North Cambridgeshire & Peterborough Care Partnership

Progressing integration of health and care

Fenland Overview and Scrutiny Committee

4 March 2024 | John Rooke

Who are we?

North Cambridgeshire & Peterborough Care Partnership

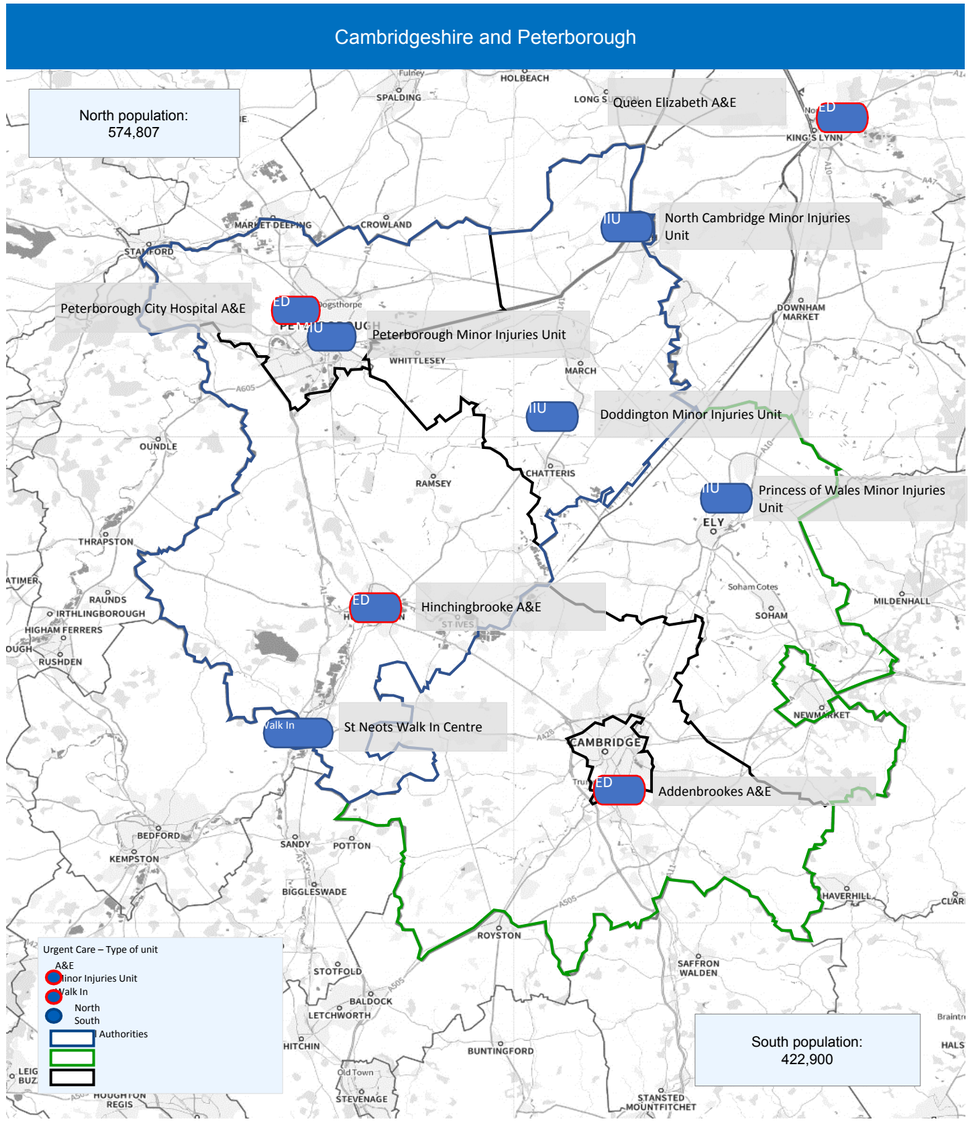
Our partnership is composed of NHS providers, County and District Councils, Healthwatch, voluntary community and faith sector partners.

Our partners work together to provide health and care services for our population:

- **Two upper tier local authorities**: Cambridgeshire County Council, Peterborough City Council
- **Two District Councils:** Fenland, Huntingdonshire
- **One hospital provider**: North West Anglia NHS Foundation Trust
- **Two community providers**: Cambridgeshire and Peterborough NHS Foundation Trust and Cambridgeshire Community Services NHS Trust
- **One mental health provider**: Cambridgeshire and Peterborough NHS Foundation Trust
- **Two ambulance trusts**: East of England Ambulance Service NHS Trust, East Midlands Ambulance Service
- **48 GP practices**
- **One Integrated Care Board**: Cambridgeshire and Peterborough ICB
- **Healthwatch** Cambridgeshire and Peterborough providing an independent patient and service user voice for health and social care
- **Circa 2,000** local voluntary, community and faith organisations

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

- **13 Integrated Neighbourhoods Teams** with a population ranging from 30,000 to 60,000 where local partners come together to respond to local needs and challenges



