Cambridgeshire & Peterborough
Integrated Care System

Cambridgeshire and Peterborough Winter Plan 2023/24

September 2023

Contents

Introduction

There has been significant investment in Cambridgeshire and Peterborough services over the past year, facilitated in large by the new Capacity and Demand funding introduced in winter 22/23. The additional investment in capacity was accompanied by significant collective efforts from system partner organisations across health and social care, resulting in substantial progress and improvement in performance particularly:

- ✓ Cat 2 ambulance response times
- ✓ Average ambulance handover times
- ✓ Urgent community response
- ✓ A&E attendances
- ✓ A&E 4-hour performance
- ✓ Non-Elective admissions

UEC activity is below plan across all providers with non-elective activity below plan and below the same period in 22/23. Nevertheless, some challenges remain as a result of both historical and newly emerging risks. As of July this year, our G&A average bed occupancy is 0.3% above plan, zero day Length of Stay (LoS) is below plan at 27.6% against a 40% target, non-elective average LoS remains higher than the system ambition at 6.37 days and the number of patients in hospitals not meeting criteria to reside has seen a slight increase from the previous months.

A number of factors will undoubtedly increase the challenge faced by all system providers this winter; these include:

- Reduced staffing levels and ongoing recruitment challenges
- Impact of sustained periods of Industrial Action on activity and staff
- Scheduled care waiting lists and the impact of delayed and postponed care on patients
- Increases in population, particularly the ageing population
- Opportunities yet to fully realise offered by better integration across acute and community services

Looking back: Learning from last winter

What worked well?

Planning and processes

- Building shared vision and objectives
- Evidence base and data driven
- Relationships, values and behaviours

System coordination and continuous learning

- Clear and transparent decision-making processes
- Robust shared governance to engender peer accountability
- Flexibility and learning approaches – PDSA methodology

Targeted and collective interventions

- System first, person centered outcomes
- Coordinated interventions across pathways
- Bold decisions to drive integration

Last winter three areas were highlighted as critical to making a difference on the level of operational "grip" and responsiveness demonstrated during the winter months, even when confronted with new challenges posed by consecutive periods of Industrial Action and their impact on system providers, alongside the anticipated seasonal surges in demand for health and care services.

Of particular importance were our approach to system prioritisation and simplification of key objectives; the establishment of processes that allowed for ongoing coordination of delivery, monitoring of impact and continuous learning; and the commitment from system Executive leaders to adopt open and transparent decision making in agreeing priorities for investment, whilst balancing risk across the system.

Based on the success of this approach, the same processes were applied to the later selection and approval of investment of any additional funding for 23/24 to continue to support successful winter projects from April 23 onwards.

Our winter plan for 23/24 is based on the unplanned care and primary care investment priorities and improvement plans agreed at the beginning of this financial year. This is in recognition that whilst winter may require some additional preparedness to support our collective response to seasonal surges in demand, we must also remain focused in delivering the 23/24 priorities agreed across the system to improve quality of care for our population.

Priority Areas

Our seven priority areas have been selected in order to:

- ❑ Implement bespoke local action plans focused on improving UEC performance (and/or sustaining improvements already achieved), and alleviating seasonal winter pressures
- ❑ Deliver against national and regional expectations including winter guidance as published by NHSE on 4th August 2023
- ❑ Maximise opportunities to enhance admission avoidance, patient flow and discharge from hospital and community interim care settings during the winter period
- ❑ Continue the implementation of initiatives agreed and supported in April as part of our 23/24 planning cycle

As part of the delivery of local action plans in these seven priority areas, the Cambridgeshire and Peterborough Unplanned Care Board (UCB) will:

- ✓ Keep oversight on spend of capacity and demand funding so that local governance structures can develop and agree initiatives to respond rapidly to newly emerging challenges during winter
- ✓ Ensure a discrete number of key metrics are set up for each plan and updates provided to UCB meetings to oversee progress against delivery
- ✓ Ensure winter initiatives are also supporting longer term objectives as set out in the C&P Operational Plan and Joint Forward Plan respectively
- ✓ Ensure inclusive governance structures and implementation teams are in place to drive implementation, performance and responses to new operational challenges as they emerge over the winter period

Local Priority Areas for Winter

Alignment of local priorities and national objectives

Local Plans	Urgent Community Response	Frailty	Inpatient Flow & Length of Stay	Virtual Wards	Home First	Access to Primary Care	High Intensity Users
NHS Objectives 23/24	• Improve A&E waiting times • Improve Cat 2 ambulance response times • Consistently meet or exceed the 2hr UCR standard • Streamline direct access & direct referrals		• Reduce adult general and acute bed occupancy • Deliver system specific (elective) activity target		• Make it easier for people to access GP practice • Continue on trajectory to deliver 50 million more appointments in general practice		
UEC Recovery Priorities	• Increase workforce size & flexibility • Expanding care outside hospital • Making it easier to access the right care		• Expanding care outside hospital • Increasing discharges • Tackle unwarranted variation		• Increase workforce size & flexibility • Expanding care outside hospital • Increasing discharges		• Increase workforce size & flexibility • Expanding care outside hospital • Making it easier to access the right care
Hight Impact Interventions	• Reducing variation in acute frailty provision & improving recognition of cases and referrals to avoid admission • Reducing variation in patient LoS • Same Day Emergency Care • Urgent Care Response		• Standardising & improving care across VW services • Implementing SOP & minimum standards for care transfer hubs • Increase bed productivity & increase flow				• Urgent Community Response • Driving standardisation of urgent integrated care coordination & whole system management of patients

Cambridgeshire & Peterborough
Integrated Care System

Action Plans

Urgent Community Response

Exec Sponsor / SRO	Stacie Coburn/Kate Hopcraft	Programme Lead	Paula Merrell	ICS

Winter 23/24 Deliverables

	Completed By	Lead
Direct access to ambulance stack by UCR services (pilot & embed)	August 23	EEAST
Improve integration of services across UCR operating a trusted assessor model and reducing hand offs between teams	October 23	ICB
Open pathway direct referrals from 111 & care homes to CB4C service	November 23	ICB
Review of current offer against 9 UCR pathways, identify gaps and solutions for winter	November 23	ICB
Ensure direct Cb4C / SDEC pathways in advance of winter	October 23	Acutes / GPN
Evolution of current UCR offer into a clinically led Integrated Community Hub	December 23	PCNs /EEAST

Risks

1. Buy in from system partners to implement trusted assessor model
2. Activity through UCR services is not true admission avoidance
3. New referral pathways overwhelm service with non-urgent requests

Mititgations

1. Develop MOU for each organisation to sign / commit to before go live
2. Regular audits of activity and weekly monitoring of operational metrics
3. Wide communication to ensure services understand nature of UCR versus scheduled care and regular reviews of appropriateness of referrals

Ambition

To develop a comprehensive urgent community response across C&P seven days a week that enables the system to respond within the national 2hr standard

Programme Metrics

Average utilisation (as % of total capacity)	85%
2hr UCR response time	70%
Patients resulting in non-conveyance (%)	TBC

UEC metrics supported

- Delivery of 76% target A&E waiting times 4hr standard
- 2hr UCR response time (70% national target)
- Cat 2 Ambulance response time (30 min target)

Frailty

Exec Sponsor / SRO	Harvey McEnroe / Kate Hopcraft	Programme Lead	Sara Rodriguez-Jimenez	ICS

Winter 23/24 Deliverables

	Completed By	Lead
Develop whole system falls prevention and falls response pathway	Nov 23	ICB / North / South
Develop comprehensive directorate of services for frailty (including DoS profiling)	October 23	ICB
Deliver equipment and training (raiser chairs) to all care homes across C&P	Dec 23	ICB
RESPEct forms for all frail residents in care homes with care staff upskilled to support completion of these	Nov 23	ICB
Improve acute frailty pathway as part of relaunch of the Medical Assessment Unit	Nov 23	CUHFT
Implementation plans for the use of virtual wards in frailty North and South maximising occupancy	Dec 23	CUHF /NWAFT

Risks

1. Scope “creep” due to wide reach of frailty into a large number of pathways and services across providers
2. Lack of visibility/coordination of commissioned service capacity supporting frailty resulting in patients not accessing the right services

Mititgations

1. Focus on a small number of deliverables over winter in areas of greater need/poorer performance, i.e. falls
2. Ensure directorate of frailty services is widely shared with C&P stakeholders increasing visibility of services and referral routes

Ambition

Develop and implement integrated care pathways that deliver safe, effective, patient centred care and reduces variation in healthcare.

