with a 'health' voice across the safeguarding partnership with our safeguarding professionals speaking for the Integrated Health Board and not from an organisational perspective.

As a system we have prioritised career pathways into safeguarding roles and have created a Safeguarding Support Officer Apprenticeship in the ICB – the first in the country.

"Navigation of services is really difficult, it is never simple... and no information is shared between the different organisations."

"If you have more than one specialist/condition you can easily get lost in the system as departments play pass-the-patient with you."



9. Our Enablers

Research and innovation

Research helps us to develop better treatments and services and improve diagnosis, prevention, care and quality of life for everyone. We have developed a Research and Innovation Strategy that sets out how we will deliver this for our people and communities.

Examples of how research is supporting delivery of our system priorities:

- Create an environment to give people the opportunity to be as healthy as they can be: Testing of environmental behaviour interventions related to alcohol, food and smoking by the University of Cambridge Behaviour Change by Design.
- Ensure our children are ready to enter education and exit prepared for the next phase of their lives: locally led research on mental health outcomes in children and young people with social workers.
- Promote early intervention and prevention measures to improve mental health and wellbeing: local research on very brief behaviour interventions to improve adherence to anti-hypertension medications.
- Reduce poverty through better employment, skills and housing: generating growth, investment and jobs as a national and international centre of excellence for research and innovation.

Locally we benefit from world leading academic and life science collaborations. We have developed a five-year strategy to further promote research, support a focus on local priorities, encourage greater participation among our local people and communities and accelerate the spread and adoption of research and innovation across all services and geographies in our ICS. We have also undertaken community-based research such as the Healthwatch South Partnership Health Champions community-led research.

Although national policy and investment remain the main drivers, progress is being made through local structures, such as the Clinical Research Network, which has an emphasis on inclusion. The primary care research portfolio addresses important system priorities as prevention and early diagnosis; however, researchers need to secure more funding for this and more funding for public health and social care research.

Areas of focus for the future:

- Stronger ICS links with the Eastern Academic Health Science Network, Cambridge University Health Partners and the Cambridge University Hospitals Biomedical Research Centre, to increase the local benefit of world class research and innovation.
- Greater provider focus on inclusion and involvement in research through collaborative working via the Clinical Research Network.
- Additional National Institute for Health Research (NIHR) funding for priority areas such as prevention, public health, mental health and social care, as set out by the National Institute for Health Research.

"We have already seen the positives of working with the ICS and Integrated Neighbourhood partners. By working together for our communities, 374 seniors have engaged in a variety of health and community engagement programmes from wellbeing walks to lunches and dementia cafes. Through this, we've seen anxiety reduced by an average of 26% after 3 months and lower feelings of loneliness than national and regional averages." **Vicky Neal, Cambridge United Community Trust**

Sustainability

There is a close relationship between the environment and health, with the most vulnerable communities often the ones most affected by the harmful impacts of climate change.

Extreme weather events can cause significant disruption to health services and have direct impacts on human health. Air pollution is the single greatest environmental threat to human health, accounting for 1 in 20 deaths in the UK.

Local authorities and the NHS have acknowledged their responsibility in this agenda and have committed to net-zero targets.

Sustainability will be integral to all our plans, programmes, and everyday practices. As service providers and employers, we have the opportunity, and a responsibility, to ensure that we deliver our strategic aims in a sustainable way.

Taking action is not optional and the scale of the task will challenge us all. However, we believe that by working together, as one integrated system, we are in a unique position to change the way we deliver our services, reduce our carbon footprint and ultimately improve the health and wellbeing of our local people and communities.



Where are we now?

We are taking joint action to respond collaboratively to the recommendations of the Cambridgeshire and Peterborough Independent Commission on Climate Change, through the Climate Working Group, a collaboration across the public, private and VCSE sector organisations, to lead system-wide action on tackling the causes and effects of climate change.

We are building an integrated approach with our local Hospital Trusts, local authorities, the Cambridgeshire & Peterborough Combined Authority (CPCA) and wider partners across Cambridgeshire and Peterborough, linking with existing regional and local groups such as the Local Resilience Forum and the Green GP Network

Our plan

Our approach is built on knowledge, science, and guidance and will be delivered through working in close partnership with health, local authority, care, voluntary sector, research, community, industry, and policymakers.

