Cambridgeshire and Peterborough ICS Joint Forward Plan Draft 09/05/23

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Partner statements

IN DEVELOPMENT

Statement of support from trusts and partnerships:

"We collectively confirm our support for the Cambridgeshire and Peterborough Joint Forward Plan that gives assurance on how we will deliver our duties and core requirements as an Integrated Care Board and System. This is underpinned by detailed delivery plans for each area that collectively support our strategic priorities and NHS commitments. We will work together, alongside our wider partnership which includes voluntary, community and social enterprise and local authority colleagues, to deliver this plan."

Section 1: Introduction

Purpose of this plan

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

Firstly, setting out how we will support the delivery of our system's health and wellbeing and integrated care strategy (HWICS), published in December 2022.

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

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

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

Secondly, describing how we are delivering on our key functions and duties, including the delivery of the Long Term Plan (LTP); quality as everyone's responsibility; and making a meaningful contribution to the achievement of the four core purposes of an ICS. Throughout our plan we demonstrate how we are fulfilling our statutory duties and how our delivery priorities are actively supporting the four aims of the ICS:

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

Thirdly, directing the collective endeavour of the ICB and its delivery partners towards key system priorities.

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

Within this plan we set out specific priorities which we will deliver over the next five years. Additionally, over the same timeframe there will be strategic decisions that we need to make together. We need clarity and focus for the former, which is set out in our delivery plans. For the latter, we need data to inform decision-making; a constant focus on the needs of our population; good governance; and diversity of perspectives to inform ICB decision-making. Collectively, this will increase our capability to identify, develop and recommend innovative solutions for implementation.

We need to be realistic about our focus and intent; we have finite resources and must use these wisely. Cambridgeshire & Peterborough health system has historically experienced severe financial challenges, which built up a cumulative deficit over a sustained period of time. Similar fiscal challenges have been experienced by our public sector partners over the same period. However, in 2022/23 after a tremendous amount of work across the system we were downgraded from System Oversight Framework Level 4 (SOF4) which enabled increased autonomy with a lower level of national and regional scrutiny. At the end of 2022/23 our system was able to report a breakeven position, delivering our financial plan whilst also delivering our operational and strategic aims.

There is still more to do. Our financial plan for 2023/24 therefore shows a continued commitment to deliver within our financial allocation. This will not be achieved in isolation, and particularly considering the ongoing challenges for local authorities and other public sector organisations, which will have a cumulative impact on services. It is for this reason we are committed to making financial decisions alongside, and in conjunction with, the delivery of our system ambitions, and where possible across health and care organisations. In doing so, we can ensure financial sustainability, a focus on delivery and alignment of shared purpose across all system partners.

Our principles and approach

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

Additionally, we have used our locally developed strategic planning principles to inform our plan:

- **Think local**: Development and ownership at a local level, with the right expertise and insight.
- **Keep it simple**: Alignment across the integrated care strategy, joint forward plan, operational plans and local strategies.
- **Do it together**: Collaborative planning and shared accountability through system groups.
- **Prove it**: Delivery focused, with measurable outcomes and milestones.

These directly correlate with the NHS England (NHSE) JFP principles of alignment, subsidiarity and focus on delivery.

Our delivery commitments

As the ICB establishes its new role, it has agreed the following key areas of focus:

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

Tackling longer term challenges: We need to mobilise now to meet the growing health needs of our population in the future. In particular, through preventing cardiovascular disease which is where the

NHS can make the most impact over the next 10 years, and by providing earlier, better care for people with high and complex needs.

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

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

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

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

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

It is critical that the Joint Forward Plan is co-developed and co-owned by the ICB, its partner trusts and delivery partnerships, and as such is informed by and responds to the needs of our communities. In our ongoing Let's Talk campaign to engage our people and communities in this plan, the majority of people agreed with the priorities we have set as a system. However, there is further engagement work to do as a significant proportion were unsure. This underpins the need to continue to develop our coproduction efforts to engage our population in focus areas and how we develop effective solutions to the challenges we face.

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

Section 2: Our Integrated Care System

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

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

We have significant health inequalities. For example, there is a 10-year life expectancy gap between those living in the most deprived areas compared to those living in the least deprived. The difference in life expectancy is driven predominantly by conditions such as cardiovascular disease, respiratory conditions and cancer.

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

The area is home to a range of NHS services. There are three hospital providers: Cambridge University Hospitals NHS Foundation Trust, which is a regional centre for specialist services, comprising Addenbrooke's and the Rosie hospitals; North West Anglia NHS Foundation Trust covering Peterborough City and Hinchingbrooke hospitals; and Royal Papworth Hospital NHS Foundation Trust which is a national heart and lung specialist centre. In addition, there is a community provider (Cambridgeshire Community Services NHS Trust), a community and mental health provider (Cambridgeshire and Peterborough NHS Foundation Trust) and a range of other vital NHS services including 87 GP Practices (who form 21 Primary Care Networks), the East of England Ambulance Service NHS Trust, Hertfordshire Urgent Care (HUC - our NHS 111 provider) and 145 pharmacies. Working in partnership are our expanding neighbourhood teams which comprise a range of staff such as community services, social care and the voluntary sector, as well as medical professionals. We are covered by two upper tier authorities, Cambridgeshire County Council and Peterborough City Council (a unitary authority), and five district councils: Fenland, Huntingdonshire, East Cambridgeshire, Cambridge City and South Cambridgeshire, as well as the Cambridgeshire and Peterborough Combined Authority.

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

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

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

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

North Cambridgeshire & Peterborough Care Partnership

Population 586,049

Partnerships:

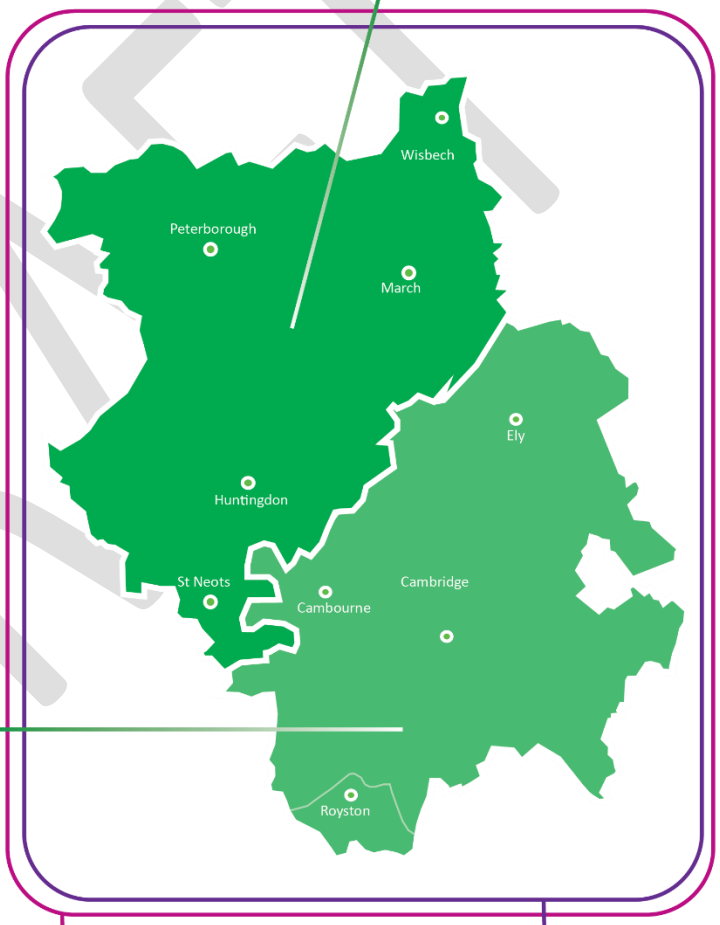
- Healthwatch Cambridgeshire & Peterborough
- Cambridgeshire County Council, Peterborough City Council, Fenland District Council, Huntingdonshire District Council
- Cambridgeshire & Peterborough Combined Authority
- 49 GP practices, 13 Integrated Neighbourhood Teams (INTs): A1 Network, Huntingdon, St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

Cambridgeshire South Care Partnership

Population 445,420

Partnerships:

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



Children's & Maternity Partnership

Population 1,031,469

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

Mental Health, Learning Disabilities & Autism Partnership

Population 1,031,469

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

Section 3: Our population health challenges and outcomes

Population health needs

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

- One of our greatest challenges is the rate at which our population is growing - between 1.5% and 1.8% per year - with significant future housing developments planned. Growth across the system is not even; we are seeing significant population growth in our urban areas which are also some of our most deprived areas. We are also expecting to see considerable growth in our older population which we anticipate will have grown by 128% by 2041. This is important because we know that 87% of those aged 85+ have a chronic condition, with 31% having five or more. We need to make sure our services continue to meet the needs of this growing population with a variety of health needs, some of which are complex. Meeting the needs of this growing and ageing population is key to delivering the NHS Long Term Plan. The risk of long term conditions, incurable cancer, frailty and dementia increase with age, so developing services now will help improve the outcomes for our population.
- We have significant level of need. Our Population and Person Insight Dashboard shows that 27% of patients are living with a chronic condition i.e. long term conditions, disabilities, incurable cancer, organ failure, frailty or dementia. In the North of our system, approximately 30% of the population have chronic conditions compared to 24% in the South. Hypertension affects almost 10% of our population, with asthma, diabetes, depression, cancer, osteoarthritis and coronary heart disease affecting between 3.6% and 6.0% of the population. We also know that these people have comorbidities, for example 27% of our hypertension patients also have coronary heart disease and 29% have diabetes. Services that focus on a single condition aren't meeting the increasingly complex requirements of the population. The environment these populations live in further affects their ability to live with and recover from ill health, exacerbating inequalities.
- There is a wide life expectancy gap across the whole system - approximately 10 years between the most and least deprived areas. Across the ICS, 50-60% of the gap in life expectancy between the most deprived and least deprived areas is due to circulatory conditions, cancer and respiratory conditions. In Peterborough, approximately 40% of the gap in life expectancy in men is due to circulatory conditions, compared to 18.5% in Cambridgeshire. It is important to note that although deprivation is more widespread in the North compared to the South of our system, there are pockets of deprivation throughout, e.g. Cambridge and Huntingdon have lower super output areas (LSOAs) in the top 20% most deprived across our ICS.