Programme Metrics

Emergency admission rate >65 falls	reduction
Permanent admission rate to care homes	reduction
Patient and carer experience of services	improve

UEC metrics supported

- Delivery of 76% target A&E waiting times 4 hr standard
- Reduction in G&A bed occupancy to 92%
- Delivery of 70% target 2hr UCR response time

Inpatient Flow & Length of Stay (LoS)

Exec Sponsor / SRO	Harvey McEnroe / Stacie Coburn	Programme Lead	Paula Merrell

Acutes

Winter 23/24 Deliverables

	Completed By	Lead
Process audits at CUH, NWAFT, CPFT inpatient beds against best practice (IPS, full capacity protocols, CTA principles, SAFER / Red to Green, criteria led discharge)	Oct 23	ICB / Acutes/ CPFT
Recommendations from audits drafted into improvement plan per site	Nov 23	ICB / Acutes / CPFT
Review cardiology pathway (CUH / RPH) to identify gaps and opportunities to improve flow and LoS across C&P	Nov / Dec 23	ICB/CUH / RPH
Review dementia / delirium pathway to identify gaps and opportunities to improve flow and LoS across C&P	Nov/ Dec 23	ICB / NWAFT

Risks

1. Workforce capacity / skill in discharge planning
2. Clinical buy in into process changes
3. Assumptions on benefits realisation do not materialise as expected

Mititgations

1. Revisit “basics” of discharge planning across wards / disciplines
2. Engagement with Medical / Nursing Directors in each organisation
3. Establish steering group to oversee progress against delivery monthly

Ambition

Reduce overall length of stay (LoS) within inpatient settings focusing primarily on non elective LoS (medicine) in acutes, LoS in community non mental health inpatient beds (IPR), and LoS in pathways with variations in performance (i.e. cardiology)

Programme Metrics

Reduction in LoS	0.5 day
Daily total discharges (P0)	TBC
Discharges before midday (%)	TBC

UEC metrics supported

- Delivery of 76% target A&E waiting times 4 hr standard
- Reduction in G&A bed occupancy to 92%
- Reduction in LoS

Virtual Wards

Exec Sponsor / SRO	John Rooke	Programme Lead	Rob Murphy	ICS

Winter 23/24 Deliverables

	Completed By	Lead
Recruit further capacity at CUH, NWAFT, RPH	Dec 23	North ICP
Both hubs have a VW for frailty, heart failure and respiratory and whilst CUH can offer technology to support 24hr monitoring, that needs to be in place in the north too	Nov 23	North ICP
Rationalise IV antibiotic provision and technology solutions across provision.	March 24	North ICP
Maximum capacity (164 beds) achieved across C&P	Nov 23	North ICP
Achieve 80% occupancy of 164 beds.	Nov 23	North ICP
Working across the system, review the implementation of paediatric and MSK pathways	Mar 24	North ICP

Risks

1. Ability to recruit staff into proposed bed capacity
2. Clinical buy-in into model and confidence in the service
3. Assumptions on benefits realisation do not materialise as expected

Mitigations

1. Working with ICB workforce lead. Filling shifts from bank if necessary
2. Robust and regular communication with all clinicians regarding VW
3. Monthly reporting being led by ICB including support with evaluation

Ambition

Deliver an alternative home based care option for those who are frail, elderly or with specific conditions who become unwell and would normally be spending [longer] time in hospital.

Programme Metrics

Total VW capacity achieved	164 beds
Occupancy rate in VWs	80%
Average LoS in VWs	<7 days not including IV's

UEC metrics supported

- Delivery of 76% target A&E waiting times 4hr standard
- Reduction in G&A bed occupancy to 92%
- Reduction in LoS

Home First

Exec Sponsor / SRO	Heather Noble	Programme Lead	Sabina Fitton	ICS

Winter 23/24 Deliverables	Completed By	Lead
Implement and embed Online PTL supported by all system partners (pre-Digital solution)	October '23	LA/CPFT
Implement Trusted Referrer model at CUH Trust wide	October '23	CUHFT
Commence Trusted Referrer Pilot at NWAFT & agree roll out plan	November '23	NWAFT
Development and implementation of C&P & Out of Area Escalation Processes	October '23	North ICP
Evaluate Triage and Assessment provisions and agree a plan to mitigate any identified gaps	October '23	LA/CPFT
Existing private cars held under ICB to transfer to CPFT (PW1)	October '23	CPFT
Development of the new Discharge Notification form / CPFT trial	December '23	CPFT
Development of new process for Restart and Returns	December '23	CUHFT
Analyse PW2 Capacity and Demand (HI beds, Spot Purchase & IPR) and agree mitigations	October '23	ICB
Delivery of a Single Point of Access supported by VCS network	October '23	ICB

Risks

1. Staff shortages - Workforce levels required to deliver timely and safe PW1-3 transfers of care
2. Commissioned service capacity – in particular PW2 and lack of D2A

Mitigations

1. Daily reviews of workforce gaps to maintain service delivery with TOCH oversight and escalations
2. Review of commissioned and available capacity (PW2 being the priority) and development of D2A model

Ambition

Helping people to receive the right care, in the right place, at the right time, returning home whenever possible.

Programme Metrics

Number of Discharge Ready pts on Complex PTL	No's to be agreed at Trust level
Number of Discharge Ready pts on Complex PTL (RAG rated as Red & Amber)	

UEC metrics supported

- Delivery of 76% target A&E waiting times 4hr standard
- Reduction in G&A bed occupancy to 92%
- Reduction in LoS

Access to Primary Care (General Practice and Community Pharmacy)

Exec Sponsor / SRO	Nicci Briggs	Programme Lead	Dawn Jones

Primary Care

Winter 23/24 Deliverables	Completed By	Lead
Deliver high impact interventions: • Delivery of Primary Care Recovery plan – *CAIP, digital, transformation system level PC Recovery Plan, Workforce* • identification and management of people with complex needs. – *Population health management LCA requirement*	31/03/2024	ICB (Primary Care Contracting and Enabling, Digital, and Workforce Teams)
Surge Planning • Maintain access throughout winter incl Bank Holiday's – *Consider additional investment/ extended hours delivery* • Additional capacity to support demand surges – *consider additional surge capacity through Feds*	31/03/2024	
System Working: • Improve Primary and Secondary Care Interface – *medical directorate leading* • Maximise role of General Practice and Community Pharmacy – *Comms, Empowering patients, integration*	31/03/2024	
Workforce: • Increase capacity with larger MD teams including over Christmas period – *Use of ARRS funding to create additional workforce*	31/03/2024	

Risks

1. There is a risk that commissioned bank holiday hours may not meet demand or there is limited appetite to work outside of contractual hours
2. There is a risk that the digital framework will not be published by the required date to enable the ICB to select the tools to support general practice
3. Risk that services will be disrupted as a result of industrial action

Mititgations

1. Providers will reopen during core hours and are asked to prioritise patients where appropriate to manage capacity during these hours.
2. The ICB are exploring digital tools and solutions for implementation in the absence of the framework
3. Continue to work with EPPR and develop plans to mitigate impact of IA

Ambition

To deliver recovery of access to general practice tackling the 8am rush for appointments, reduce the number of people struggling to contact their practice, and improve management of on the day requests from patients.

Programme Metrics

All PCNs to have robust Capacity and Access Improvement plans in place ahead of Winter to include digital interventions.	31/08/2023
Consider investment to create surge and BH Capacity at practice, Community Pharmacy and Federation level	30/09/2023
Implement system concordat to tackle bureaucracy between primary and secondary care	31/03/2024
Implement Pharmacy First	31/03/2024
Work with PCNs to review workforce plans for 23/24 to ensure that forecasted ARRS underspend is fully utilised.	30/09/2023

UEC metrics supported

- Delivery of 76% target A&E waiting times 4 hr standard

Hight Intensity Use of Services

Exec Sponsor / SRO	Louis Kamfer	Programme Lead	Jonathan Bartram	Place

Winter 23/24 Deliverables

	Completed By	Lead
Recruitment HIUs leads (and other staff)	Sept 23	Place
Finalise operating model	Sept 23	Place
Stakeholder engagement and identification of patient cohort	Sept 23	Place
Independent evaluation methodology sourced	October 23	ICB
Tier 1 go live	October 23	Place
Tier 2 go live	September 23	Place
Initial evaluation	March 24	ICB

Risks

1. Duplication with existing services & programmes that are also working with HIU and targeting same patient cohort
2. Inconsistent approach across North & South in delivery impacting on the way in which effective evaluation can be carried out
3. Go live date for Tier 1 delayed beyond October due to delays in recruitment of HIU staff

Mitigations

1. Maintain ongoing dialogue with operational colleagues, ensure wide system representation at Steering Group & review operation of the delivery model on a regular basis
2. Steering Group established with monthly meetings. Delivery groups also being set up as well as approach for data collection and evaluation to shape approach across C&P
3. North and South Place to agree process for hosting staff and confirm recruitment timelines

Ambition

Deliver a proactive and personalised approach to addressing high or increasing use of services by exploring opportunities for care and support through pathway transformation and personalised care approaches.