Diversity and inequity of outcomes

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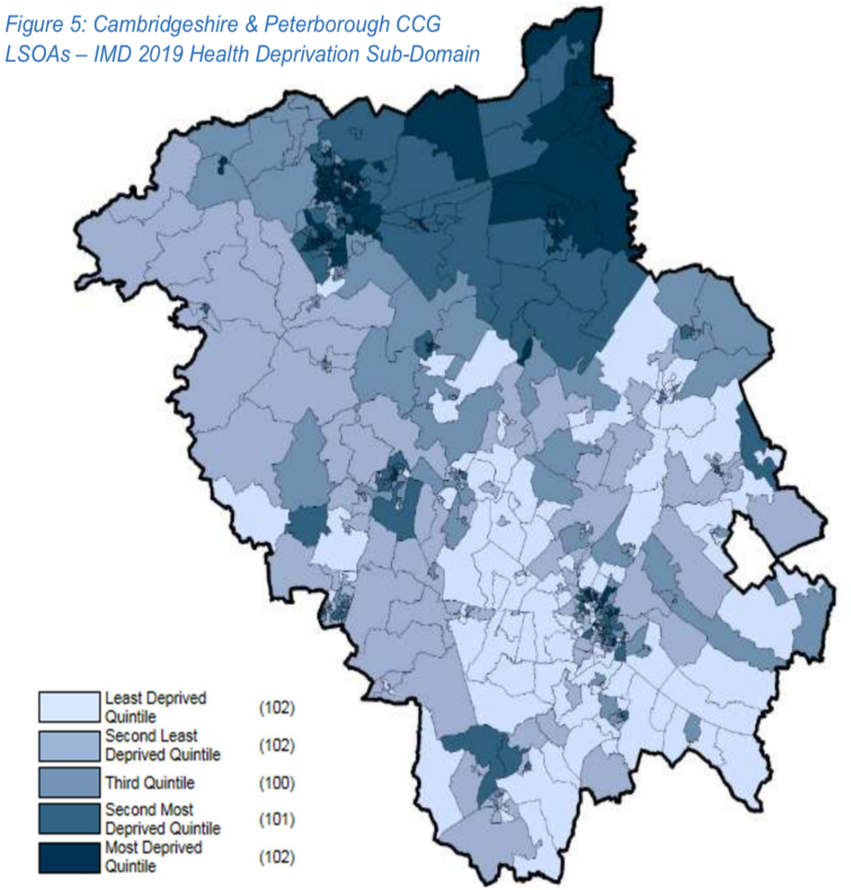
Our partnership serves a diverse population that experiences significant health inequalities

- There are 574,000 people registered with North Cambridgeshire and Peterborough GP practices
- North Cambridgeshire and Peterborough has **higher proportions of Black, Asian: Indian/Bangladeshi/Pakistani and 'other' ethnic groups** compared to the Cambridgeshire average
- **Deprivation is higher for North Cambridgeshire and Peterborough** compared to Cambridgeshire. Approximately 16% of children and 15% of older people live in income deprived households.
- Male and female **life expectancies are statistically significantly lower** compared to life expectancies for the Cambridgeshire at 80.5 years and 83.7 years respectively.
- **Recorded prevalence of obesity and estimated smoking prevalence are statistically significantly higher** compared to the average for Cambridgeshire. It is estimated that **10.1% of adults are obese and 19.8% of adults smoke**.
- Estimates of **people reporting long-term activity-limiting illness and being in Good or Very Good health are statistically significantly worse** than the averages for the Cambridgeshire.
- Statistically **significantly high recorded prevalence of Coronary heart disease, hypertension, stroke, COPD and diabetes** compared to the Cambridgeshire averages
- North Cambridgeshire and Peterborough has statistically significantly **higher all-age and premature all cause mortality rates** compared to Cambridgeshire.
- Statistically significantly **high rates of children's and adult social care users** compared to the Cambridgeshire average.
- North Cambridgeshire and Peterborough has statistically **significantly higher rates of hospital use** compared with the Cambridgeshire average.

2019 IMD Health deprivation across Cambridgeshire and Peterborough

Figure 5: Cambridgeshire & Peterborough CCG LSOAs – IMD 2019 Health Deprivation Sub-Domain