Our system's health and wellbeing ambitions and health outcomes

Outcomes framework

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

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

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

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

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

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

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

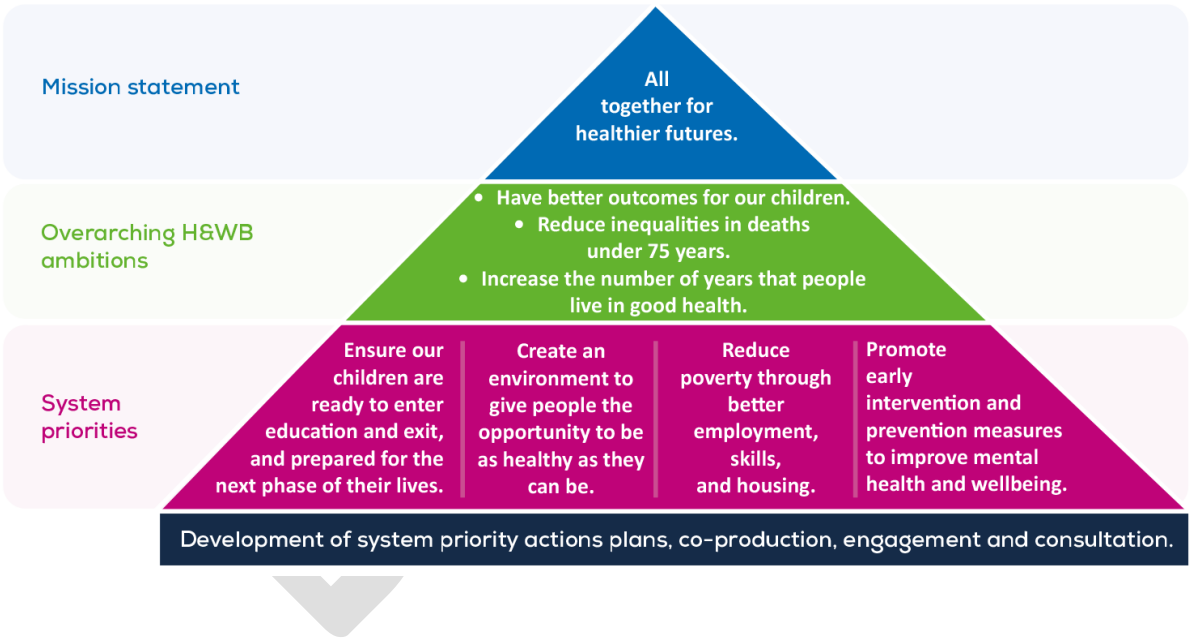
Our joint system health and wellbeing and integrated care strategy sets out a comprehensive explanation of how we will deliver our strategic priorities together as a system, based on evidence we have gathered and feedback from our people and communities.

It describes in our approach how we plan to address our priorities using 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.

Within Cambridgeshire and Peterborough, we are working collaboratively as a system to integrate our services, address inequalities and develop local solutions focused on prevention. This focus is embedded across all areas of health service provision.

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



These ambitions are jointly owned and were agreed across local authorities, NHS and wider partners in our system as they reflect the needs of our people and communities. All partners have committed to delivering on these ambitions and the joint action plans that underpin them. These should be considered a key part of the context for our Joint Forward Plan.

Prevention (including action on smoking; obesity; alcohol; hypertension, diabetes; hyperlipidaemia; NHS health checks) is covered within this Joint Forward Plan, in particular within our cardiovascular disease (CVD) prevention plans and the integrated delivery plans at place level.

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

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

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

ICB aligned delivery areas include: Integrated family approach across perinatal and early years; Emotional wellbeing and mental health; Special needs, disabilities and neurodiversity; Mental health transitions. Further details are provided in the children and young people delivery plans.

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

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

ICB aligned delivery areas include: Identification of risk factors through primary care (this will aim to target obesity in year 1 but may also include smoking and harmful alcohol consumption and onward referral); Empowering people to manage and live well with their health conditions through personalised care and supported self-management; Regular medication reviews, social prescribing and shared decision-making; Identification and treatment of hypertension, high blood sugar & cholesterol; Embedding the prevention offer in secondary care – stop before the op, get fit before the op, hospital cessation support and onward referral to sustain quit. Actions to deliver on environmental sustainability (including waste, travel and energy efficiency) are also critical for preventing ill health.

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

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

The priority 3 area leads have held a housing and health summit to support completion of the action plan focusing on identification of immediate deliverables for 23/24. In addition, the system has a well-developed draft work and health strategy that has involved significant system engagement. The system strategy group (involving public health, district council, upper tier local authority, ICB representatives and wider partners) has identified key areas of focus which will form the system action plan for this strategic priority.

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

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

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

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

Section 5: Reduce inequalities in health outcomes

Our approach

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

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

Addressing health inequalities requires a coordinated, cross-sector approach that, alongside the improved delivery of care, addresses the wider social, economic, and environmental factors that contribute to poor health outcomes.

Our system is committed to addressing health inequalities and improving the health and wellbeing of all residents. Our overarching ambition is to increase the number of years people live in good health and reduce premature mortality. We will support this through a renewed focus on primary and secondary prevention, partnership work to address the root causes of health inequalities and promoting population health management approaches.

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

Our overarching objectives are:

- To reduce the gap in health outcomes between different population groups, including those from disadvantaged backgrounds.
- To promote healthy lifestyles and behaviours and increase access to early intervention services.
- To improve access to healthcare services for vulnerable and marginalised populations
- To improve the quality of care and patient experience across the CPICS.
- To ensure that resources are allocated effectively to address health inequalities, taking a Core20PLUS approach.
- To work closely with research and innovation functions to adopt and implement both clinical and non-clinical best practice to better support our underserved communities.
- To work with local people and communities to better understand the challenges they experience and coproduce solutions that best meet their needs.

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

Core 20PLUS5 approaches

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

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

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

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

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

For adults, the five areas of clinical focus include:

- Maternity – To ensure continuity of care for 75% of women from ethnically diverse communities and the most deprived groups. We will continue to develop our partnerships and integration with community partners to triangulate and address the inequalities that exist, through delivery of the ICS's equity and equality plan (link: https://www.cpics.org.uk/download.cfm?doc=docm93jijm4n1835.pdf&ver=3684). This is covered in more detail in the Children and Maternity section and in the Maternity and Neonatal Services delivery plan.
- Severe Mental Illness (SMI) – To ensure annual health checks for those living with SMI (bringing in line with the successes seen in Learning Disabilities). Over the next two years, we will expand the specialist SMI Annual Health Check (APHC) programme via our GP Federations to increase the number of health checks completed, with the ambition of achieving 80% completion year on year by March 2028. Additionally, by March 2025, we will enhance our community stop smoking service provision amongst SMI patients, in collaboration with wider CPICS partners, as an extension to the NHS Long Term Plan Treating Tobacco Dependency Programme (TTDP).
- Early Cancer Diagnosis – To diagnose 75% of cancers at stage 1 or 2 by 2028. To meet this ambition, over the next five years, we will continue to focus on those more deprived communities through targeted Lung Health Checks in Peterborough and Fenland; establish Community Diagnostic Centres (CDCs) to provide diagnostic services closer to patients who need it most (this is covered in more detail in the Community Diagnostic Centres Delivery plan);

develop faster diagnostic pathways for population cohorts who are most disadvantaged (for example previous work has focussed on the Gypsy, Roma and Traveller populations and non-English speaking population groups in Fenland); and build upon the lessons learned from the cancer screening projects, which were designed to increase screening uptake in more deprived areas of higher deprivation by allocating resources on an deprivation-weighted basis.

- Chronic Respiratory Disease – To focus on Chronic Obstructive Pulmonary Disease (COPD) driving uptake of Covid, Flu and Pneumonia vaccines. Over the next five years we will continue to promote recommended vaccinations for eligible respiratory patients. Building on the Covid vaccination outreach programme, we will continue to monitor vaccination uptake by deprivation, ethnicity and other protected characteristics and respond to such variations by ensuring future delivery approaches are co-designed with those populations and communities to maximise uptake.
- Hypertension case finding and optimal lipid management – To allow for interventions to optimise blood pressure and lipid management to minimise the risk of myocardial infarction and stroke. This work forms part of the wider cardiovascular disease strategy (see cardiovascular disease delivery plan for more information). We will continue to develop programmes of work that specifically target our Core20PLUS population groups, such as the establishment of a new Lipid Management pathway in 2023/24 through the Innovation for Healthcare Inequalities Programme (InHIP) funding. An evaluation of this programme will be carried out and will be used to expand the investment and pathway across Cambridgeshire and Peterborough in 2024/25 and beyond.

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

- Asthma – To address the over-reliance on reliever medications and decrease the number of asthma attacks. We will achieve this ambition by 2028 through the increased partnership working and targeted interventions such as the AsthmaApp pilot, commenced in 2022/23 which supported self-care in our most deprived adult populations. We plan to extend this pilot in 2023/24 to broader population groups, taking a Core20PLUS approach.
- Diabetes – To increase access to real-time continuous glucose monitors and insulin pumps across the most deprived quintiles and from ethnic minority backgrounds; and increase the proportion of those with Type 2 diabetes receiving recommended NICE care processes.
- Epilepsy – To increase access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism, as set out in our delivery plan for children and young people. In 2023/24, we will pilot an innovative model of care where epilepsy nursing is delivered across primary care networks, through our children's community provider (Cambridgeshire Community Services) and in special schools. By 2028, we envisage this model being adopted more widely to ensure children and young people living in our most deprived areas receive access to epilepsy specialist nursing.
- Mental health – To improve access rates to children and young people's mental health services for certain ethnic groups, age, gender and deprivation, as set out in our 2022-25 children and young people's mental health strategy. This is covered in more detail in the Babies, Children and Young People delivery plan.
- Oral care – To reduce tooth extractions due to decay for children admitted as inpatients in hospital, aged 10 years and under. Our analysis from 2022 has shown that Peterborough has the highest prevalence of dental decay in 5-year-olds, while East Cambridgeshire had the lowest, although there is an increase in prevalence over the last three-years. In terms of the tooth

extraction index in 5-year-olds in lower tier local authorities in 2022, Huntingdonshire had the largest extraction index at 2.6%, followed by Cambridge City and then Peterborough.

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

Priority 1: Restoring services inclusively:

- We will continue to monitor and evaluate waiting list data by ethnicity and deprivation to help identify and address differences between groups.
- We will develop and implement innovative initiatives that improve access to healthcare services for vulnerable and marginalised populations, including developing targeted interventions for disadvantaged and inclusion health groups such as the homeless, asylum seekers, and people with disabilities.
- We will continue to develop our data sources to help identify health inequalities within elective care and work with our communities to co-produce different ways to deliver services.
- We will continue to develop our "waiting well" initiatives and to work with our population to develop wraparound services.
- We will improve diagnostic wait times across the system, ensuring equitable and timely access for all.
- We will redesign pathways for key specialities (ENT, dermatology, urology, endocrinology, MSK, ophthalmology and cardiology) ensuring each is impact assessed from a health inequalities perspective.

Priority 2: Mitigate against digital exclusion:

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

Priority 3: Ensuring data sets are complete and timely

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

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

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

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

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

In addition to preventative lifestyle programmes, the ICB will also establish High Intensity Use (HIU) services in 2023/24 (see the HIU delivery plan for more information). The effective identification and management of those who utilise NHS services more frequently is vital in terms of reducing demand and increasing capacity across the system, while ensuring individuals receive the wider care and support they require.

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

Priority 5: Strengthening leadership and accountability

- We will continue to ensure the ICB, and its partners, have named Senior Responsible Owners who will be responsible for tackling health inequalities.
- We will, as part of the Strategic Commissioning Unit (see below for further information), ensure all ICB programmes of work have a focus on tackling health inequalities and the appropriate impact assessments have been carried out as
- We will evolve the existing Health Inequalities Board to incorporate or align wider strategic priorities such as implementation of Population Health Management strategy.