Through our ICS Green Plan, we are embedding sustainability across our local health and care system. We are developing strong leadership and actions to promote a knowledgeable and empowered workforce; decarbonise estates and facilities; support the adoption of green innovations; promote active and sustainable travel; procure and utilise resources based on circular economy principles; and encourage sustainable health care practices.

Key activities will include supporting more environmentally friendly patient transport, changing the way our buildings are constructed and managed, reducing our waste, investing in research and digital technology, and empowering and motivating our workforce to lead the way in more sustainable healthcare.

Sustainability is a major focus for our work, our staff, and the people and communities we take care of. We need strong leadership across the system to drive the change and help prioritise the actions needed.

The pace and scale of this change represents a huge opportunity for improving clinical outcomes and reducing inequities.



"We have trained 26 colleagues across the system to use Appreciative Enquiry as part of the Care Together programme – an approach which uses deep listening techniques to understand issues. This team from health, council, police, community and voluntary sector has listened to our communities to understand what helps people live happily at home for longer."
Wendy Lansdown, Place Coordinator, Cambridgeshire County Council

Digital and data access

We are focused on managing the long-term health of our local people and providing them with every opportunity to access the services they need to improve their health and wellbeing and to prevent any decline in health or risk factors we can. An integrated and tailored digital offer forms part of many of the solutions we expect to see across our services. Digital services and infrastructure will:

1. Deliver population health management and research tools with joined up data to help us build and adopt processes to allow for full system operational planning, and research capabilities supporting our population health management approach.

2. Co-design our services; build services that work for local communities with differing digital access and literacy together with our local people, to address the problems they have and simplify access to services. Use our buildings across health and social care innovatively to deliver services closer to home. Work collaboratively with our places to ensure that digital services are part of their solutions and drive efficiency.

3. Maximise the time and safety of care; by supporting our people through training, upskilling, decision support tools, multi-location working and easier communication, we will make our ways of working easier, more auditable, and safer so that we can learn and improve as a system.

Where are we now?

Our Shared Care Record Team and project board is in place, with testing underway, clinical safety planning near complete. Funding for infrastructure is confirmed and we have a digital programme management team in place who are working on:

1. Secure data environments.
2. Population Health Management Programme.
3. Addressing health inequalities through digital access and new models of care.
4. Frontline digitisation.
5. Governance arrangements and accountability within the ICS.

Case study

Health Inequalities Challenge Prize

Digital and online services are part of our everyday lives, and the pandemic has highlighted just how important it is to be able to access such services. The Cambridgeshire and Peterborough Health Inequalities Challenge Prize 2022 was created to encourage local innovation and tackle digital exclusion amongst some of our most vulnerable groups. Finalists were awarded a grant of £3,000 to support development of their proposed solution with the winning bid being awarded £10,000 investment for their project.

Sandie Smith, Chief Executive Officer of Healthwatch Cambridgeshire and Peterborough, said:

"It has been fantastic to see local people involved in an array of truly exciting and innovative projects to help improve access to health and care for people who can often find it hard to use online services."



"We are in the process of service development and listening to our service users. It has been great to hear how successful our service is, and how we can work to improve it. We have also had the chance to visit another service in the partnership to share learning and meet professionals in similar teams. I look forward to what is next!"
Dr Sapphire-Violet Rossdale, Principal Psychologist, Forensic Community Team

Our plan

We have a clear roadmap to provide improved data sharing for people accessing health care through patient held portals, direct care, and research and to support the development of a regional 'secure data environment' to improve access to anonymised data for research and development. We will be developing our cyber resilience, ensuring that we have better protection. We will be supporting the improvement of our electronic patient record systems, ensuring that providers are digitised and on a path to improved digital maturity, including social care record digitisation.

We will support regional radiology networks and the development of community diagnostics centres to improve accessibility, ease, cost effectiveness and a place-based vision for care delivery. We will support innovations that improve prevention and reduce health inequalities, including providing access to Wi-Fi and local resources.

Estates

The NHS Long Term Plan 2019 set an ambition for the NHS to 'move to a new service model in which patients get more options, better support, and properly joined up care at the right time in the optimal setting'. As an ICS we recognise that the location and standard of accommodation where we deliver care for our people and communities, not just for NHS services but for all partners, in an integrated way, are critical to the delivery of our vision.

Our services cover a diverse geography which means that our local people have mixed experiences in how they access services. The need to reduce travel for people to access care is a high priority that brings many benefits. Not only does delivery of care closer to home improve accessibility and equality for our communities but it will also play a major part in reducing the carbon footprint for our system whilst freeing up capacity at our most expensive facilities to deal with the most complex care. Particularly when 77% of people told us, via 'Let's Talk', that they currently attend health or care appointments by car.

