

# Fenland District Council - All Members Session Integrating health and care

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# Our Integrated Care System (ICS)



Is a partnership of organisations that have come together to take collective responsibility for planning services, improving health and reducing inequalities with four key aims:



- <u>Integrated care board (ICB):</u> the statutory body responsible for planning and funding most NHS services in the area
  - Allocates the NHS budget and commissions services for the population, takes over the functions previously held by CCG and some of the direct commissioning functions of NHS England.
  - ➤ Directly <u>accountable</u> to NHS England for NHS spend and performance within the system.
  - Can exercise functions through delegation to Accountable Business Units (ABUs), but the ICB remains formally accountable.
  - Operates as a unitary board.
  - Accountable for the <u>Joint Forward Plan</u> that sets out how we and our partners will achieve our commitment to deliver a positive change.
- Integrated care partnership (ICP): the statutory 'committee in common' with the Health & Wellbeing Board that brings together a broad set of system partners (including local government, the voluntary, community and social enterprise sector (VCSE), NHS organisations and others) to develop an Integrated Health and Wellbeing Integrated Care Strategy.

# Partnership Working





#### North Place-based Partnership

#### Population 574,807

#### **Partnership**

- Cambridgeshire and Peterborough Health and Wellbeing Board
- Cambridgeshire and Peterborough NHS Foundation Trust
- Cambridgeshire Community Services NHS Trust
- Cambridgeshire County Council (4)
- East of England Ambulance Service NHS Trust
- Fenland District Council (2)
- Healthwatch Cambridgeshire and Peterborough
- Huntingdonshire District Council (3)
- Cambridgeshire LMC (Local Medical Committee)
- North West Anglia NHS Foundation Trust
- Parish councils
- Peterborough City Council (1)
- 12 Primary care networks
- Royal Papworth Hospital NHS Foundation Trust
- Voluntary community and social enterprise sector.

#### **Urgent Care**

- Addenbrookes Hospital A&E
- Hinchingbrooke Hospital A&E
- Peterborough City Hospital A&E
- Ely Minor Injuries Unit
- Doddington Minor Injuries Unit
- North Cambridgeshire Minor Injuries Unit (MIU)
- Peterborough Urgent Treatment Centre (UTC)
- St Neots Walk-in Centre.
- · City Care Centre, Peterborough
- · Elizabeth House, Fulbourn.



## Cambridgeshire & Peterborough Integrated Care System



## South Place-based Partnership

#### Population 422,900

#### **Partnership**

- Cambridgeshire and Peterborough Health and Wellbeing Board
- Cambridgeshire and Peterborough NHS Foundation Trust
- Cambridge City Council (6)
- Cambridgeshire Community Services
   NHS Trust
- Cambridgeshire County Council (4)
- Cambridge University Hospitals NHS Foundation Trust
- East Cambridgeshire District Council (5)
- East of England Ambulance Service NHS Trust
- Healthwatch Cambridgeshire and Peterborough
- Cambridgeshire LMC (Local Medical Committee)
- Nine Primary Care Networks
- · Parish councils
- Royal Papworth Hospital NHS Foundation Trust
- South Cambridgeshire District Council (7)
- Voluntary community and social enterprise sector.

- Two upper tier local authorities: Cambridgeshire County Council and Peterborough City Council
- Five district councils: Cambridge City Council, East Cambridgeshire District Council, South Cambridgeshire District Council, Fenland District Council, and Huntingdonshire District Council
- Three hospital providers: North West Anglia NHS Foundation Trust (NWAngliaFT), Cambridge University Hospitals NHS Foundation Trust (CUH) and Royal Papworth Hospital NHS Foundation Trust (RPH)
- Two community providers: Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) and Cambridgeshire Community Services NHS Foundation Trust (CCS)
- One Mental Health provider: Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
- **East of England Ambulance Service** NHS Foundation Trust (EEAST)
- 89 (this number can vary) **GP practices**
- Cambridgeshire Local Medical Committee (LMC)
- Mealthwatch Cambridgeshire and Peterborough
- Cambridgeshire and Peterborough Health and Wellbeing Board
- **Other partners** including parish councils, voluntary, hospices, community and faith organisations.