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

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

- A reduction in health inequalities between different population groups, as measured by a range of indicators for life expectancy, healthy life expectancy, infant mortality and disease prevalence. Residents from disadvantaged backgrounds will experience better health outcomes and quality of life.
- Vulnerable and marginalised populations will experience improved access to healthcare services, such as treatments, diagnostics, primary care, and community services, as measured by reductions in waiting times, improvements in patient satisfaction, and reductions in missed appointments, leading to better health outcomes and quality of life.

- Improvements in the quality of care and patient experience, as measured by a range of indicators including patient feedback, patient outcomes, and compliance with national quality standards.
- Effective allocation of resources, as measured by the development of an outcomes delivery framework and the use of appropriate measures and evaluation criteria, contributing to better outcomes, reduction in health inequalities and improved financial sustainability for the CPICS over the longer term.

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

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

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

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

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

Population health management

Population Health Management (PHM) is an important methodology to support our goals on prevention of ill-health, tackling health inequalities, improved outcomes, and quality of care. PHM is an approach that enables local areas to deliver the most appropriate services for local people. It uses linked datasets from health, care, and other services to plan and deliver proactive and preventative care. Using a PHM approach drives a change in culture towards more integration, more prevention, and more provision, based on need rather than service use.

Our vision is that all organisations within the ICS will have the skills, resource, and information they need to use PHM approaches, with all partners using the same database to align priorities and operationalise PHM. Most operational PHM will happen at Place and Integrated Neighbourhood level, but we will also use a PHM approach at system-level to allocate resource, manage risk and identify system priorities. As part of our commitment to sharing intelligence across organisations, we know that PHM data can be further enhanced by qualitative information incorporating voluntary

sector and public feedback. This ensures it reflects community insight and knowledge, bringing rich qualitative feedback alongside quantitative data.

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

- Across Cambridgeshire and Peterborough, we have rolled out the Eclipse tool (provided by Prescribing Services Ltd). Eclipse combines Primary and Secondary Care data to segment the population into Population Health Management pathways which align with either Long Term Conditions e.g., Diabetes, COPD or with High-Risk Users such as those with multi-morbidities or high usage of services.
- The system allows GP practices to understand variation in their patient groups. An example of this is diabetes where current achievement of the Care and Treatment targets can be compared to other practices across PCNs, the ICS and nationally.
- This system has been used to improve the care for patients with diabetes by identifying their unmet needs.

We will be developing our PHM capability further to understand current and future demand for different patient cohorts and to help prevent ill health. We will do this by:

- Building on the work of the C&P Analytics Community to develop an ICS intelligence function which also supports wider system aims.
- Providing the tools for our intelligence function & system partners to understand the needs of the population via segmentation and stratification techniques.
- Using this data to understand the drivers of variation in our populations.
- Continuously researching wider data sources that could be added to the data set to allow more nuanced intelligence insights and multi-agency approaches to health and care problem sets.
- Creating the capability to derive short, medium- and long-term intelligence forecasting through advanced actuarial and risk stratification analysis.

How we will develop our infrastructure:

- We will create a linked dataset spanning social care, secondary care, primary care, community and MH. This will build on the data warehouse currently commissioned by the ICB from North of England CSU.
- We will add additional data sources (e.g., wider local authority, Police, Fire, VCSE) to the capability iteratively as and when technical capability, information governance and organisational alignment activities allow.
- We will procure and generate the tools to carry out the analysis we need to understand our population e.g., R, PowerBi, Python.
- As the capability increases, we will use it to redesign services and evaluate their impact iteratively. We will ensure our clinical community develop the skills to harness and understand these rich data sources so they can maximise its use in the clinically led redesign of care pathways.

The PHM methodology isn't just about data and tools, it's a way of working that puts the patients desired outcomes at the fore, then looks at what they need rather than just what services we think they need. It's about preventing ill health or preventing deterioration by working together to reduce unwarranted variations in outcomes. This means analysts from all ICS partners working with clinicians, the voluntary sector, Local Authorities, District Councils, Police, Fire and countless other

organisations to understand our population better, by looking at them as whole person, not just a health condition. This will be via the developing ICS Intelligence Function but also by aligning analytical support to our North and South place.

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

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

Cardiovascular Disease (CVD)

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

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

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

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

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

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

To support the above outcomes, new pathways are being developed with an integrated team based out of a Peterborough hub to start to address the whole heart failure pathway. This approach will then be adapted and modelled in Cambridgeshire. As part of this work there will be a focus on diagnostics (especially echocardiograms) being able to be delivered more locally and having sufficient and alternative workforce to support. The Population Health Management section earlier in this narrative supports the outcomes set out above.

Key risk factors and areas of focus for CVD prevention:

Obesity

The prevalence of obesity in Cambridgeshire and Peterborough is influenced by various factors, including lifestyle choices, access to healthy food options, the availability of fast-food outlets and access to safe green spaces and active travel options. The percentage of adults (aged 18+) classified as obese in Peterborough (22.5%), East Cambridgeshire (23.4%) and Fenland (31.7%) is higher compared to other areas of Cambridgeshire and Peterborough, with Fenland higher than the national average (25.3%). Source: OHID Fingertips

Tackling obesity is a key shared priority as part of our health and wellbeing and integrated care strategy. We aim to reduce childhood obesity to pre-pandemic levels by March 2026. We will work proactively with the local authority, public health and other partners on the delivery plan. We will increase the identification of obesity in patients through increased opportunistic engagements and increase referrals from areas of high deprivation and obesity prevalence through targeted promotion of weight management, complementing other prevention work. We also need to consider, with our Local Authority colleagues, planning decisions and the implications these have on population obesity.

Diabetes

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

Smoking cessation

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

- By March 2024, we will have fully implemented the NHS Long Term Plan Treating Tobacco Dependency Programme (TTDP) across all maternity and mental health inpatient services.
- By March 2025, we will have piloted and commenced a new community mental health tobacco cessation pathway aligning this to the annual health checks for those with Severe Mental Illness (SMI).
- By March 2026, we will have fully implemented the TTDP across all acute inpatient services.
- We will introduce new technologies (e.g., digital applications and disposable carbon monoxide monitors) to support quit attempts as well as widen the incentives on offer to support pregnant women and mental health inpatients.
- We will focus on increasing uptake of stop smoking services in our Core20PLUS population through our integrated care partnerships and in collaboration with integrated neighbourhood teams.

Alcohol treatment

In 2023/24, we will evaluate the effectiveness of the opimised Alcohol Care Team (ACT) at CUH, which has been established to provide a 7-day-a-week service. We aim to establish other ACTs across the system by 2028 to support implementation of the wider Cambridgeshire and Peterborough Drug and Alcohol Strategy. We will also increase the integration of alcohol care services between primary, secondary and community services. We will continue to support the work of the local Combatting Drugs Partnership (CDP) and delivery of Cambridgeshire and Peterborough's Drug and Alcohol strategy, including the prevention and risk reduction of alcohol harm at a primary care level, as well as increased screening in secondary care, building upon the ACT optimisation programme within other acute sites.

Children and young people

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

To tackle inequalities and improve health outcomes for babies, children, young people and families we will:

- Co-produce quality improvements of services with a commitment to always listen, discuss and act on the voices of children, young people and their families, ensuring all communities feel able to contribute.
- Through the development of the Maternity Strategy in 2023, introduce a single framework response to the quality and safety improvements required as a result of findings from the Ockenden and Kirkup reports.
- Promote the Healthy Start Scheme and Best Start for Life to support a healthy pregnancy for all and tackle health inequalities through early identification and support of vulnerable parents.
- Ensure local service providers including midwifery, health visiting, and community partners have an aligned approach to supporting new families with their mental health during the perinatal period and to develop good parent/infant relationships.
- Introduce new roles and digital solutions through the Family Hubs programme to improve perinatal and infant-parent mental health, promoting good attachment and bonding, infant feeding support and early childhood development.
- Use place-based approaches to coproduce solutions which match the individual needs of young people, their families and the communities they live in, joining up services through Integrated Neighbourhoods and outcome-based joint commissioning.
- Implement the 2022-25 priorities of the Cambridgeshire & Peterborough children and young people's mental health strategy; improve access and equity to emotional wellbeing and mental health help and treatment for 0–25-year-olds, target children and young people who are known to the Justice System and improve the safety and experience of young people moving from children's to adult mental health services.
- Improve mental health, emotional wellbeing and resilience among the school-aged population.
- Increase immunisation rates at entry into school and exit from school.

- Ensure that everyone who works with children and young people who have special educational needs and disabilities (SEND) embodies the vision and culture of our C&P SEND strategy, recognising that SEND is everyone's business.
- Identify and respond to neurodiverse and special educational needs early and deliver care in the right place at the right time, through best use of jointly commissioned resources. Ensure a graduated, integrated and high-quality SEND Local Offer to support children to flourish and achieve their potential.
- Deliver consistent, evidence based integrated neurodevelopmental care pathways to simplify autism diagnostic processes and provide better post diagnostic support to reduce long term poor health outcomes, including mental health.
- Reduce the health inequalities of people with learning disabilities (LD) and autism through improved uptake of Annual Health Checks, train and upskill the workforce to support the specific needs of people with LD&A, increase the use of digital solutions to monitor health; and implement CPICB LeDeR (Learning from Lives and Deaths) review action plans to embed sustained and targeted service improvements across the ICS.
- Promote the Homes Not Hospitals programme, expanding the Dynamic Support Register through the Keyworker Collaborative, and ensuring every learning disabled or autistic child or young person on the Dynamic Support Register is offered the support of a keyworker.
- Ensure that every child attending a special school is given the option to access their routine health review appointments at their school rather than in a hospital when this is clinically appropriate.
- Prepare for the Cambridge Children's Hospital by transitioning more care to being delivered in community settings, ensuring that children, young people and families only need to attend hospital to access the types of intervention that can only be delivered in a hospital setting.
- Increase the advice, guidance and direct support available to parents, carers and the child or young person's naturally connected support network in order to improve outcomes.
- Increase apprenticeships through Anchor institutions (Councils, Combined Authority, NHS, commissioned services).
- Improve access to Children's Epilepsy Specialist Nurses to decrease emergency epilepsy admissions to hospital, improve mental health and provide better continuity of care between settings for children with Learning Disabilities and Autism who have epilepsy.
- Improve outcomes for childhood asthma through community respiratory services, training and support to primary care and families and medicines optimisation. Ensure damp free accommodation for children with a respiratory condition.
- Ensure improved monitoring and treatment of diabetes, in line with NICE recommended care processes, leading to better outcomes and reduced complications from excess weight.
- Ensure holistic individualised plans and support for CYP with obesity.
- Improve oral health and reduce tooth extractions in young children, focussing on deprived areas where rates of tooth decay are highest.
- Ensure children and young people requiring support with high risk or complex behaviours and relationships will have more choice about different approaches to getting help.

Children and Young People Engagement

We will work in partnership with young people with lived experience as well as their parents, carers and support networks, to ensure that improvements are led by communities and their needs. We will build on existing partnerships, such as the Parent Carer Forum and the networks built through the co-production of the Children and Young People Mental Health (CYPMH) and SEND strategies

and will develop a system-wide approach to co-production and engagement, in which power and decision-making are shared. We will continue to ensure strategies and service developments are co-produced.