How our collective estate develops must be led by a clear professional vision. Our ambition must align to the ICS vision and strategic aims and be right for our local people and communities.

The 'Next Steps for Integrating Primary Care: Fuller Stocktake Report' sets out an ambition for a full alignment of clinical and operational workforce within Integrated Neighbourhood footprints. The report finds amongst other things that there must be 'a shared, system-wide approach to estates, with organisations co-locating teams in neighbourhoods and places'.

We have several major hospital developments being planned within our area, which must be delivered as the smartest, most efficient and sustainable buildings possible. To achieve this, we must ensure that as much care as possible is delivered at home/closer to home and that attendance at hospital is a last resort. We must also look at wider care and wellbeing services that can help to support our local communities.

To support this, we are developing an integrated estate infrastructure plan that supports the system strategy and services the changing social economic and local people that we serve.



"I am a health support worker for the Intensive Support Team based in Peterborough. We support people with a learning disability within the community who have gone into crisis. I work alongside the nurses within the team as well as service users, staff, and families to develop a better understanding of why they are struggling."
Ray Everton, Health Support Worker, Intensive Support Team

Case study

Community-based health support at Melbourn Hub

Local people in and around Melbourn can now access a range of health and wellbeing services closer to home thanks to the Melbourn Hub, a partnership between the hard working Melbourn Hub team and Meridian Primary Care Network (PCN).

The first of its kind in South Cambridgeshire, the Hub offers the local community support on a range of issues, including anxiety, help to give up smoking, and the menopause. Social prescribers, health coaches, care-co-ordinators and other members of the Meridian personalised care team provide some services traditionally based at GP surgeries to visitors at the Hub, making it easier for local people to access the care and support they need.

Where are we now?

Looking at local health estate alone, we have **690,000m² of physical space** at a cost of circa **£200m per annum**. That's 9% of our health budget. We are mapping local authority estate as well to maximise the benefits of a fully integrated health and care system.

Our aging and growing people and communities, and the need for more integrated services together with demand on both planned and unplanned acute services are creating pressure on all of our health and wellbeing estate. Much of our estate is below modern standards in terms of suitability and condition, particularly Primary Care estate, which is also unable to accommodate the delivery of local and integrated care.

We have developed Outline Business Cases to seek national funding for Cambridge Children's Hospital, Hinchingbrooke Hospital, Cambridge Cancer Hospital, and Princess of Wales integrated community and primary care facility.

Our plan

We want to ensure that our estate can serve our local people and communities well into the 21st century. It is critical that our buildings are used to maximise productivity and that investment is made appropriately and with caution. We also need to address our existing and future carbon footprint, in line with the NHS Estates Net Zero Carbon Delivery Plan. This might include the following considerations:

- Our most expensive acute estate is utilised for our most complex procedures.
- Routine care takes place in more local and less expensive settings including home were appropriate.
- Review opportunities for extended hours of use of estate.
- Review impact of digital care on requirements for the estate.
- Consolidation of contracts for maintenance and cleaning of the estate.
- Closer collaboration/amalgamation of skilled workforce that oversee the operations and development of the estate.

"I am working on the Cambridgeshire & Peterborough Diabetes Programme, and we have already seen the benefits of partnership working for our communities. Almost 1,000 people a week who currently live with pre-diabetes have been offered the opportunity to attend our local Diabetes Prevention Programme since June 2022."
Dr Jessica Randall-Carrick, GP, ICS Clinical Lead for Diabetes & Obesity



Specifically, we will:

Develop Integrated Neighbourhood Hubs

Co-location of front-line staff from primary, community, social and VCSE sector providers all caring for the same local people around a defined 'neighbourhood geography' including Family Hubs, is embedded within our priorities to support an increase in delivering more care closer to home and a reduction in inequalities. We will develop a blueprint for the health and care infrastructure at Primary Care Network and North and South to support this.

Create safe and comfortable environments for local people and staff

Safety and compliance with quality standards is fundamental to delivering 'world class services'. Given challenging financial pressures capital investment will continue to be difficult, but it must be a core part of the Estate Strategy. Capital will be allocated for spend on the estate where it is most needed to ensure safety and delivery of this strategy.