# Who is in our partnership?



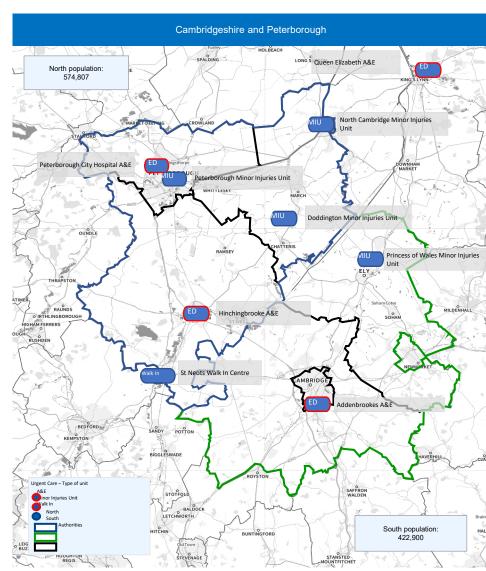
Our partnership is composed of NHS providers, County and District Councils, Healthwatch, voluntary community and faith sector partners.

# 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



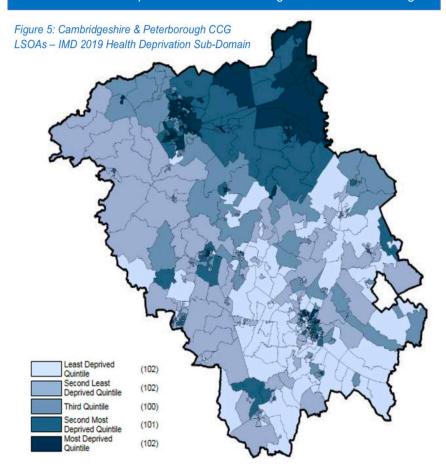
# Diversity and inequity of outcomes



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.

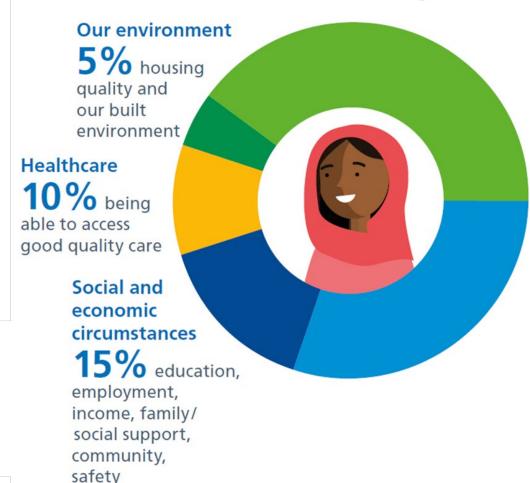
2019 IMD Health deprivation across Cambridgeshire and Peterborough



