Cambridgeshire and Peterborough
Integrated Care System

Meeting Minutes - STP Board Meeting – IN PUBLIC	
Meeting:	**System Partnership (STP) Board**
Date and Time:	**31 March 2021 at 2.15 pm**
Venue:	**Virtual Meeting by MS Teams**

Attending Members:		
Cllr Anna Bailey (AB)	Chair of Adults Committee	Cambridgeshire County Council
Gary Howsam (GH)	Clinical Chair	Clinical Commissioning Group
James Morrow (JM)	GP/Co-Chair South Alliance	Granta
Jan Thomas (JT)	Chief Officer	Cambridgeshire and Peterborough Clinical Commissioning Group
Julie Spence (JS)	Chair	Cambridgeshire and Peterborough NHS FT
Katie Bramall-Stainer (KB)	Chief Executive	Cambridgeshire Local Medical Committee
Dr Raj Lakshman	On behalf of Liz Robin, Director of Public Health	Cambridgeshire & Peterborough
Mary Elford (ME)	Chair	Cambridgeshire Community Services NHS Trust
Matthew Winn (MW)	Chief Executive	Cambridgeshire Community Services NHS Trust
Julie Farrow (JF)	Chief Executive	Hunts Forum
Michael More (MM)	Fixed Term Non-Executive Chair	
Rob Hughes (RH)	Chair	North West Anglia NHS FT
Roland Sinker (RS)	Interim STP Accountable Officer	
Stephen Posey (SP)	Chief Executive	Royal Papworth Hospital NHS FT
Tracy Dowling (TD)	Chief Executive	Cambridgeshire and Peterborough NHS FT
Alex Gimson (AG)	Chair	Joint Clinical Group
Wendi Ogle-Welbourn (WO-W)	Corporate Director	Cambridgeshire County Council and Peterborough City Council

Piers Ricketts (PR)	Chief Executive	Eastern Academic Health Science Network
Val Moore (VM)	Chair	Healthwatch Cambridgeshire & Peterborough
Carolan Davidge (CD)	Non-Exec Director	East of England Ambulance Service
Neil Modha (NM)	GP/ Co-Chair North Alliance	Greater Peterborough Network
Prof John Wallwork (JW)	Chairman	Royal Papworth Hospital NHS Foundation Trust
In attendance:		
Louis Kamfer (LK)	Chief Finance Officer	Cambridgeshire and Peterborough Clinical Commissioning Group
Kit Connick (KC)	Director of Corporate Affairs	Cambridgeshire and Peterborough NHS FT
Sharon Fox (SF)	Director of Governance	Cambridgeshire and Peterborough Clinical Commissioning Group
Julian Huppert (JH)	Chair of the System Wide Ethics Committee CCG Deputy Chair	Cambridgeshire and Peterborough Clinical Commissioning Group
Apologies:		
Kanchan Rege (KR)	Medical Director	North West Anglia NHS FT
Cllr Wayne Fitzgerald (WF)	Deputy Leader and Cabinet Member	Integrated Adult Social Care and Health, Peterborough City Council
Tom Davis (TDa)	Acting Chief Executive	East of England Ambulance Service NHS Trust
Arshiya Khan (AK)	Co-Chair	North Alliance
Dr Liz Robin (LR)	Director of Public Health	Cambridgeshire County Council and Peterborough City Council

1. Welcome and Introductions

Mike More, Fixed Term Non-Executive Chair (Chair) welcomed everyone to the System Partnership Board (Board) meeting in public.

2. Apologies for absence

Apologies for absence were received from Arshiya Khan, Kanchan Rege, Councillor Wayne Fitzgerald, Tom Davis, and Dr Liz Robin.

The Chair welcomed back Matthew Winn to the Board after his national work during the Covid-19 pandemic.

3. Declarations of interest

There were no declarations of interest related to the agenda.

4. Minutes of the Last Meeting

The minutes of the last meeting of the System Partnership Board meeting held in public on 23 November 2020 were agreed as a correct record.