Programme Metrics

No's identified (T1 & T2)& offered & accepted a personalised care plan	TBC
Decrease in AE attends and NEL admissions in the selected cohorts	40% reduction
Increase QoL measured by EQ5D tool (or similar) in the selected cohort	TBC

UEC metrics supported

- Delivery of 76% target A&E waiting times 4 hr standard
- Reduction in G&A bed occupancy to 92%

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Surge & Escalation

Overview

The ICS completed last winter a full review of the system escalation framework resulting in a new protocol that focuses on the proactive management of daily operational risks. This framework has underpinned the operations of the SCC to date and will continue to operate during this winter.

Demand and capacity modelling has also been completed with ECIST support to understand the bed / bed equivalent capacity the system is likely to require during winter taking into account possible reductions in LoS and other productivity gains.

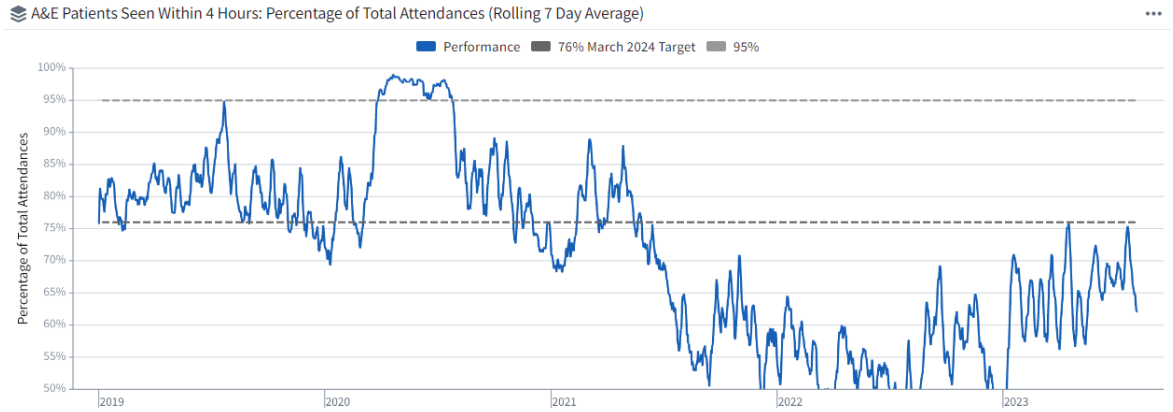
Our approach to managing seasonal demand surges continues to centre around three key areas:

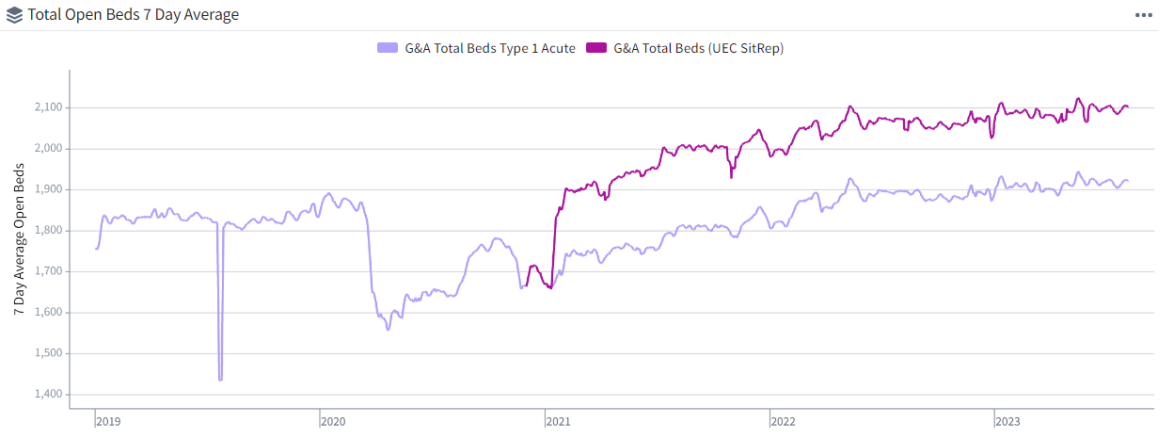
- **Surge Planning:**
  - Demand and capacity modelling carried out to ensure agreed capacity increases (beds and bed equivalents in acutes and community) meet anticipated winter pressure
  - Workforce planning for peaks in demand during winter

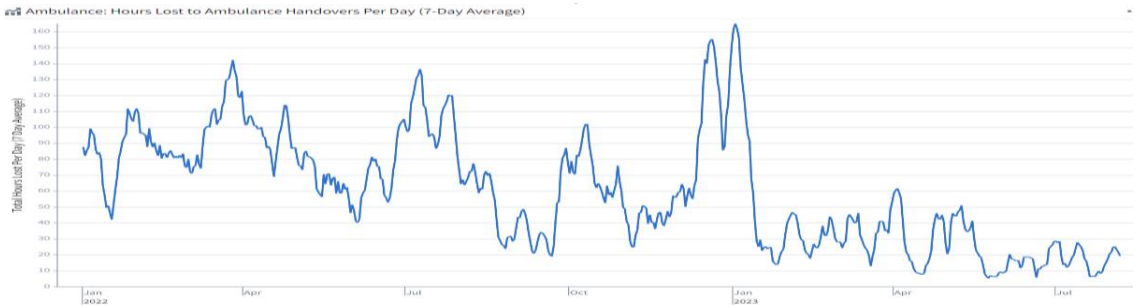
- **System Coordination and Escalation**:
  - Clear systemwide pathways and approach for the escalation of issues daily and development of robust contingency plans
  - A System Coordination Centre that meets the new national Minimal Viable Product standards

- **Seasonal Planning:**
  - Targeted plans for holiday periods such as Christmas and New Year to ensure continuity of key services

Anticipating Seasonal Demand Surges: Baseline Capacity







We have secured significant investment in extended capacity – **2100 beds vs 2030 average in 22/23** (+20 more to come online)

We have also invested in primary and community services to keep people well in their own homes and manage demand for unplanned care services outside the hospital setting whenever clinically appropriate to do so:

- UCR
- Falls vehicle
- Wrap around care

We have invested in other alternatives to ED such as:

- Joint MH / police cars
- Same day emergency care
- Frailty unit

And additional investment has also been applied to discharge capacity and coordination:

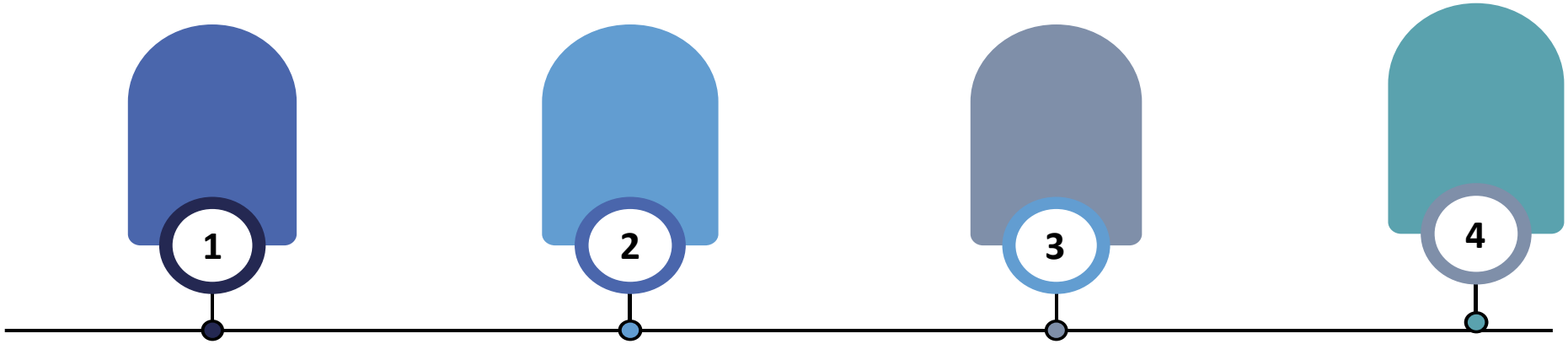
- Virtual wards
- Pathway 1 capacity
- Voluntary and community sector single point of access

Anticipating Seasonal Demand Surges: NHS Reservists

The Reservist Programme is becoming an integral part of the temporary workforce support for C&P ICS. As part of our One Workforce and working in different ways ethos, providers will be supported to think creatively with managing surge in demand during winter and beyond. Whilst Reservists are an option within the temporary workforce arena, Reservists are not bank workers and cannot be utilised in the same manner. The key to the success of this programme is how organisations utilise Reservists in synergy with permanent and bank staff.