# Finding non-traditional solutions to improve outcomes



## Which factors impact your health?



Our behaviours 40% smoking,

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



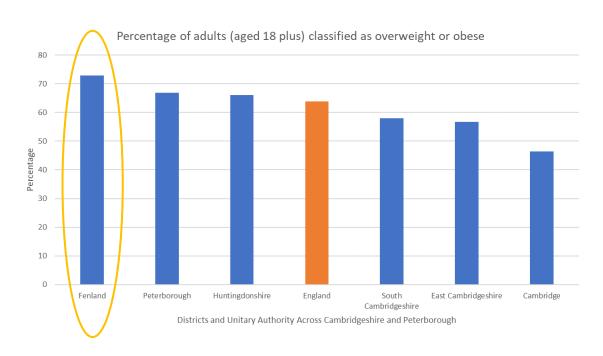
# Responding to Fenland's challenges



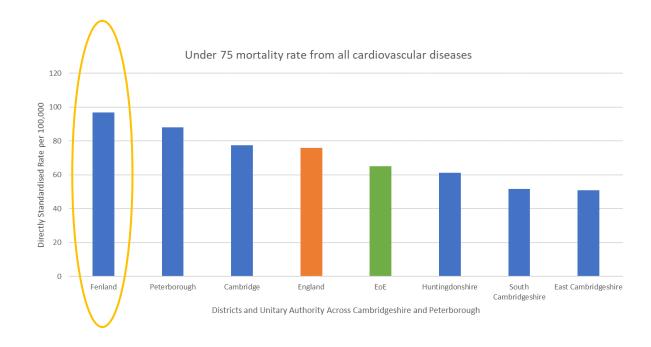
## **Benchmarking Outcomes**



### Obesity



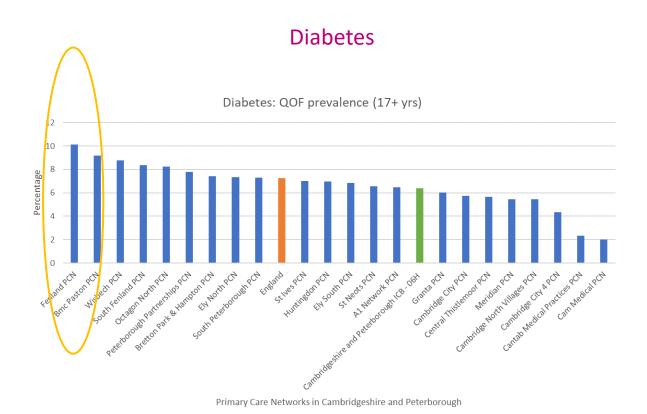
#### Cardiovascular Disease

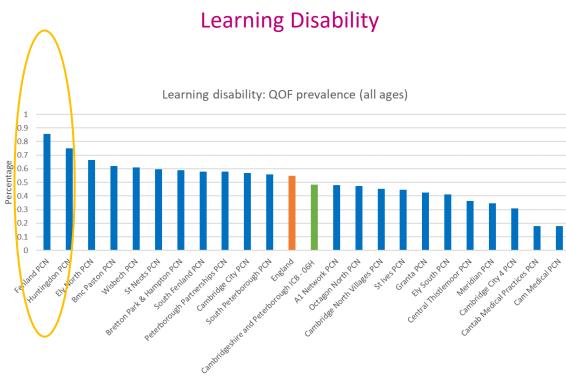




## **Benchmarking Outcomes**







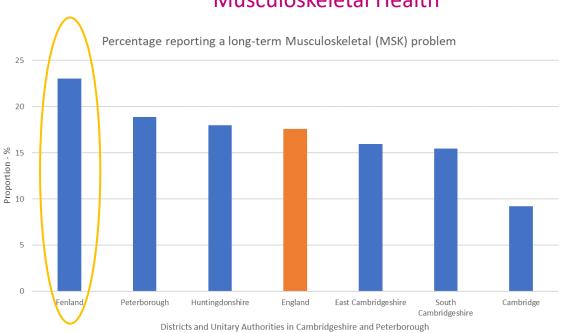
Primary Care Networks in Cambridgeshire and Peterborough



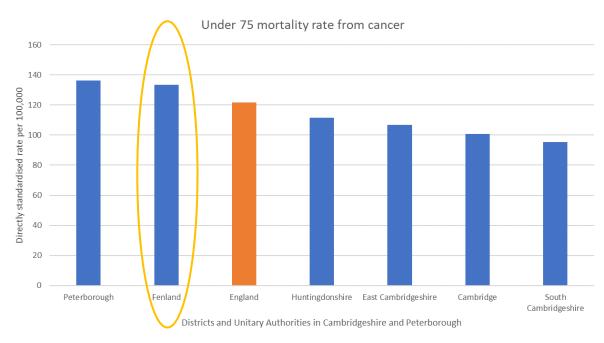
## **Benchmarking Outcomes**



#### Musculoskeletal Health



### Cancer





## Taking a more local approach to designing & providing care

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Integrated Neighbourhood (IN) Level



Start closest to the person

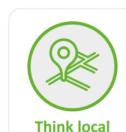
**Place Level** 



Only things that can't be done at IN level will be at Place level Integrated Care System Level



Only things that can't be done at IN or Place level will be done at ICS level



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



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



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



Use evidence to show the impact of

what we are doing.

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## **Concept of an Integrated Neighbourhood**





# Concept of Integrated Neighbourhoods

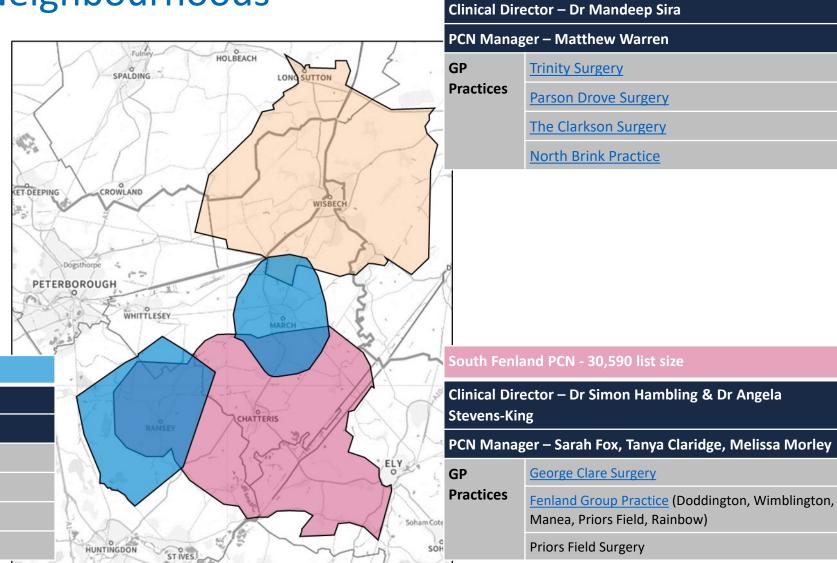


Integrated Neighbourhoods aim to bring together all the local health and care partners to work collaboratively in a coordinated way with the local population, tailoring the support they provide to meet the needs and challenges of the local communities so local people can live healthier and happier lives.