Finding non-traditional solutions to improve outcomes

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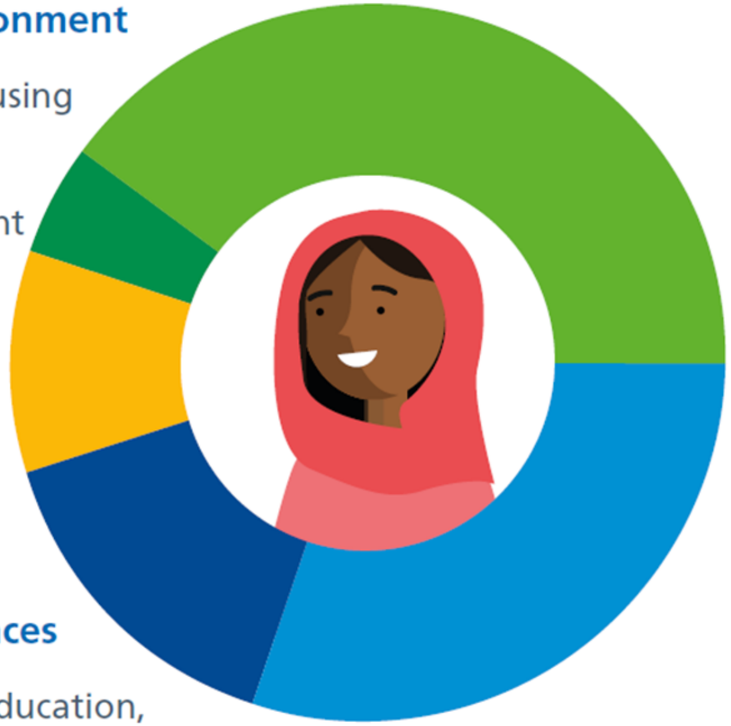
Which factors impact your health?

Our environment
5% housing quality and our built environment

Healthcare
10% being able to access good quality care

Social and economic circumstances
15% education, employment, income, family/ social support, community, safety



Our behaviours
40% smoking, diet, alcohol use, poor sexual health

Genetics
30% your genes can directly cause or increase your risk of developing a wide range of medical conditions

Each year lifestyle and environmental factors cost the NHS **£11 billion**

Impact of social and economic inequalities costs a further **£4.8 billion**

Our concept of integrated neighbourhoods

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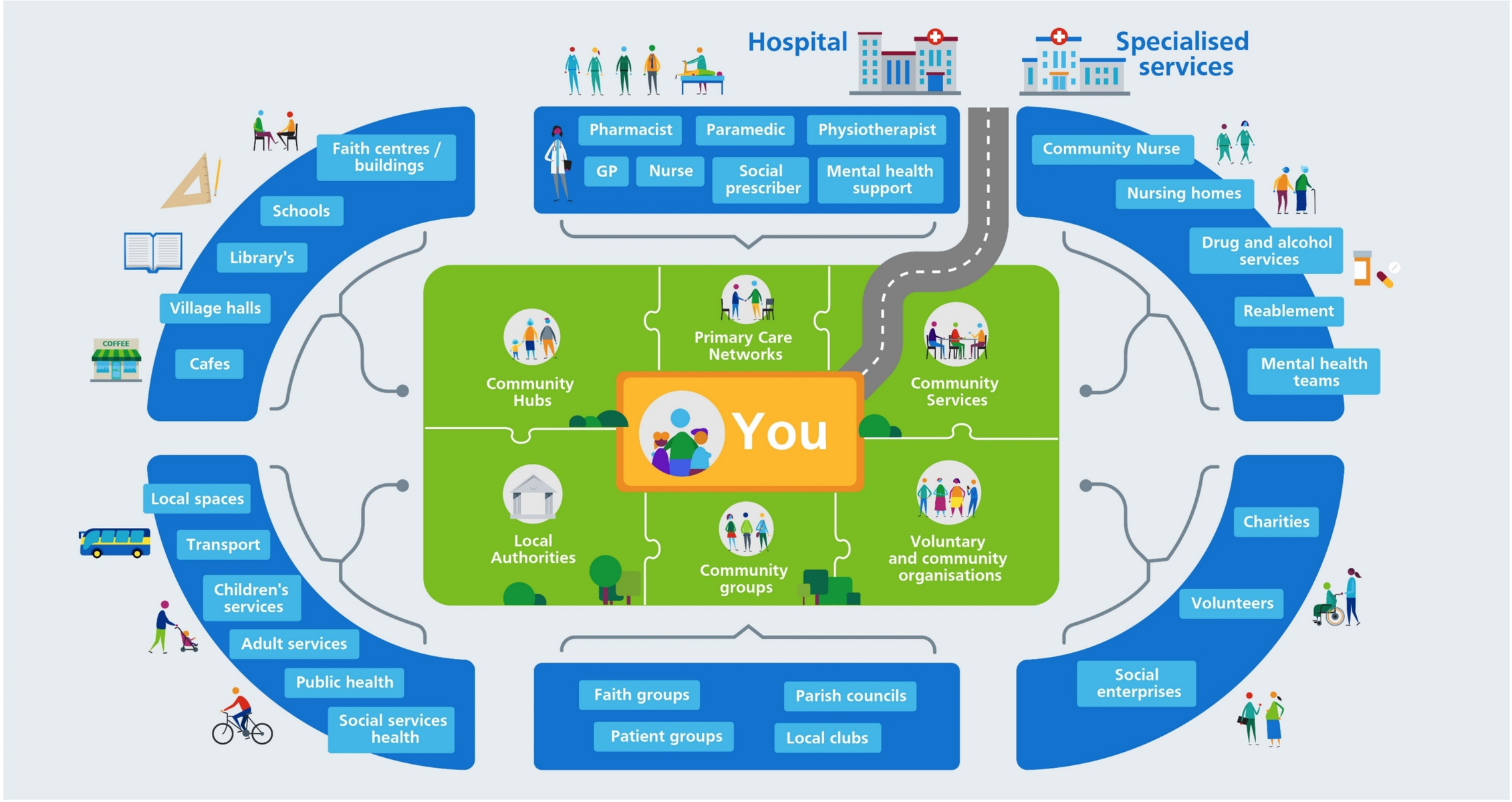