5. Matters Arising / Action Log

The Board received the Action Log which was updated and is appended to the minutes.

6. Notification of Any Other Business

There was no notification of Any Other Business.

7. Update on Covid-19

Jan Thomas gave an update on the Covid-19 response and the delivery of the Mass Vaccination Programme. She advised the Board that there was a considerably tired workforce across all sectors who had given their all to the Covid-19 response and the Mass Vaccination Programme, both of which were continuing. There was good progress on the delivery of the Vaccination Programme in line with the JCVI cohorts 1-9 and national instruction on Cohort 10 was awaited. In relation to the over 80s, second doses of the vaccine had now been given to just over 80% of the local population. This was really important in fighting the Covid-19 disease. She added that it was a massive team effort, and she could not think of one area of the system that had not gone above and beyond. There had been significant flexibility shown by all to step up and there had been phenomenal innovation in primary care. Work to refine the data analysis to support the continued response. Dr Liz Robin commented on the success of the Vaccination Programme and the positive impact this had had on the most vulnerable residents. In relation to the local epidemiology, she advised the Board that over the course of lockdown, some of the issues that the system was concerned about in terms of wider health inequalities were coming to the fore such as vulnerability and Covid-19 transmission since the country locked down in early January. There continued to be higher rates of Covid-19 per 100k in some areas, however, in areas which were more prosperous and where people could work at home, there had been a faster fall in cases. She highlighted the issues around enduring transmission in Peterborough and Fenland where lockdown had not been as effective as other parts of the country. In terms of the current position, the England average for cases per 100k was 56: in the East of England this was 44. In Cambridgeshire, it was currently 50. In Fenland and particularly in Wisbech there were currently 83 cases per 100k and this was better than a week ago. Peterborough was currently reporting 112 cases per 100k. In contrast, South Cambridgeshire was reporting 29 cases per 100k. These variations were being investigated in detail and there were a lot of factors influencing the position. Peterborough and Fenland were being supported by the Covid 19 Cabinet Office Field Team. Dr Liz Robin added that it was quite clear what was happening in areas such as

Fenland where people had to go out to work in frontline jobs such as agriculture, food processing and distribution. These factors were being built into the enduring transmission work. Dr Gary Howsam commented on the truly remarkable system response and thanked Jan Thomas for her leadership of the system response over the last year. He acknowledged that there was still a long way to go. Anna Bailey added her congratulations and thanks to NHS staff, care staff, volunteers and other partners who had supported the role out of the mass vaccinations programme. She said that there had been nothing but praise from residents. It was a truly remarkable effort.

The Chair thanked Jan Thomas and Dr Liz Robin for their report. The Board **noted** the Covid-19 update.

8. STP Executive Lead Update for System Partnership Board

The Board received the STP Executive Lead Update. Jan Thomas advised the Board that the purpose of the report was to provide an update on key issues in relation to the Sustainability and Transformation Programme's transition to an Integrated Care System (ICS). It also provided a brief update on other issues for the Board's attention. Jan Thomas said she would not repeat the content of the paper, which she would take as read. She said she was delighted that Cambridgeshire and Peterborough had now received official approval for the system to progress to an ICS from 1 April 2021. At the same time, looking at our ICS, and adapting this to the expectations set out in the White Paper would be a significant challenge and it was important to continue to build on the principles of subsidiarity in the provision of care. This needed to be reflected in the 2021/22 Operational Plan and these would be heavily inclusive of all the system's recovery areas to restore the services that had to reduce during the Covid-19 Pandemic. She also welcomed that Kit Connick who had joined the Executive Team to lead the transition as Director of Strategy and Planning, and Graham Wilde who had taken an interim post with the ICS to provide bandwidth and significant operational experience around the recovery and restoration programme. Roland Sinker added that it would be helpful for the Board to receive an overview of the Operational Planning Guidance and what the next six and twelve months would bring based upon the shape of the operating framework. Louis Kamfer advised the Board that the Guidance had been published last week alongside receipt of the financial envelope for the system. The Guidance included the need to complete several technical templates, with most of returns due in draft on 6 May 2021, with final submission in early June 2021. There was a significant amount of work required to finalise the draft Plan over the next five weeks and this work would be supported by Carnal Farrar who were currently assessing the baseline, what had changed and how far the system was away from the Long-Term Plan (LTP) forecasts alongside the Covid-19 response. He added that the process of recovery and restoration would take significantly longer than the last 12 months and it was important to assess the LTP priorities and what do we need to prioritise in terms of reduced capacity. Graham Wilde had now started in his interim role and was helping to work through from an operational planning perspective, alongside Chief Operating Officers from across the system. A workshop had been planned for the middle of April 2021 to assess key priorities. Louis Kamfer added that the Regulator required a plan made up of two halves. This would recognise the ongoing Covid-19 response, delivery of the Mass Vaccination Programme and reset and restoration. The second half of the year would be more around delivering efficiencies but overall was seen as a 12-month planning process.