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

Children and Young People Safeguarding

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

Children facing additional adversity, vulnerability or risk

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

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

Preparation for adulthood

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

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

Mental Health and Learning Disabilities

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

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

The Mental Health, Learning Disabilities and Autism (MHLDA) Partnership has been set up to drive the development and the delivery of improved care and outcomes for the Cambridgeshire and Peterborough population who receive mental health, learning disability and autism services. The vision of the MHLDA partnership is to embed collective responsibility for mental health, learning disabilities and autism across our ICS, and together with system partners and people with lived experience, improve the lives of the local population by driving the transformation of health and care services.

The MHLDA Partnership will play a key role in supporting delivery of the MH and Wellbeing priority of our joint health and wellbeing and integrated care strategy. Its four key aims are:

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

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

[1] "Health matters: reducing health inequalities in mental illness" Public Health England, December 2018 https://www.gov.uk/government/publications/health-matters-reducing-health-inequalities-in-mental-illness/health-matters-reducing-health-inequalities-in-mental-illness

[2] NHS Long Term Plan, 2019

Work is in progress, led by Public Health, to develop an all-age mental health and learning disabilities health needs assessment, which will help inform the partnership priorities. Panels of experts have been established as part of this process to inform each chapter of the needs assessment, including people with lived experience.

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

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

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

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

- Ensuring waiting times and recovery rates for Talking Therapies continue to meet national expectations, as well as focussing on removing barriers to access for local populations such as older people who would benefit from the support offered by Talking Therapies.
- Continuing to invest in employment services and take opportunities to work with system partners to expand and integrate evidence-based approaches for both mental health and learning disability cohorts.
- Increasing capacity of services which provide digital access to proactively support hard to reach target communities using evidence from the MH Needs Assessment.
- Continuing to work with Local Authority partners to develop alternative places of safety to increase community resilience and access to crisis support.
- Continuing to respond to local needs such as developing relationships with local Universities to model student mental health services to improve access and early intervention for this cohort.
- Ensuring Learning Disability Mortality Reviews are a continued focus for the system and learning is implemented to reduce mortality rates for people with a learning disability and autism.

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

- Building integrated community mental health via a stepped care model, which will increase access to mental health services by 5%, improve treatment options and seek to address the wider determinants of health. This includes roll out of successful interventions from the Exemplar Pilot in Peterborough and delivering a community rehab model with access to new treatment options.
- Collaborating with voluntary organisations that support people with mental health, learning disabilities and autism, to strengthen their engagement and involvement in the MHLDA Partnership and system structures and to shape mental health support for our communities.
- Delivering targeted mental health programmes for rough sleepers to improve access to treatment and ongoing support.
- Lead the implementation of specific areas of the 2022-25 priorities of the Cambridgeshire & Peterborough children and young people's mental health strategy, including improving transition pathways between Children and Young People's and Adult MH services and ensuring access to services for 18-24 year-olds is developmentally appropriate. A transitions working group has been established and further engagement activity will take place in Years 1-2 of this plan to identify and support implementation of improvements.
- Maintaining a focus on reducing out of area placements to ensure people are receiving treatment as close to home as possible, improving discharge pathways and quality through the MHLDA Quality Transformation Programme, and reducing reliance on inpatient settings both for people with mental health needs and people with a learning disability or autism.
- Improving pathways for older people and with focus on ensuring the dementia diagnosis rate is increased to at least 67% of the estimated prevalence of dementia based on GP registered populations, ensuring individuals and families receive early treatment and support.
- Ensuring system effectiveness in the delivery of responsibilities under the Mental Health Act, through a joined-up system response with effective use of resources.
- Prioritising and enacting the recommendations from the All Age Autism Strategy to transform adult autism services and improve access and treatment options.
- Reduce health inequalities for people with a Learning Disability through improved quality and delivery of health interventions such as vaccination programmes, and completion of annual physical health checks.

Place partnerships

The North Cambridgeshire and Peterborough Partnership and the South Cambridgeshire Partnership have brought together health and care organisations at a local level to plan and deliver more joined up care to improve outcomes for their populations.

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

- Building community-based infrastructure to enable support and care to be provided at home or in a neighbourhood setting, e.g. through integrated neighbourhoods teams and a care co-ordination hub.
- Embedding an integrated proactive and personalised approach to reduce inequalities and increase years people enjoy good health.
- Enabling "home first" through optimising and integrating community/intermediate care, improved discharge co-ordination and optimising community-based pathways.
- Identifying and supporting at risk groups through population health analysis and targeted interventions.

- Optimising and improving equity of prevention services such as health checks and screening, through partnership working, utilising the full Primary care team including local GP's, community pharmacists, dentists/dental care professionals and optometrists. These professionals and their teams working in the heart of our communities can be resourced to work outside their traditional roles to maximise provision of preventative services within neighbourhoods, be that screening, lifestyle modification, medicine optimisation or disease monitoring services.
- Working together to developing person-centred care models, underpinned by local insights, co-production, data, and best practice evidence.

Section 6: Creating a System of Opportunity

Equality, Diversity and Inclusion

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

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

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

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

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

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

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

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

- Targeted interventions to address the needs of BAME staff which include:
    - Establishing a consistent approach to dealing with violence and aggression targeted toward BAME staff.
    - Embedding the “no more tick boxes” approach to recruitment, retention and progression within Cambridgeshire and Peterborough ICS organisations.
    - Supporting the training of managers to ensure a wide range of knowledge across senior leaders in our organisations.

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

Anchor System

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

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

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

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

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

Aligned to our strategic priority around addressing poverty, we will finalise our work and health strategy and support integrated pathways across our system which support more people with a long-term condition or disability to stay in and enter work.

We will build on our innovation fund approach. In 2023/24 the ICB will fund further innovation initiatives; we will build on the success of the Health Inequalities Challenge Prize by repeating the programme; provide another District Council innovation fund to target prevention initiatives through integrated approaches; and introduce a substantial VCSE Healthier Futures fund. This work will help to support infrastructure and projects within our VCSE sector through a grant-based approach which generates innovative and locally developed and owned approaches to prevention.

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

Triple aim

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

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

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

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

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

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

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

- Embed the impact assessment process across the lifecycle of ICS decision-making.

- Tackle the wider determinants of health by collaborating with ICS partners to measure and assess the health impacts of actions taken outside the NHS.
- Remove existing service inefficiencies and inequities by empowering staff.

Armed Forces

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

GP practices have the option to voluntarily sign up to become an Armed Forces Veteran friendly accredited GP practice.

Our hospital trusts have all signed up to the Armed Forces covenant which has two principles:

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

Our Local Authority have an identified lead to support veterans and is linked with the work within the ICB and trusts.

Key objectives and delivery focus for our system:

- Encourage and support GP practices to become veteran friendly based on those with the highest levels of veterans for our ICS.
- Implement a Veteran's Passport coproduced with veterans to be used to prevent veterans having to repeat their stories (thereby causing additional trauma) and to improve understanding of their needs.
- Utilise Healthwatch and Veteran organisations to enable the ICB and wider system to listen directly to the veteran voice, understand their requirements and work together to develop a better of understanding of any change requirements.
- Review and further develop the ICS website and system partners websites to include a greater accessibility and visibility of linkages to services that would support the veteran community, their families and dependants.
- Develop awareness of the impact PTSD in veterans can have on sleep to support identifying if they have sleep apnoea and treatment of this to improve health outcomes.

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

Personalised care

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

We will work alongside system partners to deliver person centred, personalised care for all our population in Cambridgeshire and Peterborough that respects personal choice, addresses inequalities and increases independence and wellbeing.

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

We will measure our impact through four measures:

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

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

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

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

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

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

In our Let's Talk feedback from our people and communities where we sought feedback on this plan just over half of respondents, 53%, would take up an offer of social prescribing instead of medication to help with a medical condition.

Supported Self-Management: We are actively supporting people who are on waiting lists with supported self-management through our local plan with links from My Planned Care to supported self-management tools. The public will also have access to the JOY app to self-refer into local support services. Health coach training is being delivered and embedded across community services. Patients can access health coaching services via primary and community care and can be supported to learn the benefits of setting goals and using outcome measures.

Personal health budgets (PHBs): PHBs are offered to people who have a legal right to have one. (https://www.england.nhs.uk/personalisedcare/personal-health-budgets/)

Coproduction and peer leadership: Training is available to everyone, and it is our aim to have people with lived experience support board level delivery and decision-making across the ICS. Leaders will have the knowledge and tools required to embed personalised care at system, place and neighbourhood levels. By 2028 we aim to have all services coproduced, with continued expansion of personalised care roles via all pathways.

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

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

We take our duties to actively promote and engage with our patients on the personalised care agenda seriously. We will achieve this in the following way:

Year 1 - 2023/2024

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

Year 3 - 2025/2026

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

Year 5 2027/2028

- Personalised Care Support Plans in place for people with long term conditions

Patient choice

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

Engagement with people and communities

We have a shared vision of 'working together to improve the health and care of our local people throughout their lives'.

We want to coproduce decisions about what services and support is needed locally with local people and communities, because life experiences and patient views can help us to make better choices.

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

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

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

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

Underpinning this approach is our commitment to transparency and involvement. Our ICB meetings are held in public, with papers available online a week beforehand and the opportunity for people to ask questions at each meeting either in person or in writing. We also ensure when we are developing strategies, such as this Joint Forward Plan, we build in opportunities for local people and communities to share their views before we write the plan and then again on the draft version.

Our work with Healthwatch is ongoing throughout the year, and we have co-funded community researcher roles to ensure we have a continuous dialogue with our local communities about what matters to most to them when it comes to health and care services.

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

As an example of these commitments in action, in October 2022 we launched our first large engagement campaign, 'Let's Talk', to ask local people and communities to share their views and

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

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

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

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

Initial feedback from our targeted Joint Forward Plan engagement work provided 225 responses to a detailed questionnaire that delved deeper into key elements of this plan. The majority of respondents agreed with our priority areas of focus but a significant proportion were still unsure indicating there is more work to do in engaging our people and communities in our plans including coproducing the solutions.

When asked what priorities from the Joint Forward Plan should be the top three, 57% felt timely access to care and advice in the community through GP and other primary care services, such as pharmacists, was the most important. 48% prioritised reduced waiting times for appointments. Ensuring that from birth right through to the end of life, people receive high quality care that is fair and reduces health inequalities was the third highest priority (40%).

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

Looking ahead, we are in the planning stages to launch our Community Representative Group and are assessing options for an online platform to enable regular ongoing conversations with a broad cross section of local people and communities to continually shape, test and (when needed) course correct our plans.

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

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

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

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

Deliver improvements in service access, experience and outcomes

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

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

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

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

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

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

Learning and continuous improvements in quality – CQI approach

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

The strategy outlines the ICB's responsibility to support all our partners across care and health to adopt a qualit improvement (QI)/continuous improvement (CI) culture that is lived and owned from the Board and our most senior leaders to those delivering care or support services to individuals. The

strategy does not mandate a specific tool/methodology to be used but focuses on the elements of a good QI culture. The aim is to support and empower our teams to deliver improvements to achieve high quality care, share and celebrate learning.