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Our plan for 2023/24

Our plan for 2023/24

Health and wellbeing ambitions

- Have better outcomes for our children
- Reduce inequalities in deaths under 75 years
- Increase the number of years that people live in good health

Integrated Care System priorities

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

North Care Partnership initiatives (2023/24)

Growing well

- Optimise and improve equity of uptake of childhood immunisations
- Development of the model of care for children and young people with complex needs through our integrated neighbourhood teams
- Support the development of family hubs with accessible services for communities
- Develop a model of virtual wards/hospital at home for children and young people

Living well

- Optimise and improve equity of uptake of screening, health checks and immunisations (all ages) providing support to stay active and healthy
- Support the design and roll-out of community mental health teams aligned to our integrated neighbourhoods
- Develop and support multi-partner initiatives (in each locality) to support those challenged by cost of living (all ages) including through community hubs
- Identify and support high intensity users and those at risk of cardiovascular disease through population health analysis and targeted interventions

Ageing well

- Deliver improvements in our urgent care system and hospital flow including the implementation of our *transfer of care* hub and virtual wards
- Develop a model of multidisciplinary support for prevention and support for those who at risk of becoming frail and who are frail
- Develop (in partnership with our South Care Partnership) and deliver upon a long-term strategy for integrated and resilient intermediate care

Implement and develop our ***integrated neighbourhood teams*** as our model of improving equity, prevention and integrated care delivery

How is our partnership responding now?

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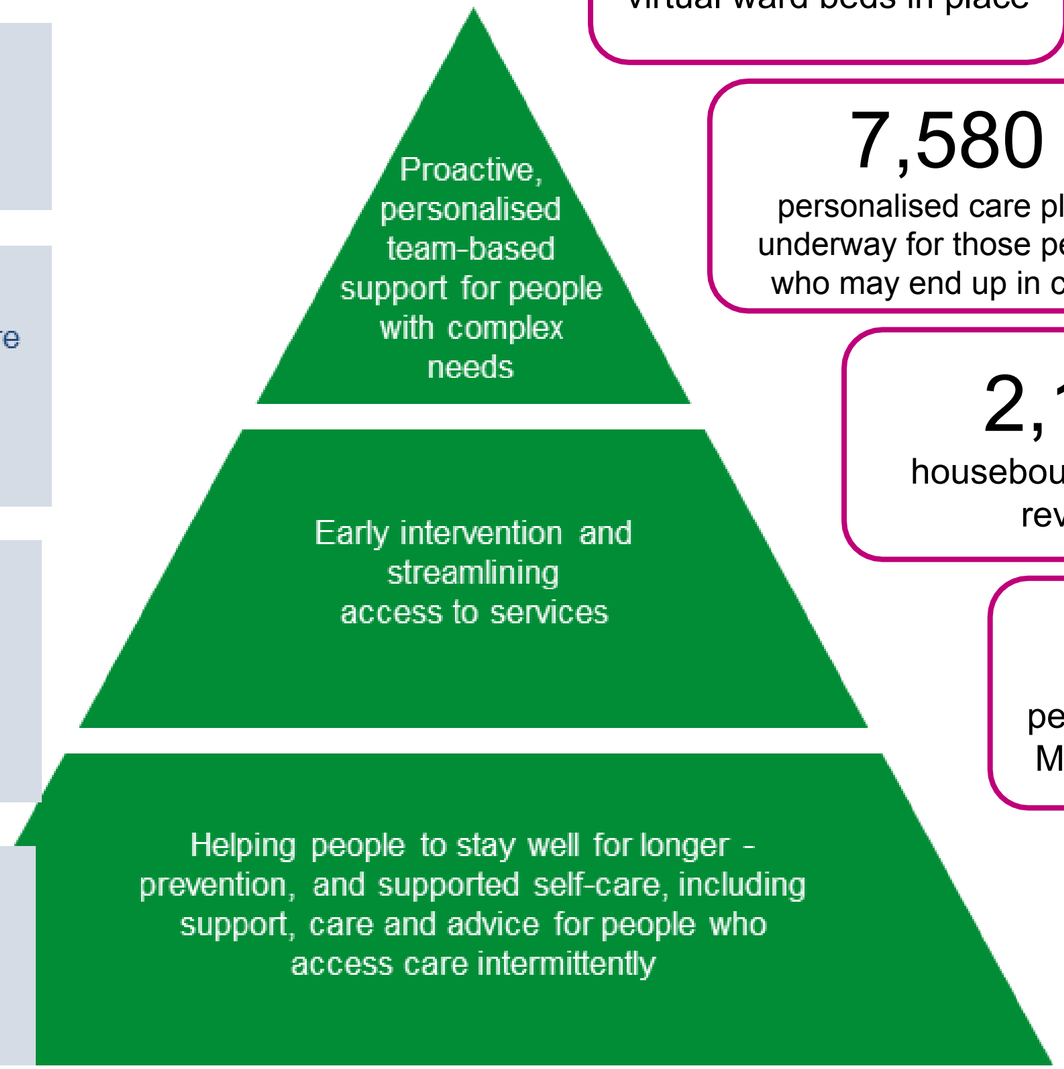
TARGETED INDIVIDUAL MANAGEMENT:
People who frequently attend unplanned health & care services