Jan Thomas said that she acknowledged that the planning guidance was an NHS health document with six key priorities which were supporting the health and wellbeing of our

staff and taking continued action on recruitment and retention; the continued focus on Covid-19, including the vaccination programme, future planning and maintaining excellent practice around infection prevention and control; accelerating the restoration and recovery of non-Covid activity, 'building back better' in a way that robustly addresses health inequalities; expanding primary care capacity to improve access, experience and outcomes; and redesigning community and urgent/emergency pathways. These key priorities needed to sit alongside the requirements from the Regulator which had been established alongside the ICS application and included the need to address finance, regional clinical leadership, workforce, provider collaboration and Local Authority engagement. She added that there were some synergies in both areas and there was a need to ensure that we provided significant and specific focus on elective cancer and mental health services and ensure we continued to expand primary care access and reduce health inequalities. This needed to be in the mindset of an ICS going forward and the challenge had been laid down around future working. The Chair said he agreed that there was a big change in moving to an ICS. He said that the Operational Planning guidance had a very heavy emphasis on working and solving issues as a system. He acknowledged that population health was as important as health delivery and a shared ambition for the whole system. There would be a need for profound and positive change over the coming years. There would be significant challenge next year as we moved to full ICS.

Piers Ricketts commented that the NHSE/I Regional Team had indicated the need for radical recovery and the pressures that had been referred to were significant. Some ideas about how to resolve backdated waiting lists were key to delivery and he anticipated that the workshops planned would be shared and would feed into the overall Operational Plan being developed by the ICS and supported by Carnall Farrar. This included the change in emphasis to health equality rather than health inequality, building on the conversation that the Chair had raised in terms of solving issues. He added that there was a need to be clear around the role of Graham Wilde in supporting the restoration and recovery work and how this would make a difference and how the system would support him. Jan Thomas commented on the previous experiences of recovery and said that Graham Wilde would take an oversight role and use his experience of being a provide Chief Operating Officer to the table in delivering the recovery plan. He had a breadth of experience working with different communities and it was helpful to have a senior operator overseeing system delivery. There was a need to challenge all our groups to ensure that delivery was the number one priority in the short term. Rob Hughes said that this was a good appointment, and he could see the need for the role. The test would be to establish how we acted as Board and work mutually to deliver on the key priorities. Dr Katie Bramall-Stainer commented on the recently published planning guidance and the requirement to expand primary care capacity. There was clearly a conversation on Operating Framework to be had and to acknowledge that the strategy would come from the Primary Care Networks and the wider system strategies. She commented on the availability of Section 106 funding and expectations around capital. She said she understood that the larger schemes were important but there was a need to acknowledge the local communities and consider initiatives such as community diagnostic hubs. She suggested that this needed to be weaved into the next steps. Caroline Walker commented on the Operational Planning Guidance and said she was pleased to see the six top priorities and it was important to acknowledge that this was not just about waiting lists. The system would be holding everything together and the route for investment and improvement was to deliver on the six priorities. Jan Thomas commented on the need to acknowledge the sheer volume of work being undertaken in primary care alongside delivery of the Mass Vaccination Programme.