Our C&P target is to have 180 NHS Reservists actively engaged in deployments by March 2024 across providers.

Next phase Reservists deployment areas are:



Secondary Care

CUHFT ward helper roles, A&E, student paramedics, OH roles, phlebotomy, c19 and flu vaccinations
RPH vaccination support

ICB

RN within safeguarding team
Nurses working in PC in 2 pharmaceutical projects

Community

CPFT enhanced observations observer (MH), ward running, specialist womens health physio, psychotherapy, psychologies, MH nurses, OT roles
Caring together care support workers

Primary Care

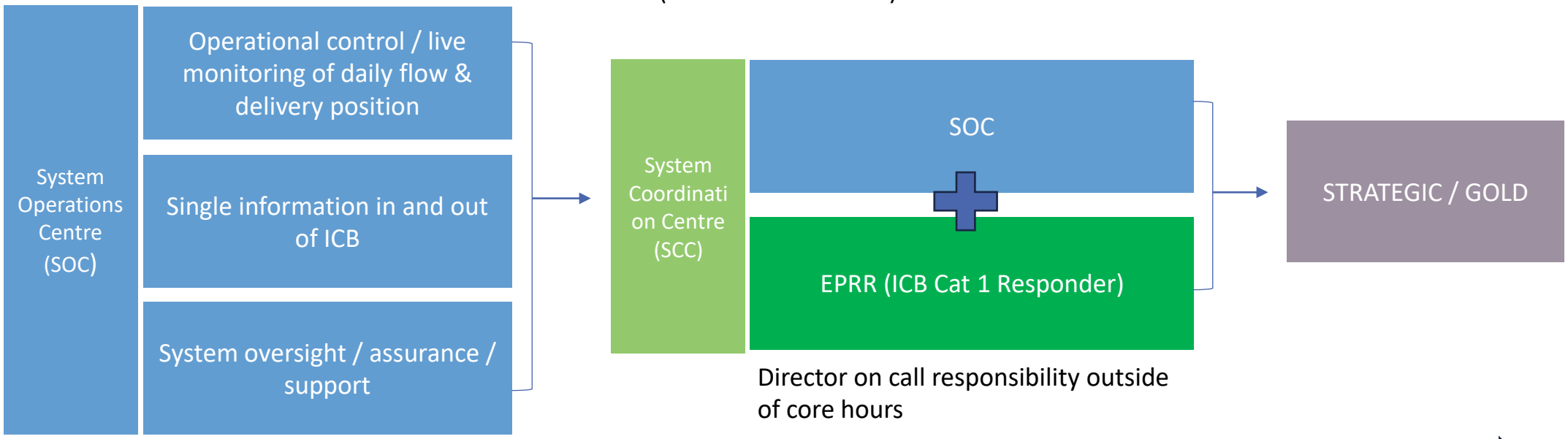
Granta Medical Practice, Boune Surgey, and Spinning Surgery

System Coordination and Escalation

Management of day to day business / grip and oversight of system

Integration of operational and EPRR escalations – including incident management (i.e. Industrial Action)

Escalation to Senior champion / GOLD if/as required



Director on call responsibility outside of core hours

Clinical leadership and support across ICB and system providers to effectively manage risk across the ICS

Consistent use of OPEL Framework AND local escalation protocol/ triggers to identify system risks and system response

Meeting the National SCC Minimum Viable Product (MVP)

	Purpose	People	Process	Place
Already in place	• Continually assess clinical risk through the Operating Pressure Escalation Level (OPEL) framework whilst co-ordinating an integrated system response • Devolved accountability as an Incident Command Centre (ICC) • Tactical coordination of unplanned interventions including ambulance response times & safety of emergency departments • Tactical coordination of planned interventions • Tactical coordination of flow (via ToCH)	• Staff to cover operations 24/7 (linked to on call) including daily senior SCC manager during operating hours (8am to 6pm) • ICB Director on call / SRO support in hours and out of hours for appropriate escalations • Accountable Emergency Officer representing ICC at ICB Board supported by SRO for SCC • SCC Operators • Dedicated clinical leadership in hours and out of hours across system (ICB and providers)	• Single Point of Access mailbox to streamline communication within ICS and with NHSE • Real time visibility of key data and information (Shrewd) and access to other relevant dashboards (ie EEAST and EMAS dashboards) • Integration with EPRR • Risk register in place and SOP for SCC • SCC role and responsibilities embedded in local escalation framework	• Able to run a hybrid model with dedicated physical locations and ability to operate effectively remotely if/as required
In placy by October 23	NA	NA	• ICS “huddles” – fortnightly operational system meetings (led by SCC) to review emerging themes behind operational pressures and actions to mitigate them • SCC mandate in enacting escalation of Acute provider full capacity protocols	NA

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Workforce

The Challenge

At a time of increased demand for services, our health and social care workforce has been put under considerable strain and as a result we continue to experience challenges with recruiting and retaining to key roles across the system. This places further strain on services. The impact has also been felt on the independent sector, both care home and domiciliary care provider markets, adding further pressure and limiting our collective ability to provide care packages for people with complex care needs to leave hospital. Pressure has been rising during recent months and the priorities for this winter are a mixture of those intended to mitigate against the current and forecast pressures felt across health and social care systems over winter and others that will have medium or longer-term value, achieving more sustainable services for the future. This will provide a foundation on which to further develop recovery plans into the coming year and beyond.

NHSE feedback from the last Operational Workforce return for Cambridge & Peterborough (CP) indicates that productivity remains a system challenge, the Office for National Statistics sub divides this into three 3 areas:

1. Lack of capacity in our system
2. Composition of staff – more staff new into roles and more experienced workforce leaving/retiring
3. Lack of leaders/managers in our system combined with ineffective work cultures

Key actions in response to workforce challenges

Leadership

- Ensure visible senior champion for health and well being working with system leadership to encourage and support employee led improvements, local initiatives on workforce, and integrate collaborative system culture
- Roll out Leadership Compact across system
- Maintain clear focus on talent management and create internal opportunities (e.g. Leading Beyond Boundaries)
- Embed continuous improvement approaches into ICS workforce strategies to keep priorities and actions under constant review

Recruitment

- Implement “Just R” passive recruitment targeted campaigns
- ARU project dedicated to recruitment, retention and education, learning and development as a multidisciplinary approach to address supply
- Pilot project with Breaking Barriers Innovation to address inequality and the NHS as an anchor organisation to draw talent from local communities
- Continue to support international recruitment providing strong onboarding and pastoral support
- Apprenticeship strategy with focus on new roles & collaborative work with Anglian Ruskin University
- Collaborative recruitment events for Health Care Support Worker roles across care, voluntary and health sectors

Retention

- Nursing workforce programme managers in place supporting the sustained investment and development of pastoral roles, promoting areas of best practice for retention of Health Care Support Workers and Newly Qualified Nurses
- Short term accommodation initiative, Homestay, rolled out following pilots including C&P
- Ensure best practice principles apply when managing clinical risk and utilising staff sharing arrangements and maximise collaborative banks
- Building of a critical mass of NHS Reservists to help demand surges
- Ensure shift rostering patterns take account of best practice on safe working and caring and provide flexibility to take account of constraints and other responsibilities staff may have
- Continue to work with HEI’s on retention plans of students within the ICS using a one system approach
- Utilise Careers Coach role and digital app to support existing international nursing workforce
- Continue implementation of Legacy Practitioner Model which includes:
    - Childrens Nursing – shared resource secondary care and VCS
    - Primary Care & Mental Health
    - AHP support combined with EEAST