TARGETED INDIVIDUAL PREVENTION:
People likely to need unplanned support, care or emergency services frequently in next 3-6 months (if we don't offer proactive, personalised care now)

POPULATION EARLY INTERVENTION:
People likely to need unplanned support, care or emergency services in next 6-18 months (if we don't offer proactive care now)

UNIVERSAL PREVENTION / EARLY INTERVETNION:
Community prevention, screening and information sharing events



Population health management approach

185
virtual ward beds in place

7,580
personalised care plans underway for those people who may end up in crisis

2,147
housebound diabetes reviews

3,474
people on-boarded to our MyAsthma self-care app

3,183
attending our family hubs in quarter 1, 23/24

Fenland Locality – Key activities

Fenland/South Fenland Integrated Neighbourhood

Cooking at Home programme: £2,500 funding secured through Clarion Futures to run three cohorts of the programme with 30 families. The 6-week course is aimed at families (with children of primary school age) and will support in educating families on how they can cook healthy meals together on a budget whilst providing them with basic cooking and numeracy skills.

Cooking At Home Film - YouTube

Falls Prevention: A weekly Multidisciplinary Falls Prevention Service was established in 2022, within Doddington which includes:

- Multifactorial Falls Risk Assessments (Healthy You)
- FaME programme (Healthy You)
- Pre-Fit and Strength and Balance classes (Active Fenland)

Successful appreciative enquiry work undertaken with class participants at Doddington. 100% improvement in physical and mental wellbeing.

Long-term conditions: 3 GPs with extended role Specialty Leads to work across both Fenland and South Fenland PCNs:

- Cardiology (role filled)
- Diabetes (role filled)
- Respiratory (role still out to advert)

This innovative approach will allow for enhanced clinical leadership provision within the PCNs. This will support in addressing the long-term disease burden across the Fenland population using a PHM approach to effectively manage patients. There will be an improved focus on holistic care to address long-term disease burden to enable proactive management of patient care. Aim to work wider across the neighbourhood.

Fenland Locality wide – Mental Health Dementia Project

'To enhance the awareness, support and services available for people with dementia, their carers/friends and family across Fenland collaborating with Integrated Neighbourhood colleagues and wider stakeholders'.

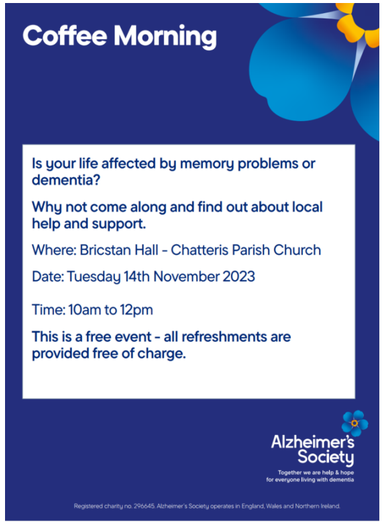
A Fenland Community Dementia Survey was created to hear from those affected by memory loss in Fenland. This includes people with Dementia, people worried about their memory loss and their carers. Three main themes identified through survey results:

1. Awareness of services and support available
2. Wider understanding of dementia in the community
3. Lack of transport

Working groups have been established to focus on the above themes.

On project initiation Alzheimer's Society clinic utilisation was 22%, this has increased to 42%, with a few individual practices meeting or nearing this target as below:

Practice	Previous utilisation (April – July average)	Current utilisation (August – September average)	% increase
Fenland Group Practice	25%	63%	38%
George Clare	0%	100%	100%
Trinity	25%	75%	50%



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Developing the Fenland Early Help Hub

North Cambridgeshire & Peterborough Care Partnership

Fenland CAMBRIDGESHIRE
Fenland District Council

Objectives

1. Increase the number of Fenland residents being connected to public and voluntary sector help and support
2. Change the profile of customers contacting the Council to reflect residents seeking help earlier to prevent issues escalating, reducing the need for higher cost interventions
3. Develop a “one team” culture between Councils, Voluntary Sector and Health teams, shaped by the principles of the trusted assessor model, reducing duplication and the need for residents to share their story repeatedly
4. Create a focal point for the public and voluntary sector to collaborate, enabling all parties who have contact with residents with support needs to share issues and learning
5. Produce a communications strategy to promote the Early Help Hub including an agreed directory of services and community assets that will be managed and maintained to support all frontline staff
6. To support residents, including those on certified sickness absence into/ back to employment and training by addressing issues and barriers to entry