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

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

Measures of success

Success factors for the System and our Partners organisations will include:

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

Six elements of our CQI strategy

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

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

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

Measuring our outcomes in CQI

Our success will be measured by all the improvements we make. We will ensure we can collate the benefits from everyone who undertakes an improvement activity, include it in our CQI Knowledge Hub and monitor all the improvements we have made. This will also provide a wealth of learning to be shared.

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

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

- We will ensure that we can demonstrate our evidence of maturity against these criteria.
- We will be able to demonstrate improving maturity through our CQI Ambassadors and delivery of our programmes and monitoring of benefits, but more importantly, the biggest test of maturity will be through our staff and patient feedback.
- We will be able to demonstrate that we are a system participating in the NHS QSIR College programme, (though not exclusively) which uses an organisational / system approach to building improvement capacity and capability.
- We will present our delivery plans and evidence of delivery to the Improvement and Reform Committee.
- We will align the work of this strategy with the other relevant ICB strategies.

Research

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

ICB research and innovation strategy

Our five-year ICB research and innovation strategy (2022-27) sets out our plans for making the most of opportunities to improve care, services, experiences and outcomes for our population, including reducing health inequalities. This will be achieved by working more closely with our research and innovation partners and local communities, supporting wider efforts to build a thriving innovation ecosystem, and making the most of excellence, evidence and innovations for our population. The overarching aims are to:

- Expand research and innovation activity and opportunities.
- Focus on local priority areas and population needs.
- Make participation more inclusive and accessible to local people, especially from communities experiencing the worst outcomes.

- Grow support and participation across all professional groups, specialties and care settings.
- Improve clinical adoption of the most important research evidence and proven innovations.

These aims will be accompanied by annual action plans and progress reviews, including evidence of progress against every strategic target.

Facilitating and promoting research

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

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

Increasing diversity in research and tackling health inequalities

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

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

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

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

Measures of success

The measures of success for these plans will include:

- Evidence of increased research activity across Cambridgeshire & Peterborough ICS (CPICS), including the number of research active sites, hosted NIHR grants and sponsored research studies.
- Alignment of research activity with CPICS strategic priorities, including health inequalities.
- Evidence of increased engagement with local patients and communities in regard to research.

- Improvements in outreach to and awareness of research opportunities for professionals across different roles, specialties and locations.

Innovation Adoption Plan

We will work with local partners and build on successes from the Adopting Innovation Hub over the five year period of this plan, ensuring that service users and staff are involved in the selection, design and implementation of innovation that best addresses local needs and inequalities.

The Hub has established networks, including the Citizen Participation Group and Adopters' Network, that will support the ICB to collaborate with user groups. We are holding an Innovation Showcase to identify local innovation success stories and promote conversations around system-wide spread; if successful, we will aim to embed this approach more widely. We are developing a digital platform to support the prioritisation of available innovations. We will work with the Adopting Innovation Hub, Academic Health Science Network (AHSN), public health teams and other allied organisations to develop this database, which will support the strategic prioritisation of innovations to target local needs and specific funding opportunities.

Innovation development:

In addition, Cambridge University Health Partners are working with provider organisations and primary care to develop Innovation Landing Zones, which are a coordinated front for innovators, investors, and providers to facilitate the uptake of early innovations in our system.

Landing Zones will work to:

- Facilitate access to our populations and their data with the appropriate controls and approvals for academic and industrial researchers.
- Encourage and engage our populations in participation in research and innovation, put in measures to ensure equity in participation. Addressing health inequalities includes accessing innovation and research opportunities in Cambridgeshire and Peterborough.
- Promote ourselves as a system to prove and scale innovations at the earliest stage by facilitating access to technologies prior to broader roll out.
- Form commercial agreements which encourage innovators to work with us rapidly scale and roll out across ICS and broader NHS if key performance indicators are met.

Digital foundations and tools to support delivery of our priorities

Digital Focus and Vision

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

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

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

Digital foundations and strategy

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

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

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

The programmes set out in our digital strategy support us to achieve this vision and to develop a world-class digital infrastructure and information systems. Our strategy builds on what already is working well across our system. For some of our partners convergence of systems may be possible. For other partners and for our Places we will strive for integration or interoperability.

Our progress towards a Shared Care Record, Digitising Social Care Records and integrated diagnostics capabilities provides the best possible foundations for our system to deliver great care.

Our digital programmes are:

- Shared Care Record
- Electronic Patient Record
- Digital Social Care Records
- Secure Data Environment
- Transforming Primary Care
- Cyber Security
- Digital Innovation and Transformation
- Digital Equipment
- Robotic Process Automation
- Virtual Wards
- Diagnostics and Digital Image Sharing
- Future Connectivity/Gigabit Pathways

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

Wherever possible we will seek to rationalise our infrastructure, reduce complexity and unwarranted duplication and variation and drive down the costs and waste. We are also promoting the increased uptake of the NHS App through promotion and links across services.

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

Infrastructure and levelling up

- Make optimal use of our existing digital infrastructure and update this when appropriate.
- Providing the best security for our IT systems and data.
- Optimising our Electronic Patient Record Systems, creating a safe, robust, and fast network.
- Enhancing our Electronic Prescriptions and Medicines Administration systems (EPMA).
- Continuing to improve our digital maturity as a system.

Improved models of care

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

Bringing our people with us (digital upskilling)

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

Supporting our residents

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

Population health management and research

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

Developing and securing our digital infrastructure

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

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

patients. Enabling health and care professionals within our system to access and share information across care settings is recognised as a key enabler for truly transformational change.

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

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

Net zero

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

The ICB, its partner trusts and primary care community are committed to the carbon reduction goals of the NHS which are to achieve a net zero NHS by 2040 for direct emissions and by 2045 for the total carbon footprint. To achieve this we are building an integrated approach with our wider ICS partners to tackle the threats of climate change and to promote sustainability and resilience across all our activities. We have worked with wider ICS partners to develop a system-wide approach, which we will further strengthen through shared learning, working through established forums, including the C&P Climate Partnership Group, the Local Resilience Forum and the C&P ICS Green Programme Board.

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

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

- Workforce and leadership: Raising awareness, building knowledge and supporting staff to feel empowered and enabled to adopt behaviours and make choices which minimise the impact of our activities on the environment and integrate environmental considerations into everyday work. We are building on our Leadership Compact and established leadership development programmes to develop carbon literacy and sustainability skills among our leaders and staff at all levels.
- Estates and facilities: Measures to reduce energy consumption and work towards decarbonising the NHS estate. We will work towards the decarbonisation of our existing estate and embed circular economy and design principles into all new capital developments. This will be achieved by aligning the system Estates strategy with the Estates Net Zero Carbon Delivery Plan and ensuring performance against targets is effectively tracked.
- Research and innovation: Supporting research and adopting innovations that improve sustainable healthcare, by developing collaborations with research and academic partners.
- Active and sustainable travel: Working with wider partners to promote active travel for health as well as environmental benefit, and enabling sustainable modes of travel for staff, patients and visitors. We will support active travel policies and move towards a non-fossil fuel fleet across all

organisations, with the infrastructure to support. We will work with partners on reducing the impact of transport on local air quality.

- Supply chain, procurement and waste: We will seek to embed circular economy principles in the way that we procure, use and manage resources, considering the cost of carbon and waste as part of our decision-making. We will further develop the skills and knowledge of staff to evaluate sustainability and social value in procurement and contract management. We will build a joint approach with our Local Authority partners to learn from best practice and align our messaging to suppliers. We will raise staff awareness of waste and incentivise sustainable practices in the use and disposal of resources through targeted campaigns and initiatives, for example effective waste separation, food waste, plastics and medical devices reuse/remanufacture.
- Sustainable models of care: Integrating sustainability principles in the way care is designed and delivered, to improve patient health, increase efficiency and contribute towards carbon reduction. Key elements are digital healthcare solutions, personalised care and social prescribing. We also have a strong focus on sustainability as part of our medicines optimisation plan, including more effective use of medical gases, greener prescribing where clinically appropriate and tackling overprescribing and medicines waste. We will look to improve our performance in the use of high carbon inhalers, working with primary care and pharmacy partners. We will review and look to extend our social prescribing activity, working with place based partnerships to maximise opportunities for integrated approaches.

Financial context

Financial Duties

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

The Cambridgeshire and Peterborough System has, over the past 3 years, established and developed a system approach to the planned use of revenue and capital resources and the regular monitoring and managing of the financial position to support the achievement of that plan.

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

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

Monthly monitoring of the system financial position has also been established over the last 3 years, which has supported the system achievement of financial breakeven each year. A monthly financial monitoring report has been developed and is continually reviewed to ensure it provides relevant information to support the system in monitoring and managing the financial position in year. The report includes the overall system financial position, as well as the ICB and Provider level performance, efficiency delivery, financial risks and mitigations and capital performance and is

presented to both the System Finance Directors Group, Quality, Performance and Finance Committee and ICB Board. The monthly report includes financial forecasts allowing the system chief finance officers to project forward and identify early mitigations or system support if required.

This plan should be supported by the organisations Board and the Quality, Performance and Finance Committee. The monthly financial monitoring pack will be further developed through 23/24 to incorporate trend analysis, benchmarking, statistical process control and long-term forecasting to further support improvement of efficiency, productivity and long term financial planning.

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

Financial Strategy

The ICB recognises that its current financial position is not sustainable, and to achieve the best outcomes for our population we need to use the wealth and diversity of data available to us to support and inform our long-term financial planning. Our 23/24 system financial plan aims to deliver a breakeven position but includes an efficiency requirement to achieve this. As a system we need to think differently and drive out system wide transformation and efficiency that will support our long-term financial sustainability.

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

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

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

The Better Care Fund programme supports local systems to deliver the integration of health and social care in way that supports person centred care, sustainability and better outcomes for people

and carers. Over the next 2 years the ICB, along with our social care partners, will be reviewing the Better Care Funding to support an improvement in the outcomes for our people and best value for money. The review will use all of our available data to inspire transformation of our integrated services to deliver innovative, integrated, community-based services to our population that will improve their outcomes and reduce a reliance on emergency secondary care services.

From 1st April 2023 the commissioning of Pharmacy, Optometry and Dental services was delegated to Integrated Care Boards from NHS England. This has provided Cambridgeshire & Peterborough with the opportunity to directly impact and influence the commissioning of these service for our population. The challenges faced in Dental services capacity are not unique to Cambridgeshire and Peterborough but the delegation to the ICB will allow commissioning to be considered at a local level to reflect the needs of the local populations. It will also allow flexibility in the services commissioned from pharmacies across Cambridgeshire & Peterborough to support the population to access advice and support more quickly, closer to home.

The commissioning of specialised services is moving to ICBs from 1st April 2024. This will allow the ICB to focus on managing Cambridgeshire & Peterborough patients at hospitals within the county boundaries, utilising resources more effectively within our hospitals. This will mean patients do not have to travel further for their specialist treatment. There will be a period of shadow running with a Joint Commissioning Board from 1st April 2023.

Efficiency and Productivity

The Cambridgeshire and Peterborough system has a duty to provide services that are of good quality, value for money and make efficient use of our resources. To do this we use local and national data to inform our decision making across the system, these include but are not limited to population health data, model system, outputs from the McKinsey work commissioned in 19/20 and national benchmarking data. As a result of the analysis of this data, the ICS has identified opportunities to deliver efficiencies and increase productivity. For example, national benchmarking data has identified potential efficiencies which can be made in our corporate services functions and work has commenced in 22/23 to scope out the financial benefit and develop solutions to address the identified opportunities for more efficient ways of working.