- Opportunity to work together differently, in a truly integrated way, providing holistic and seamless care for your local population
- Build relationships with a wide range of local partners and break down barriers so that the care people receive will be more efficient and well-coordinated, even if it may involve different agencies
- Goes beyond just health, to consider all those factors that help the local people live happy and healthy lives
- Opportunity to focus efforts and target those areas that are important in your local communities, taking full consideration of the issues in your locality or needs of the local people
- It is a culture and new way of working so will take time to develop, evolve, and embed this new approach

## Fenland Integrated Neighbourhoods

Total list size of 112,821 (as of February 2024)



Wisbech PCN - 51,115 list size

Fenland PCN - 31,116 list size

Clinical Director - Dr Nazia Ulla

Ramsey Health Centre

The Riverside Practice

The Cornerstone Practice

Mercheford House Surgery

PCN Manager – Abbi Kendall

GP

**Practices** 

## Fenland Locality IN Board Members













Healthy You





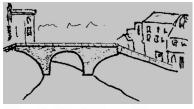






















Ramsey Health Centre



Wisbech Primary Care Network

## Fenland/South Fenland Neighbourhood Projects



#### Prevention – Children and Young People

North Cambridgeshire & Peterborough Care Partnershi

#### Ramsey area Cooking at Home course

19 October - 23 November 2023

This course provides families the opportunity to cook healthy and simple meals together, on a budget. Designed to be a fun. hands on experience for the whole family by discovering new meals, skills and techniques.

Once the course has finished families will receive a free food voucher



Cooking at Home programme: £2500 funding secured through Clarion Futures to run three cohorts of the programme with 30 families. The 6-week course was aimed at families (with children of primary school age) to support in educating families on how they can cook healthy meals together on a budget whilst providing them with basic cooking and numeracy skills.





#### Prevention – Long Term Conditions

**Long-term conditions:** 3 GPwER (GP with extended role) Specialty Leads to work across both Fenland and South Fenland PCNs:

- Cardiology
- Diabetes
- Respiratory

This innovative approach allows 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.

#### Prevention – Frailty

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

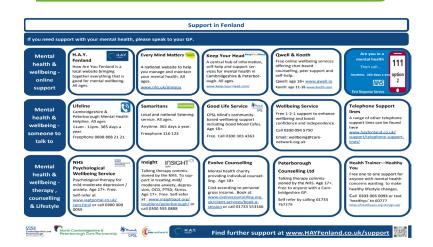
- Multifactorial Falls Risk Assessments (Healthy You)
- FaME programme (Healthy You)
- Pre-Fit and Strength and Balance classes (Active Fenland)

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

## Wisbech Integrated Neighbourhood Projects



#### Adult Mental Health and Waiting Well



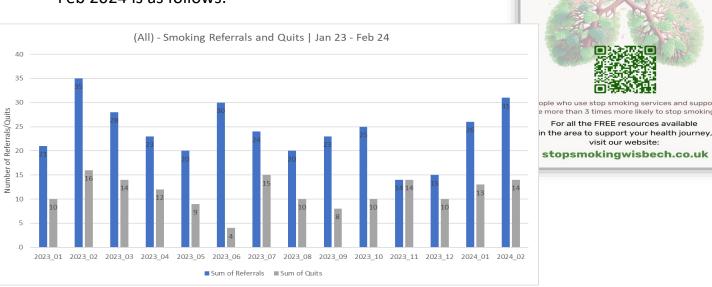
Wisbech Mens Health and Wellbeing Event Tickets, Sat, Jun 15, 2024 at 10:00 AM | Eventbrite



#### **Smoking Reduction**

The Wisbech Integrated Neighbourhood have developed an engaging campaign to support patients to stop smoking in Wisbech and surrounding villages, 1 in 4 of the population of Wisbech smoke. Further information on the support available is on https://www.stopsmokingwisbech.co.uk/

Healthy You Stop Smoking clinics commenced January 2023 for all 4 practices in Wisbech. Number of referrals/quits from January 2023 to Feb 2024 is as follows:



Watch the stop smoking campaign



onle who use stop smoking services and suppor e more than 3 times more likely to stop smoking! For all the FREE resources available