Progress report

1. Project Board established with representation from partners across the system
2. Public Health funding received for set up and Phase 1 – connecting people to employment support
3. FDC’s MyFenland team to develop capacity and capability to triage hub referrals/ enquiries
4. Simple online form hosted on Fenland District Council website for partners or self-referral
5. Project to trial different methods of bringing public and voluntary sector partners together to work in a multi-disciplinary way – learning from other areas that have achieved successful outcomes
6. Planning to develop and test pathways with a view to going live for Phase 1 in June 2024

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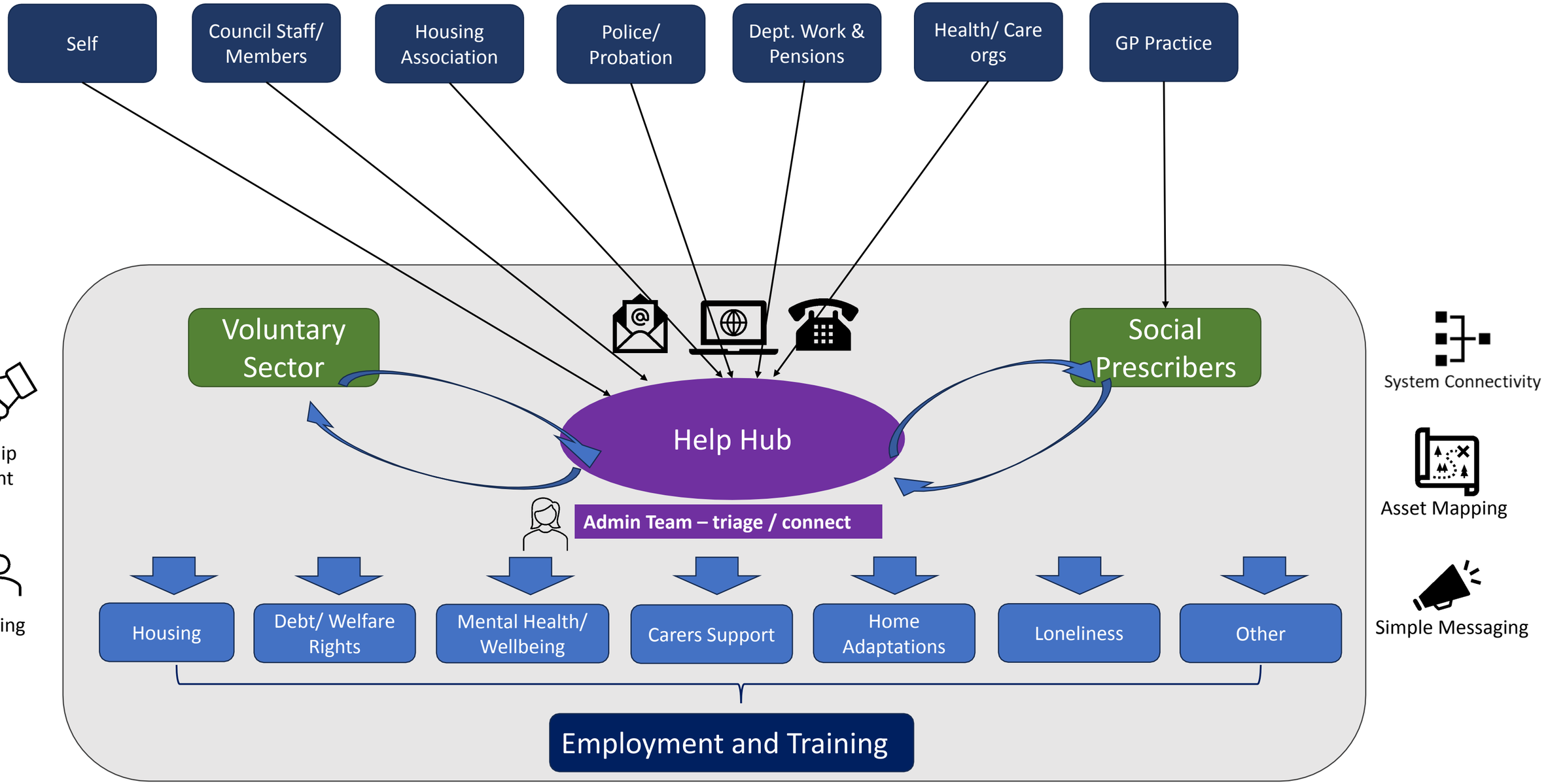
Fenland Cambridgeshire
Fenland District Council



Partnership Agreement

MDT Working

System Connectivity

Asset Mapping

Simple Messaging

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Developing the North Care Partnership and our plan for 2024/25

Population growth in North Cambridgeshire and Peterborough

North Cambridgeshire & Peterborough Care Partnership

Population growth to 2041, by age group, by locality

	15-24	75 -84	Over 85s	Total
Fenland	24.8%	70.1%	126.6%	22.7%
Hunts	16.9%	72.4%	156.6%	19.4%
P'boro	26.2%	73.6%	105.7%	17.2%

Source: Cambridgeshire & Peterborough Joint Strategic Needs Assessment, Public Health

What does this mean for our capacity?