Productivity and efficiency has not yet recovered to pre-pandemic levels and therefore remains a critical focus for the ICS. Recognising our performance is not where we would want it to be for our population, we continue to focus on specific improvement activities and ICS wide recovery plans. These plans have made a tangible impact on our UEC position in 22/23 and in mitigating long wait breaches (104ww). We will continue to review and benchmark our performance relative to others, striving for national median and then top quartile performance over the coming two years.

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

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

Our triangulation of the draft 23/24 operational plan has highlighted a reduction in productivity within the acute sector and 0% productivity loss within our community providers. This mirrors the evidence from the C&P ICS whole system productivity review underway including workforce and activity. The outputs from this review are factored into the ICS plan for 2023/24. The review has highlighted the key areas of challenge for the system:

- **Workforce:** The workforce in the C&P system has increased by 16.1% (acute only 16.3%) since 2018/19 however activity has decreased except for A&E and outpatient virtual follow ups. Even though the workforce has increased the RCN sickness rates have also increased by 2% to 5.7% and nursing support staff sickness has increased by 4.9% to 7.1%. At the same time staff stress levels and satisfaction have deteriorated; all these indicators will impact productivity.
- **Electives:** Total elective activity is 11% lower than pre pandemic levels. NWAFT has seen a significant drop from pre covid levels of 20% whereas CUH activity is only 0.6% below 2018/19 and 2.7% below 2019/20**.**

  The length of stay for elective IP has increased by over 20% since pre covid levels, this can potentially be explained, in part, by an increase in the day case rate implying lower acuity spells have moved to day case. The average price has also increased above tariff inflation showing that the acuity has increased. There has also been an increase in excess bed days which indicates that there are also productivity reasons for the increased LOS.

- **Non-Electives –** The length of stay (LOS) for non-electives has increased by just under 20% since pre covid levels. This can, in part be explained by an increase in acuity but there has additionally been an increase in excess bed days.

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

- **Waiting times for Diagnostics:** Loss of or changes to referring processes for certain diagnostics has in some instances resulted in the originating referrer making multiple referrals within the system to expedite a test. There is also evidence that inter-provider referrals may have also increased to navigate a speedier way around this issue during the pandemic. This has resulted in multiple entries/duplicates on Provider waiting lists for diagnostics, possibly leading to inflated waiting lists, compounded by the availability of clinical and non-clinical to review and triage these lists to confirm their validity.
- **Workforce:** Lost productivity within diagnostics across the system due to administrators leaving the system has had a large impact across all Trusts, directly impacting upon availability of staff to work with patients to coordinate appointments, plus delayed reaction time to respond to dealing with DNAs/CNAs. Cost of living has also had a high impact on registered staff coming into the system (especially around Cambridge) who have then relocated outside of the region. Oversees recruitment has shown some benefit but lead in times (visas) has compounded delays in reacting to staff departures.

The ICS has an increased workforce since 2018/19 as detailed above. The system will need to address the key challenges in the workforce that reduces sickness and increases staff morale that will support the transformational changes required in care models, and changes to increase productivity.

The system has a track record of developing innovative skill mix, particularly in areas specialisms where there are national deficits in suitably trained staff. For example, NWAFT have been

national and regional leaders in developing imaging practitioners with advanced practice, to reduce the reliance on consultant radiologists. We will draw on this experience and knowledge to support the workforce challenges and increase productivity.

Workforce

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

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

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

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

Supply, attraction and retention:

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

Our key priorities and deliverables are:

Priority 1: We will optimise the 23/24 Supply and Retention activity to reduce our Health care support worker vacancy rate by 40% across our ICS. Specifically, we will:

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

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

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

Priority 2: We will build our domestic workforce supply through 23/24 and beyond by exploring all supply routes for domestic and international recruitment, to build a strong, resilient workforce plan. We will:

- Refresh ICS Attraction branding.
- Use the intelligence from the 23/24 Operational plans to inform workforce transformation.
- Develop a robust Apprenticeship strategy.
- Design and implement a Clinical Education Strategy.

We will further develop our Health and Care Academy together with our Apprenticeship schemes, promoting social mobility, supporting clearer visibility of career pathways and future development opportunities in both Care and Health. Together with shared mobile recruitment facilities and the 'It's all coming together' microsite, we are promoting roles in areas where traditional recruitment methods do not effectively engage with local populations.

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

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

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

Priority 3: Implement NHSE's 5 High Impact Retention Interventions to create a resilient workforce. We will:

- Complete the NHSE Assessment tool.
- Implement a Legacy Practitioner model across Primary, Secondary Care and Voluntary Care organisations.
- Embed Flexible Working Policies across the ICS.
- Implementation of a Retire and Return policy across the ICS.

We are implementing the NHSE Five High Impact Interventions which are designed to retain staff and develop inclusivity within our workforce. These include the development of Menopause policies, Pension seminars, Preceptorship frameworks, legacy practitioners, and completion of self-assessment tools by individual providers. Together with flexible working policies and the ongoing support of our Health and Wellbeing Services available to all to NHS staff across our system, we will increase the number of those who remain at work, reduce turnover and improve workforce satisfaction and productivity.

Priority 4: Support Supply, Attraction and Retention through affordable accommodation in our system to improve the availability of affordable accommodation for international and domestic recruits in 23/24 and beyond. We will:

- Produce an ICS Accommodation Strategy
- Develop and deliver a Housing Needs Survey
- Deliver and Evaluate Homestay Pilot
- Explore Adoption of Homestay Model

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

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

We have run successful Key Worker and Housing Accommodation engagement sessions, sharing experience, challenges, and collaboration with all system partners. Together with an ICS-wide accommodation survey we will identify the scale and profile of the housing needs amongst key workers, providing evidence of where the pressures are greatest. Homestay provides our workforce with a possible interim accommodation solution where suitable. Homeshare, an intergenerational accommodation programme, is also being planned to help support Adult Social Care.

Leadership and culture:

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

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

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

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

The 'Above Difference Programme' will support the development of a cultural intelligence framework to support our leaders and staff to become more culturally aware using personal analysis

and economic modelling. This will operate alongside the Cultural Ambassadors, an evidence-based programme based on national data of ethnic minority staff with experiences of being referred to respective governing bodies, and higher levels of disciplinary and grievances with an overall focus on improving patient safety.

Equality, diversity and inclusion:

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

To take this forward we will engage with a wide variety of stakeholders in developing and implementing a programme of targeted interventions, building on the existing areas of good practice and the outcomes from our September 2021 collaboration event which identified key priorities for action around leadership and management; talent and career progression; and racial harassment. We will work collaboratively to implement innovative EDI initiatives and strengthen our policies and practices to build a truly inclusive and diverse culture.

Priority 1: Implementation of our anti-racism strategy, including embedding “no more tick boxes” in recruitment; rollout of anti-racism training programme; and implementation of the anti-violence and aggression workstream.

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

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

The five additional workforce enabling groups comprise, Health and Wellbeing; Education, Learning and Development; Creating Healthy Communities; Efficient and Effective Way of Working; Workforce Aligned with Service Transformation.

Delivery and governance

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

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

Primary care sustainability

It is important to ensure that when discussing ‘Primary Care’ we are cognisant that these services include more than just General Practitioners (GPs) and General Medical Services. Community

Pharmacy, Optometry and Dental professionals are key members of the primary care service offering across our system.

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

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

To deliver this vision we have identified three underpinning principles:

Population health and prevention	Sustainable and needs based resourcing	Patient centred transformation
• Build population health data to gain insights into our population and gather data to better serve them • Neighbourhood teams to take more active role in improving health • Data can empower neighbourhood teams to increase uptake of preventative interventions whilst also tackling health inequalities. • Use the CORE20PLUS5 approach for reducing health inequalities • Fully involve the wider primary care workforce - community pharmacists, optometrists and dentists/dental care professionals in delivery of preventative care. E.g. to screen for atrial fibrillation when patients attend for routine appointments, thus supporting the CVD strategy and reducing the risk of debilitating strokes.	• Investing in primary and community care to address patient needs and narrow health inequalities • Use C&P patient data to create funding model that can flex to existing and newly identified population needs • Simplified approach based on high trust low bureaucracy and moving to measuring outcomes • Effectively use resource to support transformation to deliver better outcomes • Ensure equitable allocations to encourage equality of outcomes	• Build integrated neighbourhood teams rooted in sense of shared ownership for improving health & wellbeing of the population • Foster improvement culture and safe environment for people to learn and experiment • Deliver the change our patients and staff want and need through improving same-day access for urgent care and continuity of care for those with complex needs • Develop current tools of healthcare into tools for self care, empowering people to maintain and monitor their own health

Recently there has been a major focus on supporting general practice resilience to meet both urgent care needs and maintenance of long term condition care, through an integrated community-based

response, with clear accountabilities and responsibilities and reduced bureaucracy. This has included targeted investment in surge capacity; increased flexibility in using existing funding streams to support general practice sustainability; digital solutions and specific agreements with Trusts about referral and discharge practices to help free up clinical time with more streamlined processes.

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

- Developing a new framework for locally commissioned services, with the aim of reducing the burden of reporting at practice level and providing financial security as the ICS moves to a needs-based model of funding.
- Utilising local discretionary General Practice spend to meet identified population needs at place and neighbourhood level through local transformation initiatives and targeted services.
- Using population health data to set outcome measures as part of a new primary care investment approach, underpinned by a culture of accountability, responsibility and reduced transaction.

How we will be taking this forward:

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

We have now assumed the commissioning responsibilities for wider primary care services and with that the associated challenges and opportunities that brings. We will work with local clinical leaders and representatives, and our local communities, to ensure the same robust support for service investment, integration, and improvement that we have previously directed to General Practice services. Primary Care leadership is already represented on the Professional and Clinical Leadership Assembly, the Joint Clinical & Professionals Executive Group and the PCN Clinical Directors and managers group. As we strive to integrate primary care service further within our neighbourhoods the breadth of that representation will increase. The building of 'teams of teams' serving local communities brings opportunities to reimagine, redefine and ultimately redesign the primary care offering that patients can access from their home. In earlier chapters we have heard how enablers such as digital maturity, nurturing leadership, and the development of a culture of continuous improvement will support these changes in primary care. The ICB will provide an environment to ignite local ambition, and the tools, training and time needed for staff to transform this sector of our system. Key elements of the current system, like the partnership model of General Practice, which where it is thriving, allows agility and early adoption of innovation, will be supported. Where current challenges mean future sustainability necessitates new clinical and business models these will be explored and co-designed with our clinical and user groups. We must embrace the opportunities of new technology, but not lose the human element to caring, affording our professionals the time they need to spend in ensuring holistic care of their patients. The four C's that have underpinned primary care services – first contact care, comprehensiveness, continuity, and coordination, are and will remain important to clinicians and patients, as we strive to design and sustain services for the future. Any misguided drive for apparent efficiency through promoting purely transactional care must be resisted and not allowed to undermine these key principles; although a balance must be struck which allows maintenance of principles but also encourages imaginative new ways of delivering care, which are judged by asking patients 'how did that work out for you?' and not just on the basis of how it worked 'for the system'.