Health and Well Being

- Supporting staff to stay safe from flu, covid 19, and respiratory illness through vaccination take up
- Ensuring staff have access to appropriate PPE
- Development and further expansion of Mental Health hubs in line with national guidance
- Ensure all staff have access to health and well being conversations and encourage them to access support
- Work on staff accommodation solutions

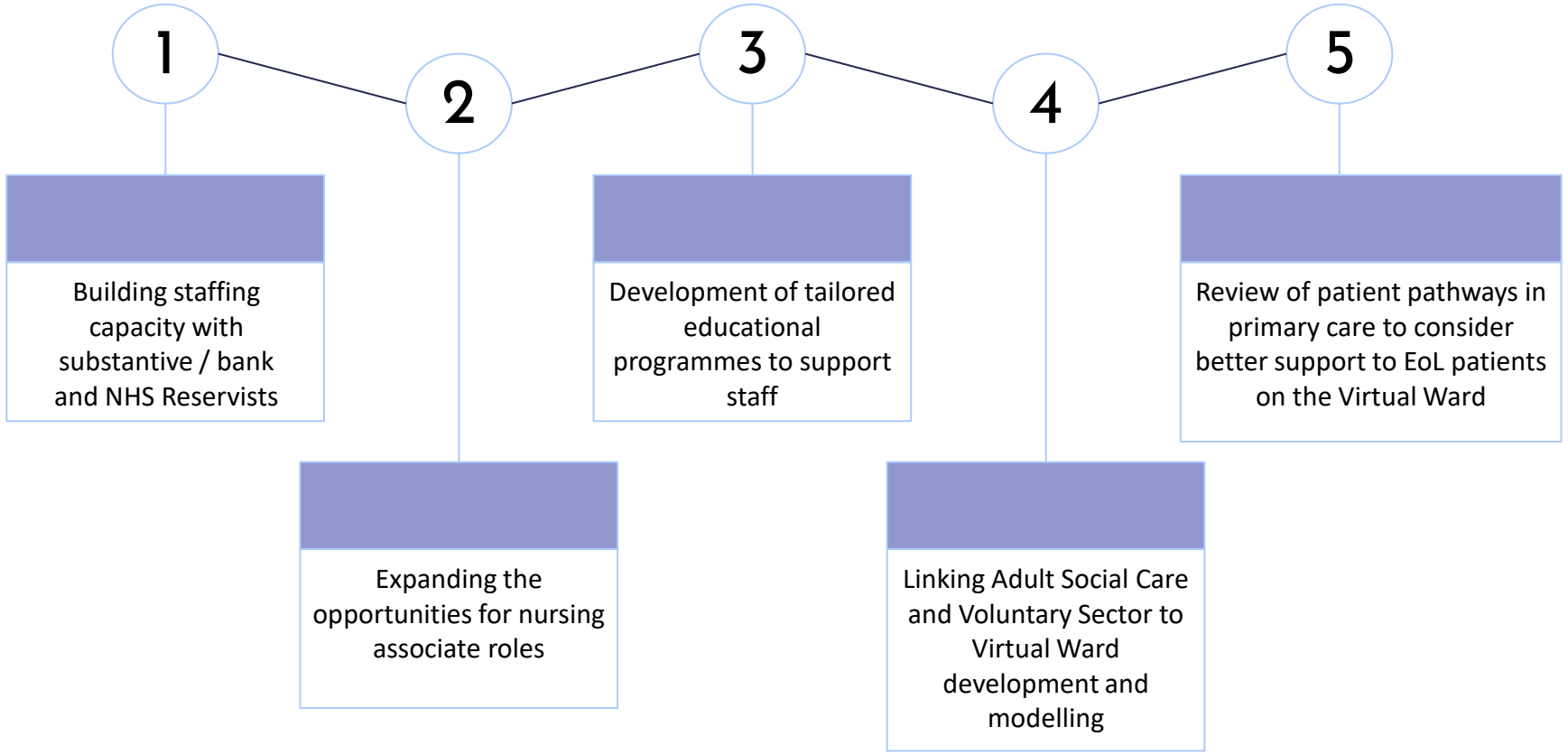
Equality, Diversity, and Inclusion

- Implementation of the Anti racism strategy
- Managers programme to develop cultural awareness and understanding
- Develop system wide networks with support & resources and develop a reciprocal mentoring programme
- Inclusive recruitment programme
- Ensure staff networks are engaged in policy development
- Promote Cultural ambassador training and update within employers

New Ways of Working Case Study: Virtual Wards

One of the critical factor for virtual wards to succeed and become a sustainable model of delivering care in the longer term, is ensuring staffing is properly planned for. There is a severe workforce and skills shortage in the NHS which impacts on the system's ability to deliver the full ambition on virtual wards.

Our staffing plan for virtual wards includes several key steps to provide both permanent and secondment-based opportunities for clinical staff (including from social, community, voluntary sector, and primary care) as shown in these five points. This will help reinforce the role of virtual wards as a permanent service which can offer real benefits to career development.



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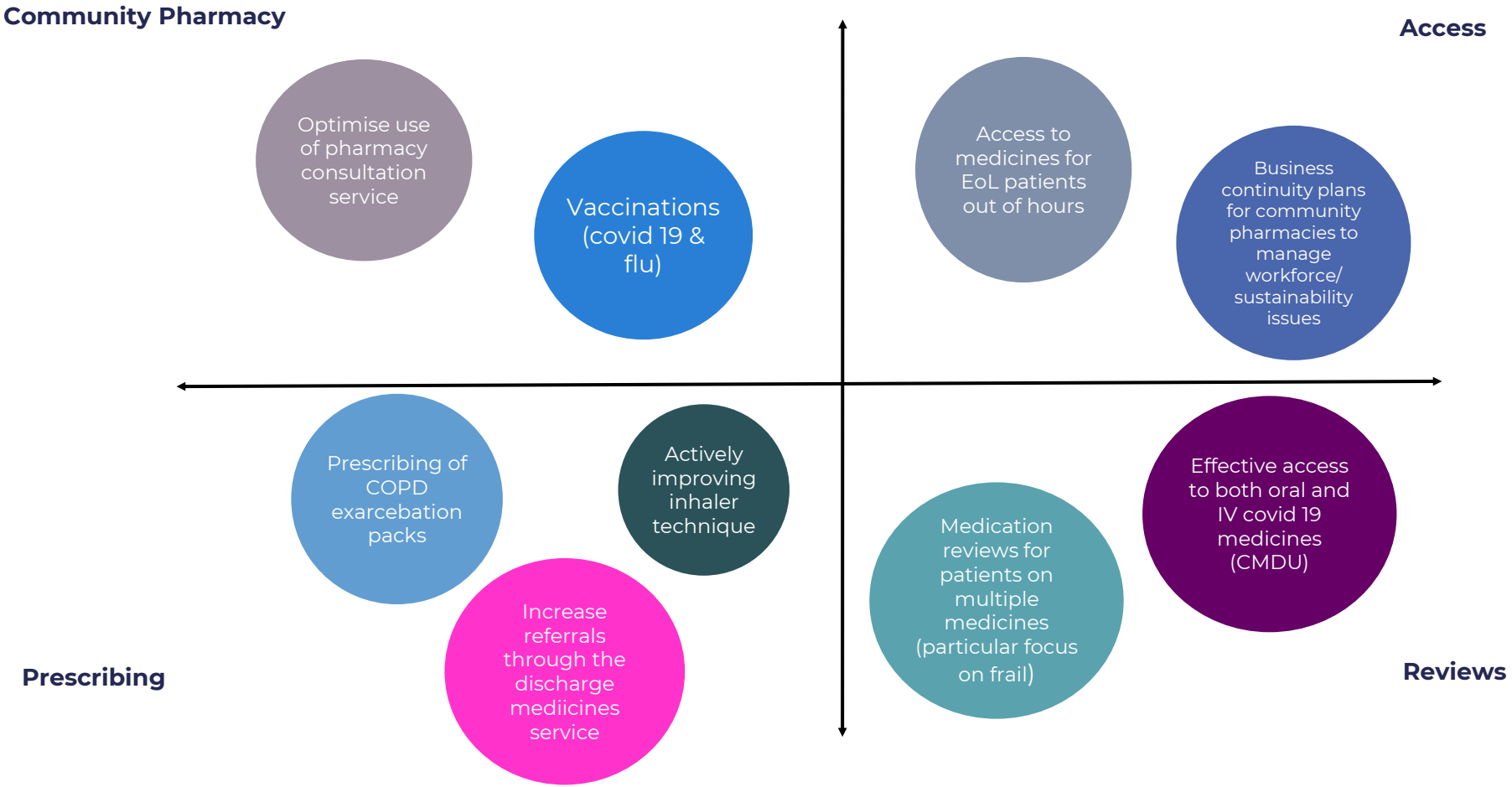
Community Pharmacy and Prescribing

Targeted interventions

There are interventions spanning across prescribing and pharmacy services where early preparation could help reduce pressure on our system during the winter months. Below are the key actions that will be implemented in C&P as they could potentially have a significant impact in supporting patients and reducing the risk of unnecessary trips to A&E or use of urgent care services.