- 27% increase in A&E attendances
- 36% increase in emergency admissions
- 52% increase in urgent care beds
- 30% increase in elective/day case activity
- 33% increase in beds for surgery

Overall (per annum):

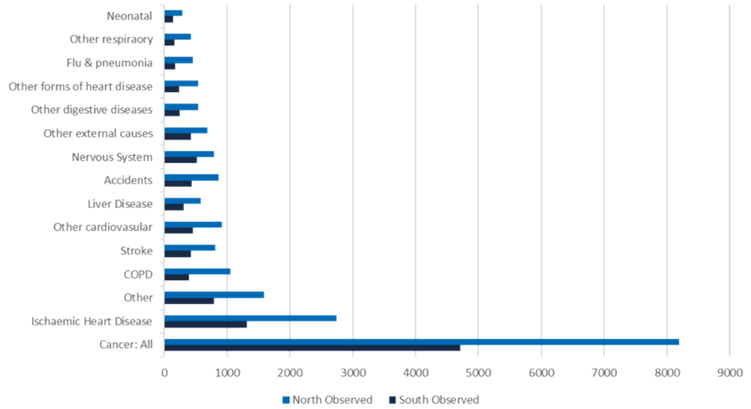
- Over 250,000 outpatient appointments
- Over 50,000 more A&E attendances
- Over 500 hospital beds

Core inputs into the work we best do together

North Cambridgeshire & Peterborough Care Partnership

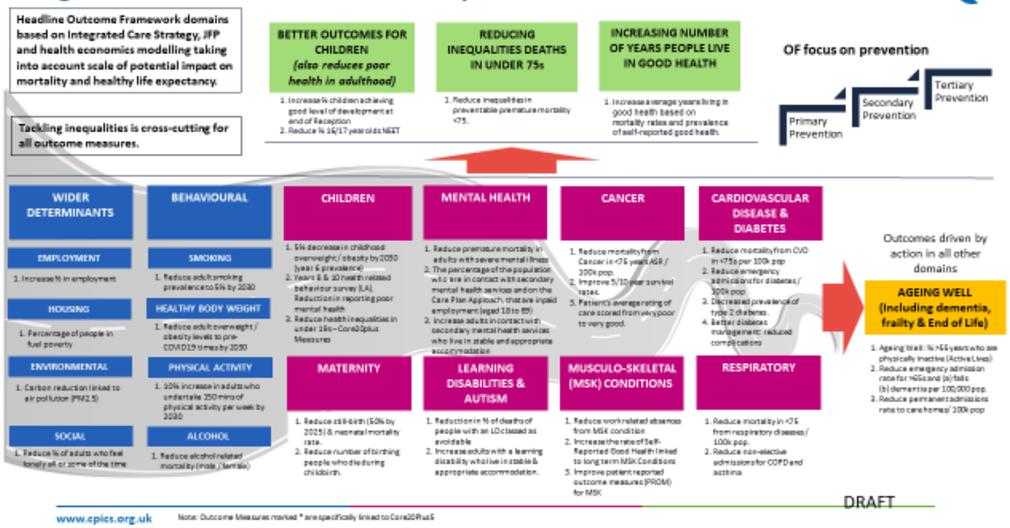
Over 1/3 of children in Peterborough living in poverty

The Joseph Rowntree Foundation has published it's latest report using figures up to 2022



Premature deaths (deaths before age 75) across Cambridgeshire and Peterborough that can be attributed to socioeconomic inequality. Source: Lewer, Dan et al. Premature mortality attributable to socioeconomic inequality in England between 2003 and 2018: an observational study The Lancet Public Health, Volume 5, Issue 1, e33 - e41 and online tool here https://public.tableau.com/profile/rob.aldridge#!/vizhome/MATI_19_11_25/MATI_dashboard

High Level Outcome Domains & Population Health Metrics (Post Workshops Draft)



Recommendations

Fast growth with more to come

All service plans need to take account of recent substantial growth and additional future growth, bearing in mind that Cambridgeshire and Peterborough have high numbers of people moving here from outside the UK.

Many overall health indicators have not improved

We should aim to turn the curve on high-level measures of health. This will require a much greater focus on prevention for all our residents, from infancy to later life. Improving health behaviour and addressing the wider determinants of health is key.

Overarching Joint Strategic Needs Assessment

Big changes to the age structure of our population

Increasing numbers of older people should encourage the whole system to focus on prevention of ill health and disease, to reduce future demands on services. This is wider than just an NHS responsibility, it requires all parts of the public sector to enable healthy living and disease prevention.

The large increases in the numbers of children in our cities, and future increases in our rural areas, needs to be recognised and planned for by all parts of the public sector; early years, education, healthcare and children's social care.

Patches of poorer health

All services across the public sector need to take account of how health and need varies across our areas, without overlooking the majority of residents who live outside the most at risk areas.

Fenland Overview

Are residents happy and healthy?