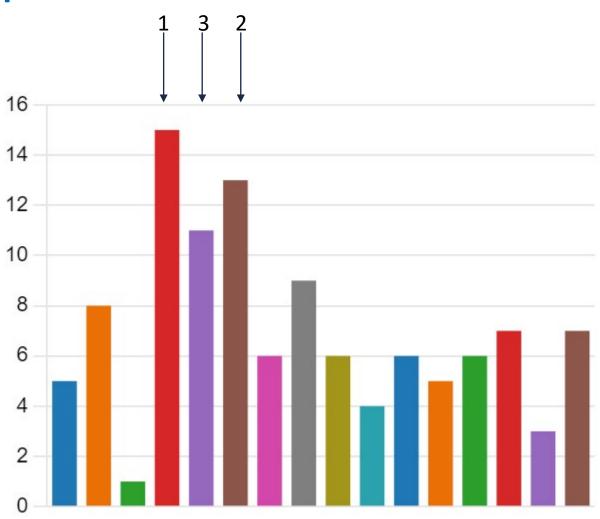
stopsmokingwisbech.co.uk

# Wisbech IN 24/25 priorities



26 responses received, 46% response rate

- Proactive detection of high bloo... 8
- Cancer awareness
- Mental health
  15
- Obesity 11
- Reducing isolation and loneliness 13
- Heart disease and stroke preven... 6
- Men's health



## Fenland Locality wide Projects

#### 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

Two working groups have been established to focus on the above themes.

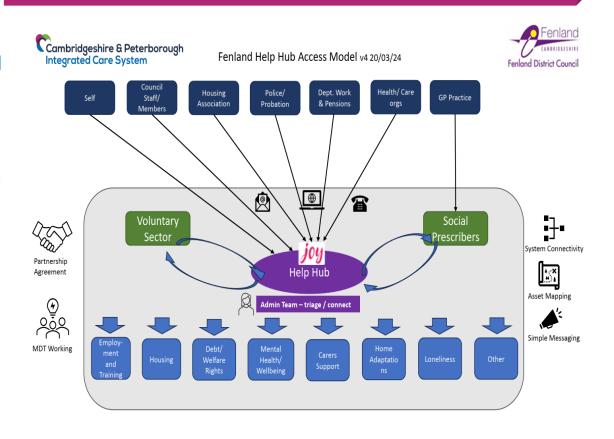
On project initiation Alzheimer's Society clinic utilisation was 22%, this has increased to 50.5%, with a few individual practices meeting or nearing target set as below:

Practice	Previous utilisation (April – July average)	Current utilisation (August – March average)	% increase
Fenland Group Practice	25%	78%	53%
George Clare	0%	83%	83%
Ramsey	25%	81%	56%



#### Prevention - Early Help Hub

'The multi-agency Early Help Hub connects Fenland residents to help and support when they first need it. Helping people to access their own capacity to thrive. '





Our plan for 2024/25



## Delivering on our Integrated Care System priorities



Have better outcomes for our children

Reduce inequalities in deaths under 75 years

ambitions

Health and wellbeing

Increase the number of years that people live in good health 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

System priorities

Integrated Care

Reduce poverty through better employment, skills and housing

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

Healthy weight children and adults

Cardiovascular disease

**Enriching employment** 

**Good housing** 

North Care Partnership 'big ticket' initiatives

Equity of access and outcomes

Frailty and life limiting illness

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

## Our plan for 2024/25



#### Healthy weight children and adults To reverse the rising trend of overweight and obese children and including approaches on: Food and culture; Physical activity; Environment and neighbourhood; and Prevention and support **Healthy weight** children and adults Cardiovascular disease Equity of access and outcomes Equity and outreach service (including Proactive identification of people with but not limited to): cardiovascular risk including high CVD blood pressure, cholesterol, pre-Equity of access and Health checks Cardiovascular disease diabetes, diabetes, AF outcomes **Immunisations** Lifestyle changes (e.g. smoking Cancer screening cessation) Damp / cold housing Type 1 diabetes model redesign Develop a model of care for children with Our initiatives for complex needs **2024/25** and beyond **Enriching employment** Frailty and life limiting illness Develop a person-centred approach People with high intensity use of care underpinned by coordination between services health professionals, employment Virtual wards and CB4UC Frailty and life **Enriching employment** specialists and employers. Proactive frailty MDTs limiting illness Optimising the role of our anchor Frailty response service institutes in recruitment, retention and

**Good housing** 

#### Good housing

Proactive identification and prevention of homelessness

training opportunities for local people

Model of integration for housing and health/care services to support 'at risk' and vulnerable people.

- Physical activity levels for older people
- Develop a model for discharge to assess
- Long term planning on intermediate care

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