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Mental Health

Targeted interventions

Crisis Mental Health

- Meet CORE24 requirements for Hinchingbrooke Hospital
- Reduce inappropriate out of area placements
- Reduce LoS and delayed discharges in inpatient MH beds
- Right Care, Right Person: replace referrals to police with action by the most appropriate agency

Community Mental Health

- Increase annual health check update and support for serious mental health illness cohort
- Expand GP capacity through MH primary care additional roles
- Complete review of services to highlight waiting times and prioritise long waiting list services for recovery action

Specialist Services

- Increase dementia diagnosis, extend DIADEM programme, increase MAS, increase CVSE pre/post diagnosis support
- Profiling local MH and well being needs using metrics of prevalance, risk and protective factors and care provision

Learning Disability & Autism

- Increase health check uptake in C&P and increase health action plan completion
- Review of equity of s75 agreement and service provision across C&P
- Review of accessibility of mainstream services for those with Autism only diagnosis

Cambridgeshire & Peterborough
Integrated Care System

Planned Activity Recovery

Performance Highlights

Providers are continuing to focus on the elimination of 65 week wait breaches by the end of March 24. Good progress is being made by all providers and as a system we are below our 23/24 operational plan trajectory.
There is however a risk that the continuation of industrial action, beyond July will begin to impact on the long waiting position, as can be seen since April, the waits have been going in the wrong direction as activity is limited due to strike impact.

All three Trusts have seen a reduction in the 62-day backlog in June 2023. This has largely been driven by significant reductions in the urology backlog .
Acutes have weekly backlog trajectories in place that are monitored at the weekly escalation meetings with the Divisional Operational Manager chaired by the Deputy COO.
The volume of skin referrals has increased significantly at both CUHFT and NWAFT.

The 28 day FDS performance deteriorated in May 2023. The performance for CUHFT slightly improved compared to the previous month but this was offset by a much larger decrease for NWAFT from 66% to 55%.
Some teams face staffing challenges particularly at Consultant level. In addition, there has been an increase in 2WW referrals. The wait for first appointment increased to over three weeks which directly impacts the 28 day FDS.

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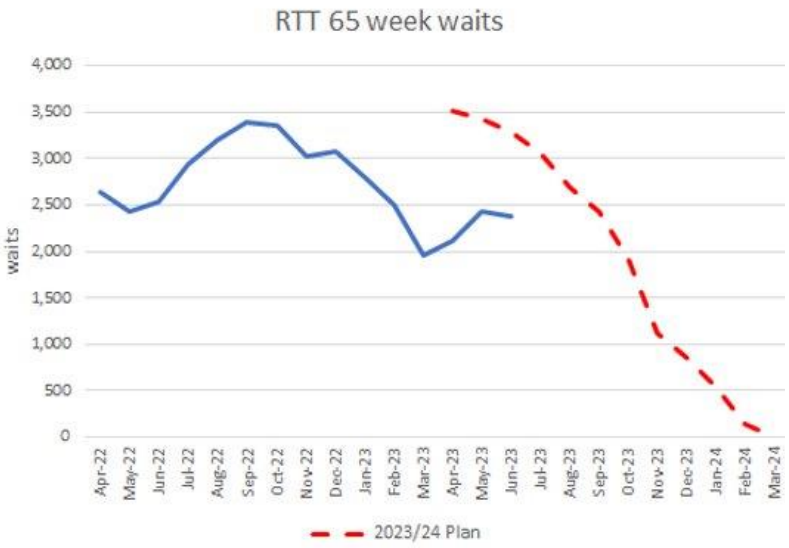

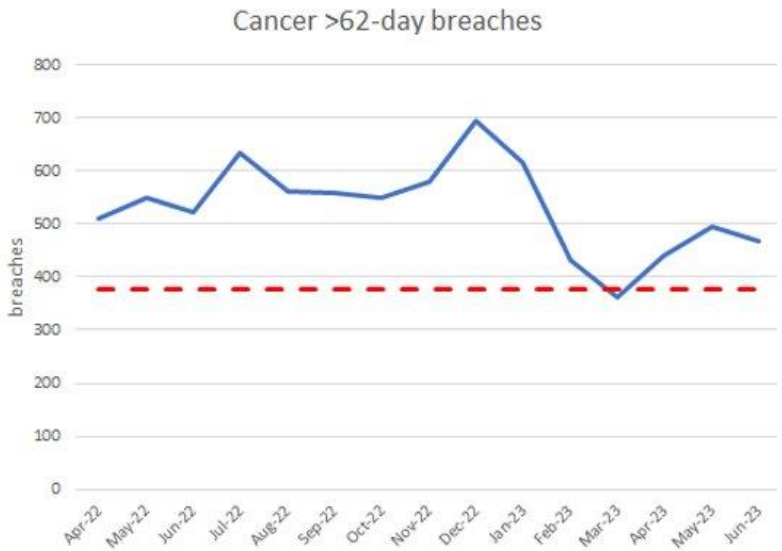

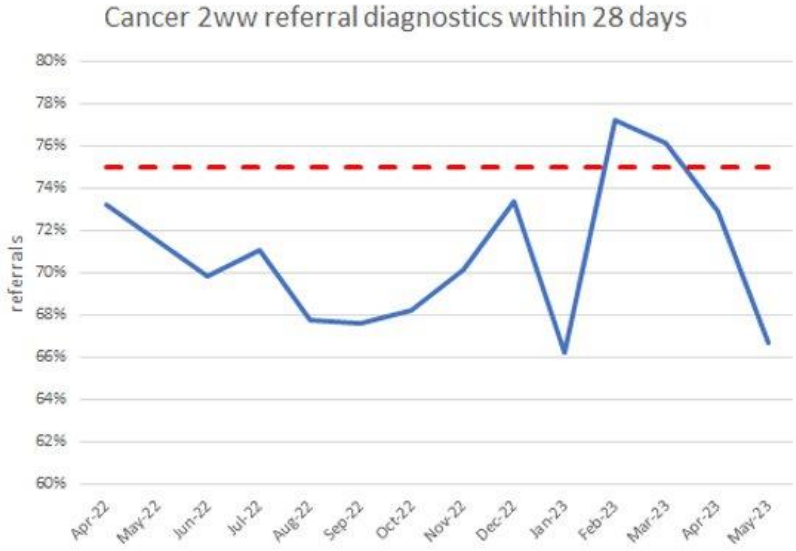

Winter Challenge

Maintaining electives through winter is always challenging with UEC pressures taking priority on inpatient capacity and increased staff absence resulting in short notice cancellations. All providers have phased their activity plans accordingly and as such, we do not expect any further changes to activity plans. However, the impact of Industrial Action (IA) has not been considered in 23/24 plans and as experienced year to date, managing ongoing strikes is having a significant impact on overall elective delivery. Work is ongoing to model the impact of continuous IAs (through to end March 24) on our overall waiting list position but even in the best-case scenario (no strikes beyond August), the ICS capacity to meet its planned waiting list number is significantly challenged. Nevertheless, system partners remain committed to sustain momentum by implementing the following:

Recovery

Maintain system commitment to keep focus on cancer and routine elective recovery including delivery of our developing Children & Young People recovery plan.
Work with wider providers including independent sector.

Governance

Ensure robust governance arrangements across planned care which focus on evolving risks and wider mitigation. Tiering, Planned Care Board & Assurance meetings will remain in place during winter.