- 65% **see family and friends** as often as they would like (average 64%)
- 68% feel they have enough **free time** (average 64%)

- 38% have struggled with their **mental health** in the last year (average 37%)
- 28% often feel **lonely** (average 29%)

- 30% of parents say their child has experienced mental health problems this year (30%)
- 70% of parents feel their child has good relationships with their peers (average 69%)

- 41% report struggling with their **physical health** this year (average 40%)
- 38% report their mental or physical health has been impacted by Covid-19 (average 39%)

Cambridgeshire County Council
Strategic Framework 2023-2028

What our partners said to each other

North Cambridgeshire & Peterborough Care Partnership

Be a delivery vehicle for the ICS outcomes framework

Launch all the integrated neighbourhoods to create local engagement and infrastructure

Game changing initiatives that act decisively on the big challenges

Take on the biggest killers / drivers of inequity and poor outcomes

Do only what we do best together

Zero tolerance on areas where we should be integrated and have failed to do so

Equity is a relentless focus for us

Population and demographic change requires significant focus of this partnership

Fewer, high impact programmes

Proactive and integrated care is our core role

Potential ‘big ticket’ items for 2024/25 and beyond

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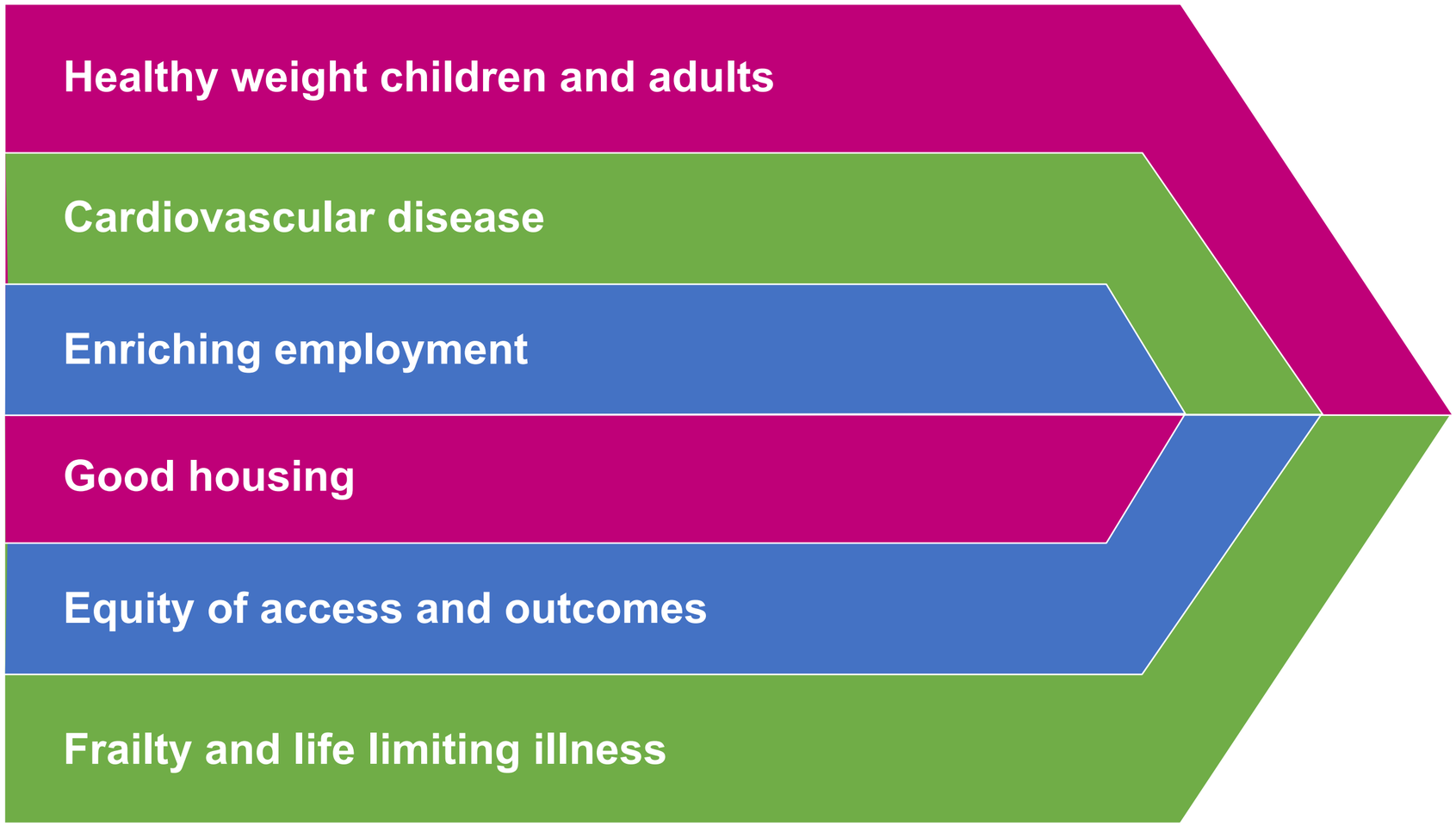

Driven through our ***integrated neighbourhood teams*** as our model of improving equity, prevention and integrated care delivery

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Questions