There would be continued investment going in the short term but there was a need to look beyond covid to the skills and capacity that was required in primary care. She reminded the Board of the clear ambitions of the Cambridgeshire and Peterborough LTP around moving care into the community. This would need to dovetail to the ICS Development Plan. There was a need to consider the future approach and the wider balance around investment, and link this in with governance and priorities and ensuring that things were done at the right time. She added that there was a need to acknowledge that there was one CCG and one set of statutory responsibilities and there needed to be an effective safety net to deliver going forward. Roland Sinker commented that at the heart of delivery was the LTP and there was a need to dovetail this into the recovery framework. Some areas had already made good progress and there was a need to go quicker faster. A big test would be to understand how to allocate our collective resources to support care close to home. On capital, he added that the Framework for the NHS was still under development. He added that the system had done an effective job on hospital care but there was a need to shift the balance to work on out of hospital care and to determine how to allocate the capital to support this. It was not a case of just shifting assets and workforce but to look differently about delivery of care in the future. The Chair said that thinking about the previous comments regarding enduring transition there was a need to be sensitive to health outcomes and how this connected to employment patterns and other issues. He said he was not sure that as a health system we had been as coherent or strong enough in our conversations with the Local Authority on economic impacts on health and how this might link in – including 106 funding. This should improve as we moved formally to an ICS.

Dr Gary Howsam said the task of the Partnership Board was to think creatively and to challenge the assumptions about the approach otherwise there was a risk of activity driven by measurement rather than by need for patients and the population. He added that accelerating the restoration of non-Covid-19 activity was essential and there also needed to be a strong on focus where no harm has occurred or potentially opportunity harm done by intervention or doing things in a different way. He said that staff needed a chance to recover but there was also a need to expand capacity and access in primary care. This could come at the cost of continuity increasing patient experience and outcomes. He added that the Anglia Health Sciences Network was vitally important to the Cambridgeshire Biomedical Campus assets and the University and there was a need to make sure we worked with colleagues outside boundaries of Cambridgeshire and Peterborough as well.

Val Moore commented on the role of the Health and Wellbeing Board which was not currently meeting as a core group. She also highlighted the role of the Integrated Commissioning Board. She said that there was still a need for these various groups and bodies to meet in the interim, as financial planning and decision-making was proceeding. There was a need to acknowledge the Health and Wellbeing Board's duty of oversight and discussions regarding forward planning were essential. Jan Thomas highlighted the Health Inequalities Strategy and the role of Joint Strategic Needs Assessments going forward. She said there were multiple different plans in train and there was a big piece of work required to consolidate this further. Dr Liz Robin said the Health and Wellbeing Board had not been meeting due to the heavy Covid-19 workload and the Local Outbreak Board had been meeting monthly – prioritized over business as usual. Health and Wellbeing Board meetings would recommence after the local elections and the Health and Wellbeing Strategy was ready for consultation before Covid-19 hit. She said there was a need to resurrect this and ensure that it was fully integrated with the ICS. – The Chair highlighted the importance of brining this

together. The Board **noted** the Joint Executive Lead update. The Board **acknowledged** NHSE/I's approval of our application to become an Integrated Care System. The Board **acknowledged** the key areas of focus that NHSE/I have set out to support our Development Plan, and our associated Road Map set out at Appendix A to the paper. The Board **formally thanked** Dr Liz Robin, Dr Chess Denham, and Councilor Anna Bailey for their contribution to the STP since its inception in 2016.

9. Workstreams

The Board received and **noted** a short paper updating on the progress with the Digital Workstream. Stephen Posey, System Lead advised the Board that the work to date was a credit to Andy Raines who was Chair of Digital Enabling Group and the whole team including Adrian Chamberlain Non-Executive Director at Cambridge University Hospitals NHS Foundation Trust. He said that the workstream benefited from senior leadership focus and there were a number of achievements to celebrate including the Shared Care Record with the procurement process concluded. A minimum viable system would be in place from September 2021 with sharing of data across a number of partners. This was an extremely complex programme of work which required digital maturity and robust information governance standards. He added that extensive work was planned to ensure all organizations could connect to Shared Care Record. This was a collaborative endeavor with all system leaders undertaking to discuss the Shared Care Record within their own organizations and commit resources to make it happen. Secondly, the virtual consultation programme – Attend Anywhere – would realise tens of thousands of appointments. The Digital Group and FPPG was working on a long-term solution for the county. The third area was focused on addressing cyber risk and resilience which was very relevant in joining up all our systems. Stephen Posey concluded that the progress to date was as a result of excellent engagement and the deliberate focus on a smaller number of priorities.