Service Transformation

Where possible, the wider transformation work across planned care will not stop during winter to ensure that we continue to improve across outpatients, theaters, High Volume Low Complexity, and diagnostics.

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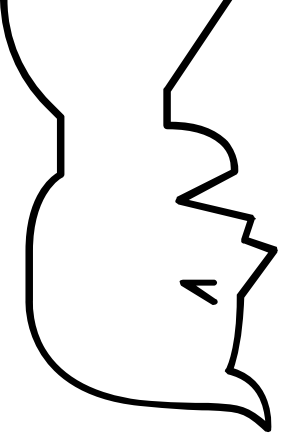
Communications



ICS communications teams help local people and communities access vital information about their health and care services, from where to get a winter vaccination to which service is the most appropriate for a given issue. The teams also protect the reputation of the ICS and ICB through reactive and proactive communications.

We have designed several proactive, targeted campaigns during winter to connect to specific audiences, encouraging them to take actions to better protect their own health and wellbeing and to ensure that people use the right service at the right time. These campaigns are data-driven, with clear evaluation mechanisms in place to consider their impact.

We will also promote significant winter projects throughout the colder months, to make local people aware of new services and initiatives that are part of the winter plan. This will help ensure that new initiatives are utilised effectively and will boost the public's confidence in local health and care services. We will also share news of these new initiatives and projects with stakeholders, including politicians, media and senior leaders within the ICS, so that they are aware of new approaches being taken to manage winter pressures.

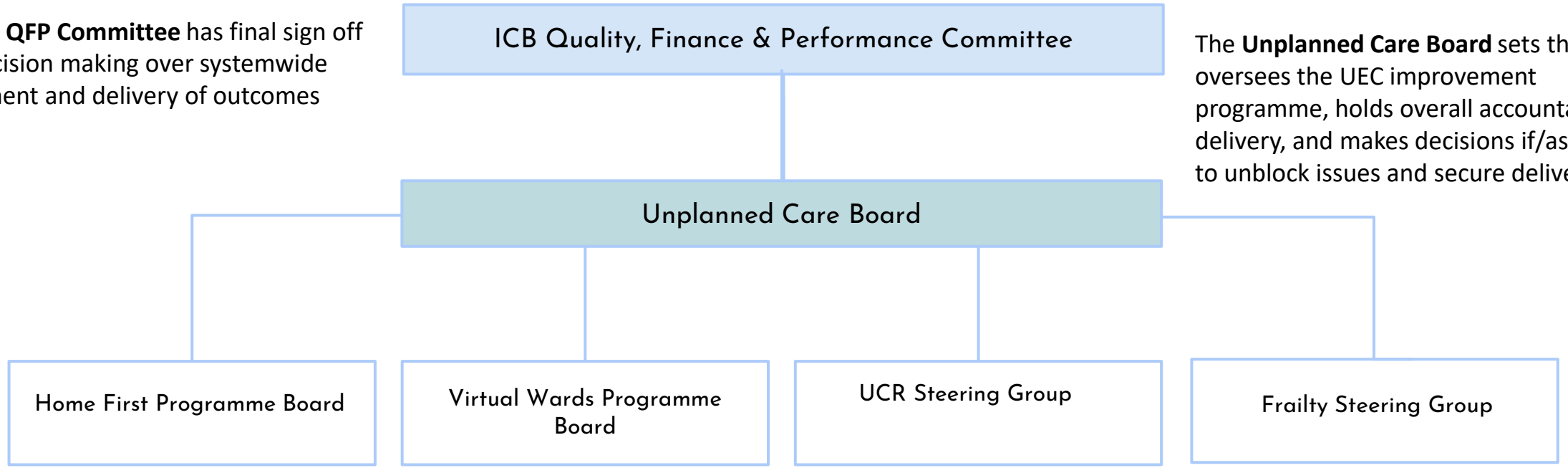
This is a dynamic and ongoing process, coordinated by the ICB communications team with input from all system partners. Operational teams are encouraged to sustain engagement with communication teams throughout the winter to continue the promotion of projects that could help to support winter pressures and/or that we want local people to be aware of and engage with, via cpicb.comms@nhs.net

Cambridgeshire & Peterborough
Integrated Care System

System Governance

Governance

The **ICB QFP Committee** has final sign off and decision making over systemwide investment and delivery of outcomes



The **Unplanned Care Board** sets the vision**,** oversees the UEC improvement programme, holds overall accountabiity for delivery, and makes decisions if/as needed to unblock issues and secure delivery

Delivery Boards/ Steering Groups are responsible for:

- Ensuring programme / project goals are aligned with overall system vision and objectives
- Gather support from system partners and commitment to delivery
- Ensuring project meets its objectives, delivers expected outcomes and realises anticipated benefits
- Providing assurance and updates to Unplanned Care Board and escalating any risks as required