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

Community pharmacies

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

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

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

Our plans for community pharmacy:

- Increase the use of the Discharge Medicines Service: Build and expand on the current service over the next 1-2 years by broadening the criteria for patients referred into the service and improving digital mechanisms for referral.
- Increase referrals via the Community Pharmacy Consultation Service:
    - Inclusion of new providers to refer into the service including Urgent Care over the next year, collaboratively working with GP Practices to align healthcare professionals ensuring increased accessibility and improving patient outcomes, including changing patient behaviours.
    - Developing clinical services provided by community pharmacies, including services which address inequalities and population need.
- Increase the number of prescriptions ordered via the electronic repeat dispensing service: Improve the ordering process, ensuring it is efficient and safe, to help patients have access to their medication when needed while reducing workload for various providers.
- Improve digital connectivity between providers through the local and national SystmOne pilot: Digital connectivity enabling access to patient records is fundamental in ensuring safe and appropriate prescribing and medication supply. The development of future clinical services provided by community pharmacies over the next 1-5 years will be largely dependent on this.
- Support pharmacies to deliver self-care and self-management for both minor ailments and long-term conditions.
- Expand clinical services provided by community pharmacies:

    - Enhance opportunities for early intervention and detection of long-term conditions to help support improved outcomes, as an example Pathfinder for the management of hypertension which will be piloted during year 1.
    - Increase provision of clinical services provided by community pharmacies, which will include development of new services; commissioning of new services; upskilling the pharmacy workforce, e.g. Pharmacist Independent Prescriber qualification.
- Maximise the use of community pharmacy Patient Group Directions (PGDs), e.g. the insect bite service, enabling community pharmacies to provide treatments for specified conditions without the need for a doctor prescription. We are currently piloting ICB commissioned PGDs, for example for the treatment of uncomplicated Urinary Tract Infections s in women.
- Make best use of prevention services - vaccination services, hypertension case finding, smoking cessation, weight management, supporting community pharmacies to further develop these services to improve prevention outcomes.
- Support workforce to minimise unexpected closures through workforce and development initiatives.

Dentistry

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

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

The dental strategy through a new model of care aims to:

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

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

Optometry

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

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

- Utilising primary eye care optometrists as first contact practitioners and as part of referral pathways for eye care, reducing demand for GP attendances.
- Developing assessment and co-management pathways, including using core competencies and the skills of higher qualified optometrists.
- Improving digital connectivity for referrals, communication and image sharing with secondary care.
- Making best use of workforce for non-optometry prevention services such as hypertension case finding, AF case finding.

Estates and infrastructure

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

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

We have worked closely with system partners and NHS Property Services on a strategic review of estates as a basis for future strategic planning. The review covered approximately 240 properties with a total gross internal floor area of 650,000 sqm, including 128 primary care properties (87 GP practices), four main acute hospitals and eight main community and mental health hospitals/main sites. At this stage, the review did not cover other public or voluntary sector estate, however we will continue the work with partners through the System Estates Group and One Public Estate to maximise the opportunities for efficiencies and integration through joined up working. This is important because the 240 healthcare facilities represent only 10% of the total footprint of our ICS estate portfolio.

Key challenges and opportunities identified include:

- Ageing and undersized primary care estate, with additional pressures from a growing and ageing population.
- Third party owned property that may not be maintained to modern standards and that may be sold and therefore lost to the system, without succession plans in place.
- NHSE require assurances from each ICB that all their General Practice buildings are not constructed of Reinforced Autoclaved Aerated Concrete (RAAC). If any are found to be, then plans need to be submitted to NHSE on mitigating the risks.
- Structural problems at Hinchingbrooke (RAAC) requiring reprovision of services.
- Strategic developments at the Cambridge Biomedical Campus (Cancer and Children's Hospitals and the wider masterplan).
- Underutilised back-office accommodation.
- Lack of comprehensive and consolidated data to support strategic planning

Our infrastructure must meet the needs of our communities, be fit for purpose, provide a good environment for delivery of care and provide a safe and effective working environment for staff. Much of our estate is aging, requires investment and, due to population growth over the past 20 years, is not always located in the right geography to meet the growing needs of our population. As we develop our vision for our estates, we need to make sure it is aligned with our strategic aims, but

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

We will seek to use the system estates strategy to inform key system decisions over the next 12 months about how best to use our existing and future infrastructure to deliver on system strategic aims. There is much to tackle, and finite financial and capacity to do so. We therefore need to identify where we will focus our efforts in the first 12 months, and the rationale for this focus.

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

Transform spaces and places

- Develop a hub strategy integrating primary, community and specialised services. Our focus will be to identify neighbourhood hubs that improve local access to a wider range of services more locally, incorporating the social and voluntary sectors.
- Develop solutions for areas of highest population growth. New localities present opportunities for the system to design new facilities that embrace our principles of integrated care closer to home.
- Increase access to diagnostics in the community and widen the reach of testing by bringing these services closer to people's homes.
- Work with partner organisations to optimise public sector estate options. We need to share estate thinking, planning and facilities to realise financial efficiencies as well as encourage better integration with social care and voluntary sector to realise our ICS objectives.

A smarter and greener NHS estate

- Develop policies to improve estate flexibility and utilisation. We need to move away from a 'name on the door' model of estate use. We need to understand utilisation better and develop a robust digital platform whereby all our estate partners can make better use of our estate, siting/grouping services with good public and active transport access.
- Rationalise the back-office estate and create multi-agency hubs. We need to assess our needs, locations and work with our colleagues within the One Public Estate to create collaborative environments.
- Develop a cost transformation programme to review under-performing assets to identify what estate is coming to the end of its useful life and what provides us with what we need now and into the future.

In particular we will work to reduce energy usage and move away from fossil fuels, utilising the best technology and design to deliver effective daylight, shade and ventilation. We will work towards reduced use of high carbon footprint medical gasses and effective management of waste, bearing in mid guidance such as the NHS Clinical Waste Strategy 2023.

We will work to ensure use of low carbon material in new build and refurbishments, and utilise our green estate to the best advantage for biodiversity, sustainable urban drainage, active travel and shade potential.

Excellence in delivery and insights

- Improved estate data and insights to provide us with the clarity on vacancy, utilisation, condition, lease dates, age, size and to aid project tracking.
- Develop an ICS capital planning strategy, with a clear definition around the prioritisation of projects set against the availability of capital.
- Develop a PMO to effectively deliver workstreams and projects, focused resource and governance to manage and track our workstreams.

Major estates projects

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

Our proposed focus for 2023/24:

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

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

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

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

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

Acute/community sites:

- Hinchingbrooke
- CUH Cancer and Children's Hospitals

- Princess of Wales Hospital, Ely
- Royston
- Doddington Hospital
- North Cambs Hospital

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

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

Section 10: Implementation

Our Culture and Values

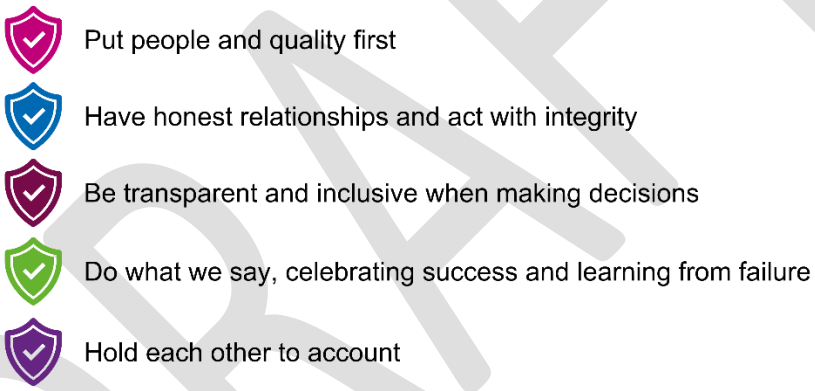
To deliver the health and wellbeing ambitions and priorities of the Health and Wellbeing integrated care strategy, we cannot do this as a group of individual organisations.

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

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

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

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



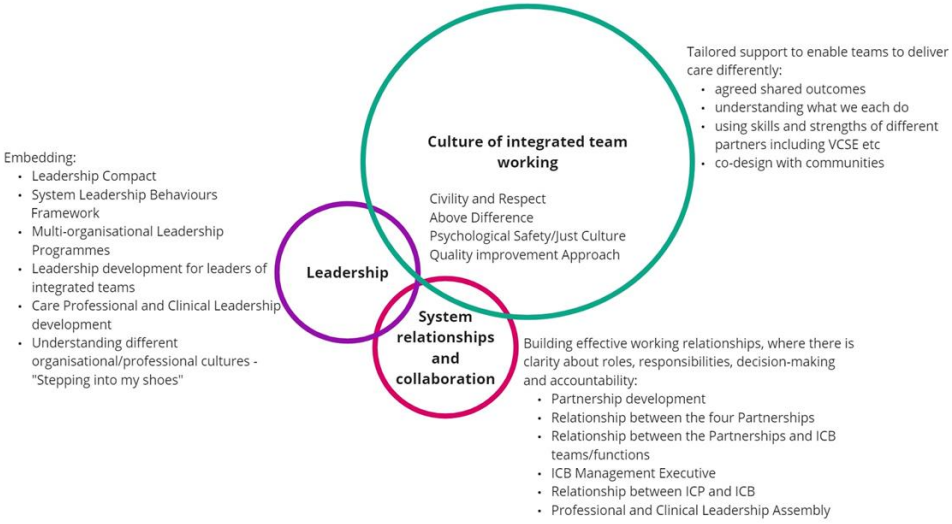
Organisational Development

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

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

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

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



Governance, accountability and performance

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

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

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

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

The ICB has agreed a Scheme of Reservation and Delegation (SoRD) which is published in full in the ICB Governance Handbook. The SoRD sets out: those functions that are reserved to the board, those

functions that have been delegated to an individual or to committees and sub-committees, those functions delegated to another body or to be exercised jointly.

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

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

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

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

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

The ICB Governance Handbook features the SoRD, the Functions and Decisions Map and the Terms of Reference for all ICB Committees and can be found on the ICB website at https://www.cpics.org.uk/constitution-for-cambridgeshire-and-peterborough-icb

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

- Unscheduled Care Board
- Planned Care Board
- Diagnostic Board
- Cancer Board
- Mental Health, Learning Disabilities and Autism Partnership Board
- Palliative and End of Life Care Board

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

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

Quality and safety

Overview

We have co-produced a Quality and Patient Safety Strategy 2021 – 2026, within which the overriding principle is to foster a culture of safety, learning and support with standards and structures that underpin safer care. The strategy has been developed collaboratively by patients, partners, including health/social care, public health and the Local Authority.

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

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

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

System Quality Oversight

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

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

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

Objectives:

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

Measurable and evidenced safe quality care across the system

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

- Summary Hospital Level Mortality (SHMI)
- Falls
- Pressure Ulcers
- Learning Disability Health Checks
- Perinatal mortality
- Reduce the incidence of Restrictive Practice

Our ICB will maximise a safety culture by working collaboratively and alongside system partners within their quality and safety meeting. As part of this collaboration and by end of March 2024 we will have implemented an integrated quality assurance peer review process.