The Board discussed the Digital Workstream progress. The Chair thanked Stephen Posey for his leadership of the programme. Dr Katie Bramall-Stainer said that the Shared Care Record was a monumental piece of work which was led really well by Andy Raines. She suggested that for the next Digital Update there should be a focus on the significant number of tools and digital initiatives being used in general practice. She said this was also a big piece of the story and she would like to pay credit to CCG colleagues for the work they had initiated to improve general practice systems. Mary Elford asked about health informatics and data and which workstream this fitted into. She said a number of ICSs were doing a huge amount around health inequalities and focusing on areas where particular families were provided with a whole range of social care in a coordinated and productive way in Liverpool. Rob Hughes commented on the significant work progressed and he commented on the need for clear understanding of the risk section of report and understanding the mitigations required. Stephen Posey said that every organisation has its own standards to address. What would slow the approach down would be if partners did not move at the same pace along the pathway. It was so important that system leaders worked with their respective leads to progress the shared care project and to build on the strengths that had been demonstrated to date**.**

Dr Liz Robin said she was excited about the population health management and whole system approach to this. It was her ambition to engage with the ICS and with the Board to progress this as soon as possible. Significant progress had been made demonstrated on the good ways of working on Covid surveillance and there had been very strong

inputs across the CCG Business Intelligence and Local Authority public health and wider functions. She looked forward to this being strengthened even further in the coming months.

The Chair commented on the need to provide more transparency and focus on digital enablers going forward. Jan Thomas commented on the rapid evolution in primary care with technology off the scale. She said there was a need to understand this in the widest sense and to acknowledge the progress. Dr Liz Robin added that the covid system report was a good example of providing data across the system, supporting leaders to make the right operational decisions and this would be essential going forward. Jan Thomas added that there was one CCG performance report which provided a system wide view across all partner organisations and it would be helpful to present this going forward. There was a need to building on what we have, taking a population health approach and building on tools such as Eclipse. There was more to do to ensure that what was available and the system work on population health management national programme wave 3 was really important.

The Board also received and **noted** a short update on Workforce and OD. The Chair said that the paper gave a clear overview of the work within local People Board – really broad in the healthcare system. Tracy Dowling, Workforce Lead said the presentation gave a clear sense of progress over the last year in particular and set out the system wide response to the People Plan, key priorities for the workstream and workforce supply, together with the need to focus on the health and wellbeing of our staff. She said there was excellent work in organisations across the whole health and care system. She acknowledged that the workforce was under particular strain and stressed the importance of leadership and organisational development. She highlighted a number of system wide programmes that had been funded and sponsored to develop system leadership skills and capabilities, bringing people together to learn together. The work on equality diversion and inclusion was progressing well with a number of funded programmes for BAME staff. There was a need for positive action and this was linked to the People Plan. A number of workforce metrics being used highlighted the progress to date and the hot spots. The presentation also started to ask the key questions about what workforce changes needed to happen as we progressed to becoming an ICS. She said that changes were significant on how we would develop workforce across the system providing lifetime opportunities for staff. She said that collectively the ICS would employ over 30k people. Highlighting Slide 7 of the presentation, Tracy Dowling said there were a number of questions posed and some clear examples of what was needed if we wanted to get much better at workforce planning and development to align workforce to reflect needs of population rather than traditional workforce planning. There was a piece of work underway to seek views on the four questions at the bottom of the slide. A Sub-Group of system leaders was meeting to explore these and seek responses, before collating views and presenting them back to System Leaders. The Chair said that the approach planned was very helpful. Julie Farrow commented on the need to consider the broader system and the role of the Voluntary Sector who were key in supporting the health and social care and also needed the right skills. Dr Katie Bramall-Stainer echoed the need to consider the third sector about what they could bring to the future. She also thanked the workforce workstream to create enhanced occupational health for pharmacies and general practice.