Matching capacity with demand

We will need to work together at every level to support the planning and delivery of capacity in the right place, that is accessible to local people to reduce inequality for those who may otherwise find it difficult to travel a distance to sites and reduce the capacity burden on our hospitals and other care facilities.

How are we going to get there and who's leading?

We have asked the System Estates Group to jointly develop an Integrated Estate Infrastructure Plan that supports the Healthcare Delivery Strategy and services our changing social and economic landscape, and the people that we serve. To be affordable, the plan will likely be radical and must be capable of being delivered

The plan will be informed by a review of the current system estate capacity and what is required to meet the clinical needs of our communities and to deliver our strategic priorities. It will also be informed by the clinical strategies of our Primary Care Networks, which are currently under development.

The Estate Infrastructure Plan will be available in early 2023 for discussion and approval before the end of the 2022/23 financial year to inform and respond to the Integrated Care Board Joint Forward Plan. This plan will inform the development of a full Estate and Infrastructure Strategy that is required in 2023.

10. Conclusion

This strategy aims to provide a comprehensive explanation of how we will deliver our strategic priorities, based on the evidence we have and feedback from our local people and communities. It provides some examples of how we are doing this already and areas where we are developing.

It is not everything we do as organisations and as a partnership, but it articulates our common ground and shared priorities that we will work on together, with implementation taking place as close to individuals and their communities as possible.

We will ensure that our collective work across the ICS delivers on our four strategic priorities and vision of 'all together for healthier futures' as a partnership.

We will make a measurable difference for our local people through the delivery of this strategy. We will aim to deliver the following:

Priority 1	
	To ensure our children are ready to enter and exit education, prepared for the next phase of their lives we will:
	Increase the number of children who show a good level of development (GLD/school readiness) when they enter education.
	Reduce the number of young people aged 16-17yrs who are not in Education, Employment or Training (NEET).
	Reduce inequalities in both these outcomes

Priority 2	
	To create an environment that gives us the opportunity to be as healthy as we can be we will:
	Achieve a 5% decrease in childhood overweight/obesity by 2030.
	Reduce childhood overweight/obesity to pre-pandemic levels by 2026.
	Reduce adult overweight/obesity levels to pre-COVID-19 times by 2030.
	Every child in school will meet the physical activity recommendations.
	Achieve a 10% increase in the number of adults who undertake 150 minutes of physical activity per week by 2030.
	Reduce inequalities in overweight / obesity

Priority 3	
	To reduce poverty through better employment, skills and housing we will:
	Reduce relative poverty, for example the proportion of children living in relative poverty.
	Deliver improved quality and availability of housing that meets health and wellbeing needs, for example increasing the supply of affordable housing for key workers and the proportion of local people in safe and secure accommodation.
	Achieve improved employment opportunities and outcomes, for example through better jobs and employability skills provision.

Priority 4	
	To promote early intervention and prevention measures to improve mental health and wellbeing we will:
	Increase the proportion of children and young people who score a high mental wellbeing score on the annual school survey.
	Increase the proportion of adults who report a 'good' or 'very good' score for their life being worthwhile in 2030 compared with 2021/22.
	Reduce the proportion of children and young people who need to be referred to mental health services.
	Increase understanding of what people can do, and what choices they can make, to best support their wellbeing and the wellbeing of those they care about.

Improve awareness of where and how people can access help and information to prevent mental health problems escalating. Put simply, this strategy and the work that underpins it demonstrates how every part of our collective system has come together and is collaborating to prevent ill health and improve the overall health and wellbeing of the people and communities of Cambridgeshire and Peterborough.

We will measure the outcomes together, hold each other to account for delivery and continuously collaborate to ensure that our local people and communities can lead happier and healthier lives.

"...those affected by lack of services/support and poverty (in particular) will likely suffer health/mental health issues and the impact of this ripples through communities. As such, more efforts should be made at local levels - schools and GP surgeries are ideal outlets - in providing accurate information, help with form filling and career advice (to name but a few). Let's have a community hub that is a one stop shop for health and wellness in every village or town!"

The Cambridgeshire & Peterborough Health and Wellbeing and Integrated Care Strategy has been developed by Cambridgeshire & Peterborough Integrated Care System (ICS) partners and was first published in December 2022.

Thank you to all of our partners who have worked so hard to create this strategy and for working "All Together for Healthier Futures".

You can find a glossary of commonly used terms here: Jargon buster | CPICS Website

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