Key targets:

Deliverable	Timeline	SRO	Oversight groups
Maintain SHMI within accepted levels of tolerance	Quarterly from April 2023	Medical Director	Individual Trust Quality Committee SQG Quality, Performance and Finance Committee ICB Board
Ensure all people at risk of falling in hospital and care home environments are risk assessed and personalised mitigations are in place	April 2023 to March 2025	Chief Nurses	Individual Trust Quality Committee SQG Quality, Performance and Finance Committee ICB Board Care Home Operational Meeting
Reduce the number of acquired pressure ulcers by 10 % on baseline of March 2023	April 2023 to March 2025	Chief Nurses	Individual Trust Quality Committee SQG Quality, Performance and Finance Committee ICB Board
Zero tolerance to missed learning disability health checks	March 2025	PCN Medical Directors	Primary Care Quality Group SQG Quality, Performance and Finance Committee ICB Board
Reduce still births by 50 % (based on 2020 data)	2025	Chief Nurse	Individual Trust Quality Committee, Local Maternity and Neonatal System Board, SQG Quality, Performance and Finance Committee ICB Board
Reduce the incidence of restrictive practice 50% and Improve the sexual safety of patients and staff by 50% above baseline by March 2024	March 2024	Chief Nurse	Individual Provider Quality Committees System Quality Group ICB Performance, Quality and Finance Committee ICB Board

Medication Incidents

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

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

System quality improvement by learning from incidents

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

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

Key milestones:

Deliverable	Timeline	SRO	Oversight groups
Commencement of orientation phase for cohort 2 of providers, which includes Primary Care	April 2023 to March 2025	Chief Nurse	1. Provider Quality Governance 2. System Quality Group 3. Quality, Performance and Finance Committee 4. ICB Board
Sign off PSIRF policies for individual providers in Cohort 1	July 2023 to March 2024	Provider & ICB Chief Nurses	1.Community of Practice 2. Individual trust quality committees 3. System Quality group 4. Quailty, Performance & Finance Committee 5. ICB Board
Implementation of PSIRF for cohort 1 providers	Sept 2023 to March 2025	Chief Nurse	1.Community of Practice 2. Individual trust quality committees 3. System Quality group 4. Quality, Performance & Finance Committee 5. ICB Board
Commencement of use of the new Learning from Patient Safety Events reporting system for Cohort 1 providers	April 2024 onwards	Provider & ICB Chief Nurse	1.Community of Practice 2. Individual trust quality committees 3. System Quality group 4. Quality, Performance & Finance Committee 5. ICB Board

Safeguarding

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

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

This is achieved through partnership working with all statutory and voluntary agencies across Cambridgeshire and Peterborough via the Safeguarding Partnership Boards and Domestic Abuse and Sexual Violence Boards. Effective safeguarding arrangements seek to prevent and protect individuals from harm or abuse, regardless of their circumstances.

We will achieve this through:

- Working as a partnership to build strong families and communities, building capacity and taking a whole family approach, with early intervention to address specific needs.
- Identification and support children and adults who experience neglect.
- Understanding and robust multi-agency response to children who are victims of sexual abuse.
- Ensure Children and Young People have timely access to appropriate crisis and mental health services.
- Ensure that children in care receive regular health assessments and dental support.
- Imbedding the Mental Capacity Act to ensure that individuals who lack capacity have their human rights met and receive appropriate care and support.
- Working with statutory and voluntary agencies to identify and capture the patient experience.
- Learning from safeguarding incidents through multi-agency working, shared investigations and reviews and development of training materials to support practitioners.
- Review how safeguarding support is delivered within each locality or neighbourhood to address inequalities.

Serious violence duty

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

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

The ICB will work as part of the Cambridgeshire & Peterborough specialist team to support strategic planning in the prevention and reduction of violence in our local communities.

This includes collating and analysing health data from NHS Accident and Emergencies, strengthening links with primary care networks and sharing of intelligence. We will also ensure links with safeguarding professionals specialising in Prevent, Female Genital Mutilation and Modern Slavery to share insight and gain a fuller picture of what is happening locally.

To gain an insight into the causes of violence and the devastating consequences for members of our communities, NHS Cambridgeshire and Peterborough ICB will connect with local agencies such as education, probation, charity organisations and faith leaders. A primary focus will be engaging with our communities and where consent is gained conducting interviews to hear the lived experience from victims of violence and/or their families. Their lived experiences will be reflected in our Strategic Needs Assessment and local strategy.

To assess readiness to tackle and prevent serious violence a training skills analysis will be completed to determine any training needs for healthcare professionals. NHS Cambridgeshire and Peterborough are proactive in ensuring healthcare staff are confident and competent in knowing how to safely identify, refer and respond to victims of serious violence.

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

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

Objectives

- Implement training to all necessary staff to meet the health requirements of the Serious Violence Duty 2022
- Embed learning and improvements to practice following children Safeguarding Practice Reviews, Safeguarding Adult Review and Domestic Homicide Reviews
- Working in collaboration with partner agencies, establish pathway for victims of serious violence
- Ensure health elements of the pathway are linked to the broader ICB health inequalities agenda.

Deliverable	Timeline	SRO	Oversight groups
Undertake training analysis of healthcare staff requirements to meet Serious Violence Duty	March 2024	Chief Nurses	Individual Provider Quality Committees ICB System Quality Group ICB Performance Quality and Finance Committee ICB Board Cambridgeshire and Peterborough Safeguarding Board
Safeguarding Audit to demonstrate learning from case reviews (as part of Section 11 Audit)	March 2024	Chief Nurse	Individual Provider Quality Committees ICB System Quality Group ICB Performance Quality and Finance Committee ICB Board
Health element of pathway to support victims of serious violence implemented	March 2025	Chief Nurse	Individual Provider Quality Committees ICB System Quality Group ICB Quality, Performance and Finance Committee ICB Board
Establish links between victims of serious crime and broader health inequalities work	March 2025	Medical Director	Individual Provider Quality Committees ICB System Quality Group ICB Quality, Performance and Finance Committee ICB Board

Clinical and care professional leadership

Our ICS Care Professional and Clinical Leadership Framework supports the development of distributed care professional and clinical leadership across the ICS. It covers the broad range of professions working together through the ICB, the ICP, place-based partnerships and provider collaboratives, and sets out the core principles and approach for involvement, leadership and development.

The Professional and Clinical Leadership Assembly (PCLA) is the main forum for overseeing the framework and ensuring that care professional and clinical representation and leadership are embedded within our system. The group has a wide representation from ICB and ICP partner organisations; from professional groups such as general practice, primary care, AHPs, community

and social care; and knowledge experts from clinical communities, public health, academia and specialist areas. The Assembly provides a focus for shared learning, collaboration and innovation, linking across all levels of the ICS. The main functions of the group are to:

- Provide a forum for clinical decision-making, recommendations of priorities and actions on new clinical strategies and implementation plans.
- Enable partners to bring new clinical issues for discussion and action and feedback into the ICB.
- Promote information sharing concerning ICP and ICB decisions and plans.

The Assembly has an executive group which reports to the ICB Board through the Quality, Performance and Finance Committee.

Place and Collaborative Partnerships

Under the ICS structure, we have four Partnerships which will, over time, take on delegated responsibility for a broad range of ICB functions.

Our Partnerships work across health, local authority, and voluntary, community and social enterprise (VCSE) organisations to provide care and support to our people and communities.

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

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

- Oversee the implementation of the assurance and delegation of services to Partnerships.
- Support the development of the Partnerships and their readiness to take on these responsibilities.
- Facilitate integrated leadership and governance across ICS providers and partners.
- Drive a strong culture of integrated delivery and transformation that improves health outcomes for all our local communities.
- Accelerate service improvement and align workforce and finances to where it is needed.

The role of the Partnerships is to understand local patient needs, drive service improvement, high quality care, and provide strategic plans that will deliver ICS and locally agreed priorities within the funding available. They are working collaboratively to ensure alignment and avoid duplication of effort to ensure joined up services and support for all our local people.

Where we are now

Over the past 12 months we have worked with the Partnerships to progress our Development Programme. A significant amount of work and progress has been made since the start of this programme.

During 2022/23 the Partnerships have started to lead on improving discharge and developing 'virtual wards' to support patients at home. Now contributing to the ICS plans for 2023/24 and will lead on more areas of work, as detailed in the delivery plans underpinning this joint forward plan.

As we move into 2023/24, the focus is on improving services for patients, learning through delivery and accelerating the establishment of four Partnerships, mainstreaming them into business as usual and ICB governance.

Delegated commissioning

We have worked to ensure the safe delegation of Pharmaceutical Services, General Ophthalmic Services and Dental (Primary, Secondary and Community) Services (POD) on 1st April 2023, in line with the requirements set by NHS England. For Pharmacy and Ophthalmic Services, the staffing, budgets and governance will be hosted by Herts and West Essex ICB, on behalf of all six ICBs in the East of England. A Memorandum of Understanding has been developed which sets out how the responsibilities will be split between the host ICB, the other ICBs and the interdependent functions that will be retained by NHSE and how they will work together to provide an effective hosted contract management function. We have prepared a Safe Delegation Checklist as part of the due diligence process to take on the new POD functions.

We are working in partnership with NHSE and other ICBs in the East of England to prepare for the future delegation of Specialist Services, through the Specialised Services Joint Commissioning Committee (SSJCC). A formal Joint Working Agreement between ICBs and NHSE has been established to support the SSJCC. Subject to due diligence, Bedfordshire, Luton & Milton Keynes (BLMK) will host the regional Specialised Commissioning team.

Both programmes of work are managed internally by Task and Finish Groups, led by the Director of Commissioning and overseen by the Commissioning and Investment Committee (CIC) of the C&P ICB Board.

Summary

This Joint Forward Plan for Cambridgeshire and Peterborough demonstrates how we will work together to sustainably tackle the strategic aims for our system and deliver the key duties required by an ICB for our people and communities.

We know that a clear roadmap and a focus on the areas of most importance will help us to define where and how we direct our resources for maximum impact. We have clarity on how we will deliver our joint Health & Wellbeing Integrated Care Strategy, alongside this plan that articulates how we will continue to improve performance of our NHS commitments. We have created detailed delivery plans for the next five years that describe how we will deliver transformation across key areas such as cancer, estates, planned care and CVD, as well as many others that underpin our strategy and plan.

We have engaged with our people and communities in the development of this plan. We have asked key questions about their priorities for health and wellbeing and prevention to ensure we are listening and responding to their needs and have a continued focus on addressing the inequalities that exist across our communities.

Our Health & Wellbeing Integrated Care Strategy demonstrated how every part of our system has come together to prevent ill health and support the sustained improvement in the overall health and wellbeing of the people and communities of Cambridgeshire and Peterborough.

This Joint Forward Plan describes how we will translate our Health & Wellbeing Integrated Care Strategy into delivery and the outcomes we expect to achieve as a result of our collective endeavours.

We will maximise the opportunities that true integration brings, working with key partners in all tiers of Local Authority and the VCSE sector as well as across the NHS. Together we will solve challenges, grasp opportunities and in doing so transform and improve the way we provide health and care so local people and communities can lead happier and healthier lives.