Tracy Dowling acknowledged the really important part played by the voluntary sector and advised that the Chief Executive of the Arthur Rank represented the charitable

sector and emphasised the need to ensure skills development. Dr Katie Bramall-Stainer added that there had been a number of varied responses and asked if the ICS was prepared to challenge the current infrastructure in each of organisation for supporting workforce and other organisations whatever their size. There was a need for equitable access for the entire workforce with the same benefits and opportunities. She said that examples of pooling resources and providing these at a system level rather than duplicating them was something to keep hold of. Julie Spence acknowledged the significant progress made and said she thought the thinking was spot on. Linking in with the financial position, there was a need to evolve the workforce living within the financial envelope, and consider how to decommission roles and transition into what the system does need with an appropriate ratio of clinical and admin. Self-service was fundamental to the continual evolution depending on the needs in the system. Caroline Walker commented on the huge agenda and thanked Tracy Dowling for the update. She said that there was a need to agree to support a People and Culture Director however there was still work to do in determining the make-up of the ICS Board. She asked for clarification if this paper was asking us to agree this development. The Chair said that the proposal was framed in the context of senior workforce development and said there was merit of appointing this role, however, he considered that this was not a decision to be made by the Board but for System Leaders. The Regional Director, Ann Radmore, had been really clear about the need for the system to progress its workforce development. There was a need to bring some dynamism into our plan acknowledged that pre-Covid there were significant workforce gaps across the system.

The key question was whether we needed a system workforce plan to enable health and care needs of population to be met and to support the workforce strategy. There was a need to develop stronger digital skills, higher levels of clinical skills and provide maximum value. It was important to acknowledge skill requirements had changed and this was critical as we move away from a traditional approach. He said that he acknowledged that this might be uncomfortable as changes were made but it would provide tremendous opportunities. Rob Hughes said there was no doubt major things needed to happen to utilise our workforce more effectively and it was important to acknowledge that all had different views but he suggested that the system needed to be clearer what the need it was trying to address. He said he could buy into this however there was a need to acknowledge individual organisational needs versus system needs. This was beyond the questions of what we were trying to achieve. Val Moore commented on the importance of carers, healthcare support workers and the need to acknowledge the continuum of skills. She said that local authorities were looking to stimulate micro enterprises within communities where support was provided. This included domiciliary support and social prescribing in some GP practices. She said that post Covid-19 there was a need to create a community and roots and skills across that continuum of care. She added that recruitment of social care was incredibly pressed and there was a need to stretch the mind even further and embrace the really rich vein of connectivity with carers and carer support workers. Tracy Dowling said she agreed that this was a really big piece of work and was a priority for all ICS. She said there was a need to have the conversation and reach a view about the priorities and seek serious investment. She said that asking the question and building the understanding through dialogue was important but without leadership the system would not make the progress it needed. This was a significant step change going forward and not just about the NHS. This was about health and care and people in communities and the development of the skills to look after the health of our population across wide spaces. The Health and Care Academy would provide opportunities to develop health and care skills with a really good introduction to both through apprentices and training routes to develop as much as their

skills can take them. Healthcare skills and social care skills were being developed side by side in an integrated way to create new roles broadly based skills. She highlighted the work in Liverpool which was streamlining services but also providing better value and outcomes were proving to be significantly better. The Chair asked if there were avenues in this positive work worth exploring that connect to workforce and to use the opportunities from the LEP and employment strategies in the county. There was a need to anchor systems as a positive employment opportunity and it was really important to outreach to schools, developing apprenticeship programmes. There was a need to consider health inequalities linked to employment opportunities and consider the economic drivers.

Dr Alex Gimson left the meeting.

Tracy Dowling commented that the People Board had a representative from the LEP. One of the key needs was to ensure a major impact on health inequalities by providing better employment opportunities. There was a need to reach into schools and provide mentor pupils and to work with education providers. This would help to address some of the workforce issues and would ensure that the ICS understood what local people wanted to progress. The Anglian Health Science Network was also a really good opportunities to join up industry and to pattern innovation. She said that healthcare was far too rigid on organisational boundaries and there was a need to think more broadly to develop career pathways and build career lifespan. The Chair thanked Tracy Dowling for her report and for her leadership in this area.

10. Finance Paper

The Board received and **noted** a summary paper which updated on the 20/21 forecast position; NHSE Run-rate exercise; Planning for 21/22; the Local Authority financial landscape; and capital planning. Louis Kamfer advised the Board that the paper set out the 2021 position and described the financial approach that had been adapted in year to cope with Covid and the restoration and recovery work. In relation to the System Deficit Plan, the actuals were being reported now and subject to receiving other income, the system was forecasting a breakeven position. Confirmation should be received in the in next few days. It was important to note that the system had not delivered all recovery and restoration but have responded and additional annual leave liabilities and lost income had been addressed. Work continued to address the underlying run rate and it was important to acknowledge the deterioration in the underlying recurrent position between end of 19/20 and 20/21. As the NHS had responded to the pandemic, providers had been unable to deliver the level of savings required to meet the financial plan. Currently, he was taking a reasonably prudent position but working closely with the NHSE/I regional team. The Planning Guidance and financial envelopes had been published and the Finance Team was continuing to work on baselines and the impact of recovery and restoration and LTP. A number of discussions had been held at the FPPG around the Local Authority landscape around the impact on the cost of social care. The Local Authority Finance Director continued to flag other pressures of around council services including debt support, economical support which would have a long term timeframe. The system had also received the capital envelope and the FPPG and Directors of Strategy and Directors of Estates across all NHS providers was undertaking a prioritisation exercise. This would need to be submitted on 12 April 2021.

The Chair said that it was hoped that the Cambridgeshire and Peterborough system would break even by the end of the year. He recognised this as positive but in the

current circumstances so unusual. It would create uncertainty and the Board recognised the prospects of future funding. On behalf of the Board. he thanked Louis Kamfer and the FPPG for their work in this area.

11. Draft Board Assurance Framework

Kit Connick presented the draft Board Assurance Framework which continued to be under development. She advised the Board that this was part of the underway to provide grip, assurance, and governance on system risks. The aim was to provide the Board with the ability to have oversight of strategic risks which were articulated clearly in the future alongside the mitigations to address these risks. A summary report on the key risks would be provided at each meeting. She asked the Board to ratify the approach.

The Board briefly discussed the draft BAF. The Chair said that the draft document provided the opportunity to provide oversight and scrutiny of the risks and it was important that this connected to delivery of the Operational Plan and the Development Plan. Roland Sinker emphasised the need for the Board to have oversight of the risks, but also the opportunity to consider the strategic risks that should be captured and monitored on the BAF going forward. Rob Hughes commented on the role of risk owners as he considered that would be beyond the role of system leaders. Kit Connick commented that each Workstream would own their own Risk Registers and significant risks should be escalated to the BAF. Jan Thomas commented on the need to acknowledge the role of both the statutory ICS Board and the health and care partnership Board and being clear on oversight and governance for each risk. The Chair said he agreed with this point and acknowledged the need for clarity on this as the BAF developed.

The Chair thanked Kit Connick for her report and the draft BAF. He said the Board **agreed** that the format of the BAF and summary paper would meet the needs of the Board and would provide sufficient oversight, scrutiny, and assurance in its current format. The Board had **reviewed** the current risks on the BAF and acknowledged the need for escalation of risks to the BAF. The Board **ratified** the proposed risk governance process for future adoption, acknowledging the comments that were made by Board members on the development of strategic risks and the ownership of risks which would be taken forward as part of the BAF's development. **ACTION: Kit Connick.**

12. NHS Charities Together

The Board received a short update on the NHS Charities Together Funding. Julie Spence advised the Board that the update provided members with an oversight of where we are with NHS Charities together bid in relation to Sir Tom More's charitable donation. The NHS was distributing funds to ICS footprints for them to consider what to use the funding for. In Cambridgeshire and Peterborough two projects were being considered – one was a Digital Support Packages (DSPs), working with the voluntary sector, social prescribers, and other community health providers. The aim was to provide over 1300 DSPs to individuals with long term health conditions in areas with low digital literacy. This would include IT equipment, WIFI provision and/or data and signposting to online health education programmes. The second project was working with The Light Project and Boroughbury Medical Centre (current funded provider) to provide a Homeless Health Hub within the grounds of Peterborough Cathedral to provide access to basic health services and digital consultations with their GP and other health and social care

providers. Outline Business Cases had been submitted and it was anticipated that we would hear the outcome and the money would be available in May.

The Chair said these were really positive initiatives and thanked Julie Spence and her Team for her update which was noted by the Board. The Board would receive regular reports on progress.

13. Questions from the Public

Sharon Fox advised the Board that there had been one written question for System Partnership Board – 31 March 2021 which had been received by the Hands Off Hinchingbrooke. Jan Thomas provided the response which would be included in the minutes of the meeting.

1. When will the STP Board announce they are becoming an ICS? NHSE/I approved the Cambridgeshire and Peterborough system's application to become an Integrated Care System on 19 March 2021. Details are included in the Executive Leads update to the STP Board meeting in public on 31 March 2021, including the areas of development that the ICS will need to focus on during the transitional year.

1a) Who will be the Independent Chair of the ICS? We will be working through this as part of our Development Plan when we have more information on the requirements for the proposed statutory and partnership boards. Much is dependent on the timing and process for the White Paper through government. The current interim governance arrangements are included in the System Governance update to the System Partnership Board.

1b) Which organisation will take the Lead Provider role and how has this LP been selected? –There is no specific requirement for there to be a lead provider, if through the development planning, we identify a need for an organisation to take the lead on an area, we will follow the required process.

1c) Will this Lead Provider hold the main ICS budget? As above.

1d) How much is that planned 'capitated budget' going to be and what is it to cover? In C&P we are lucky enough to have one sovereign CCG and one ICS, therefore the ICS already works on a capitated budget. We have agreed a principle of subsidiarity as an ICS, therefore if we decide to delegate budgets to a place or an organisation, we will follow the appropriate process. An update on the current financial position is included within the STP papers today. The Operational Planning Guidance and financial allocations were announced last week. We are now working this through. Further detail will be provided at future meetings.

1e) Have STP/ICS Transition meetings taken place and were the public informed? The system was notified of approval mid-March. A road map will continue to be updated and brought to the System Partnership Board in the coming days and weeks. The Development Plan would be brought to the Partnership Board for approval. The System Partnership Board will be meeting in public regularly over the next few months as we go through the transition process. The next meeting would be on 19 May 2021.

There were no other questions.

14. Close

The Chair thanked everyone for their attendance at the meeting. He said he would close by recording very best wishes to Anna Bailey who was stepping down as a Councillor at the next local elections. He added his thanks to Dr Liz Robin who was retiring from her role as Director of Public Health at the end of April and acknowledged all the work she had done for the communities in Cambridgeshire and Peterborough. He also offered his thanks to Chess Denham for all she had done both in her role as Medical Director at Cambridgeshire and Peterborough NHS Foundation Trust, and her clinical leadership in the wider system work.

He concluded that there was significant work underway to review all the requirements set out in the White Paper and he anticipated that there would be further updates at the next meeting, including how the statutory ICS body, and the health and care partnership would operate.

15 Date of Next Meeting

The date of the next meeting of the Partnership Board in public was confirmed as Wednesday 19 May 2021 at 12.30 pm.

Author: ***Sharon Fox***
Director of Governance, Cambridgeshire and Peterborough CCG
2 April 2021