Cambridgeshire & Peterborough
Integrated Care System

Appendices

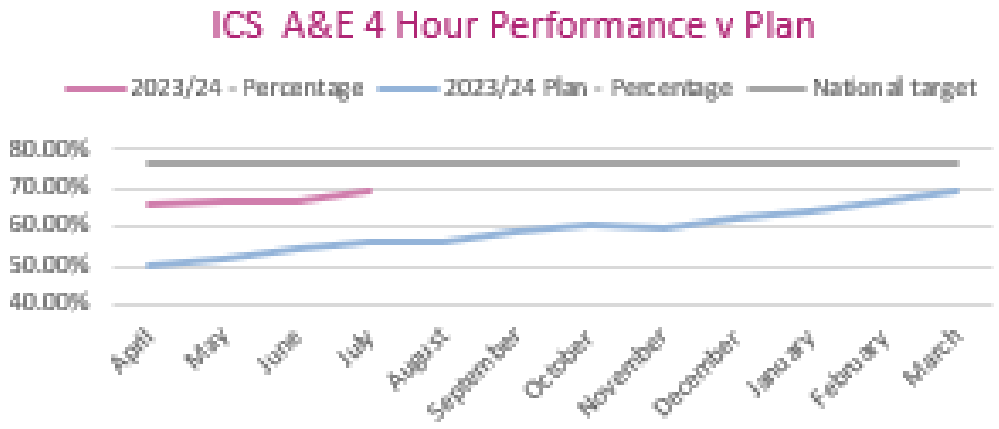
Appendix 1: Performance Score Card

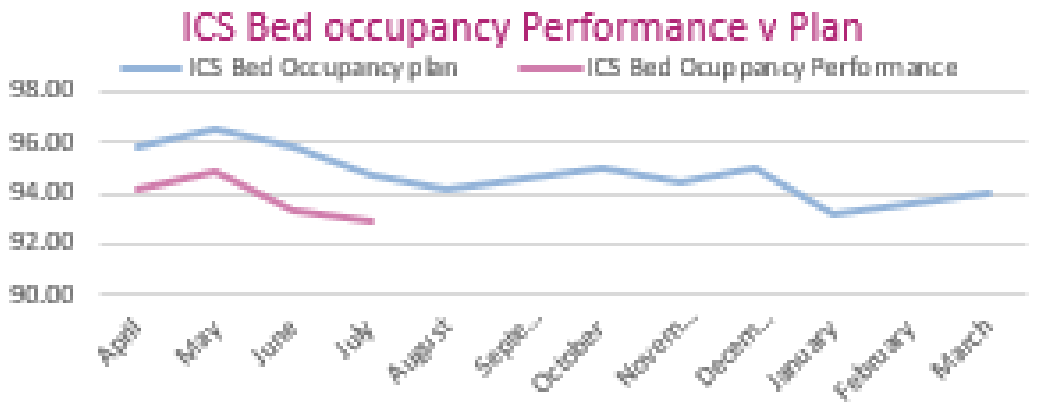
BALANCED SCORECARD

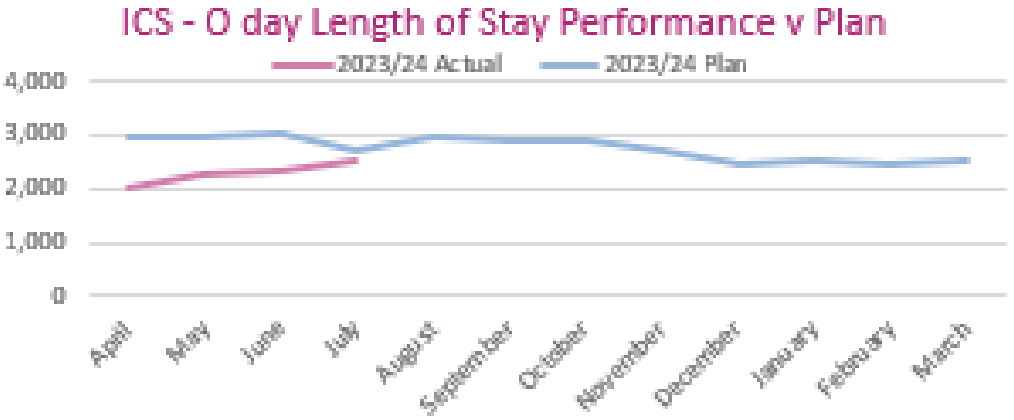
JUL 23	ACTUAL	PLAN	MOM MOVEMENT	ON TRAJECTORY
C2 RESPONSE TIME	31M	30M	-3M	✓
AVERAGE HANDOVER TIME	25M	30M	-3M	✓
URGENT COMMUNITY RESPONSE <2 HOURS	83%	75%	+1%	✓
A&E ATTENDANCES	33,914	34,657	-74	✓
A&E FOUR HOUR PERFORMANCE	69.0%	68.3%	+2.4%	✓
G&A BED OCCUPANCY (23/24 AVG)	94.6%	94.3%	-0.3%	✗
ZERO DAY LENGTH OF STAY	27.6%	40%	+1.9%	✗
NON-ELECTIVE ADMISSIONS	9,112	9,272	-37	✓
NON-ELECTIVE LENGTH OF STAY (23/24 AVG)	6.37	5.80	-0.18	✗
NOT MEETING RESIDE CRITERIA (DAILY AVG)	302	258	-7	✗
VIRTUAL WARDS OCCUPANCY	76.1%	65.0%	+10.9%	✓

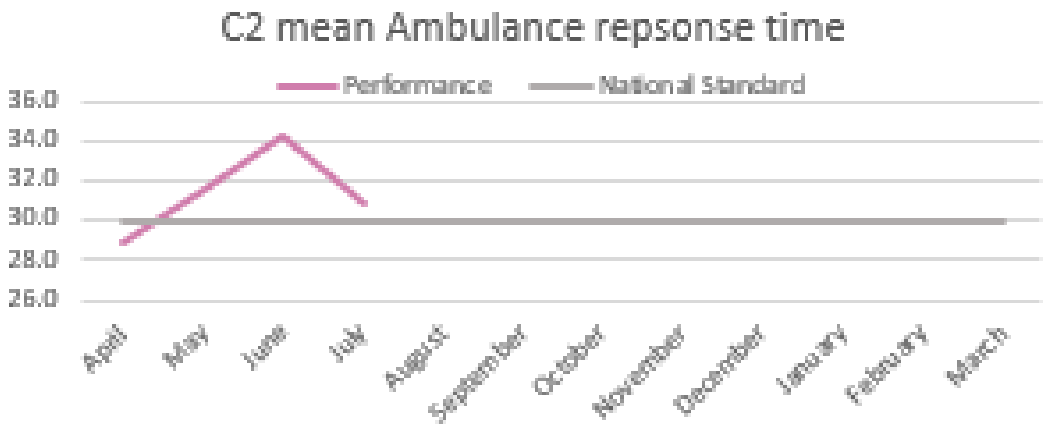
- C&P ICS IS ON TRAJECTORY FOR 7 OF 11 UNPLANNED CARE INDICATORS IN JULY AND COMPARED TO JUNE, IS SHOWING IMPROVEMENT ACROSS ALL 11.
- BED OCCUPANCY IS MARGINALLY ABOVE PLAN YEAR TO DATE BY 0.3% HOWEVER, THIS IS LINKED TO THE DELAY IN OPENING THE ADDITIONAL 20 BED MODULAR UNIT ON THE PCH SITE WHICH HAS NOW BEEN PUSHED BACK TO JAN 24.
- LENGTH OF STAY, BOTH <0 AND >1 DAY REMAIN ABOVE TRAJECTORY IN YEAR AND FULL YEAR FORECAST DESPITE MONTH-ON-MONTH IMPROVEMENT. LAUNCH OF LOS IMPROVEMENT PROGRAMME IN Q3 PLANNED.
- LOS FOR COMPLEX PATIENTS (PW1-3) AND LONG WAIT PATIENTS (+21 DAYS) IS REDUCING (-2.1% AND -2.6% RESPECTIVELY COMPARED TO JUN 23), HOWEVER THE NUMBER OF PATIENTS DISCHARGED ON PW0 IS AT 83% (JUN 23) WHICH IS 6% LOWER THAN BEST PRACTICE GUIDANCE AND 2% LOWER THAN EAST OF ENGLAND POSITION.
- PATIENTS NOT MEETING CRITERIA TO RESIDE IS REDUCING, DOWN FROM 379 TO 302 YEAR ON YEAR, WITH 57.4% OF DELAYS ATTRIBUTABLE TO PW1-3 AND 42.6% OF DELAYS ATTRIBUTABLE TO IN HOSPITAL PROCESSES. THE PROPORTION OF PATIENTS NMCTR BUT NOT DISCHARGED HAS ALSO FALLEN TO 35.5% IN JUN 23, COMPARED WITH 42.5% IN MAY 23 AND 47.5% IN JUN 22.

Performance versus Trajectories







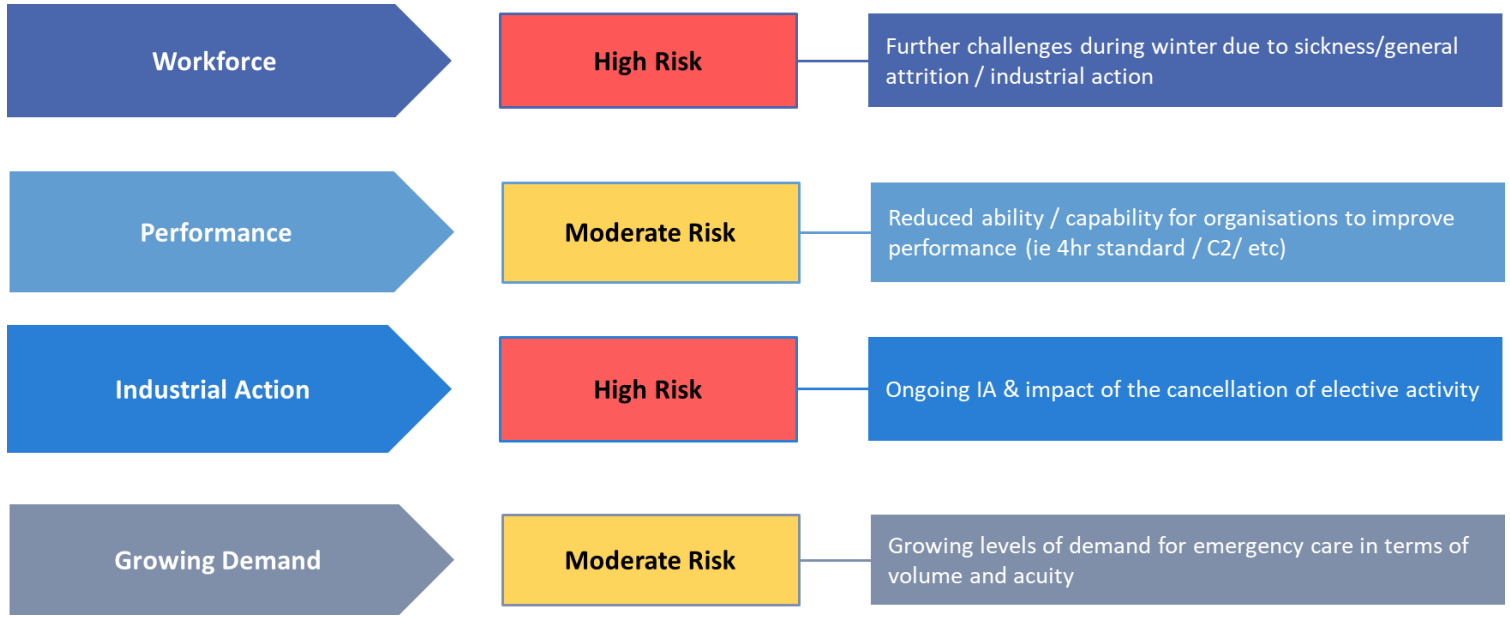


Appendix 2: System Risk

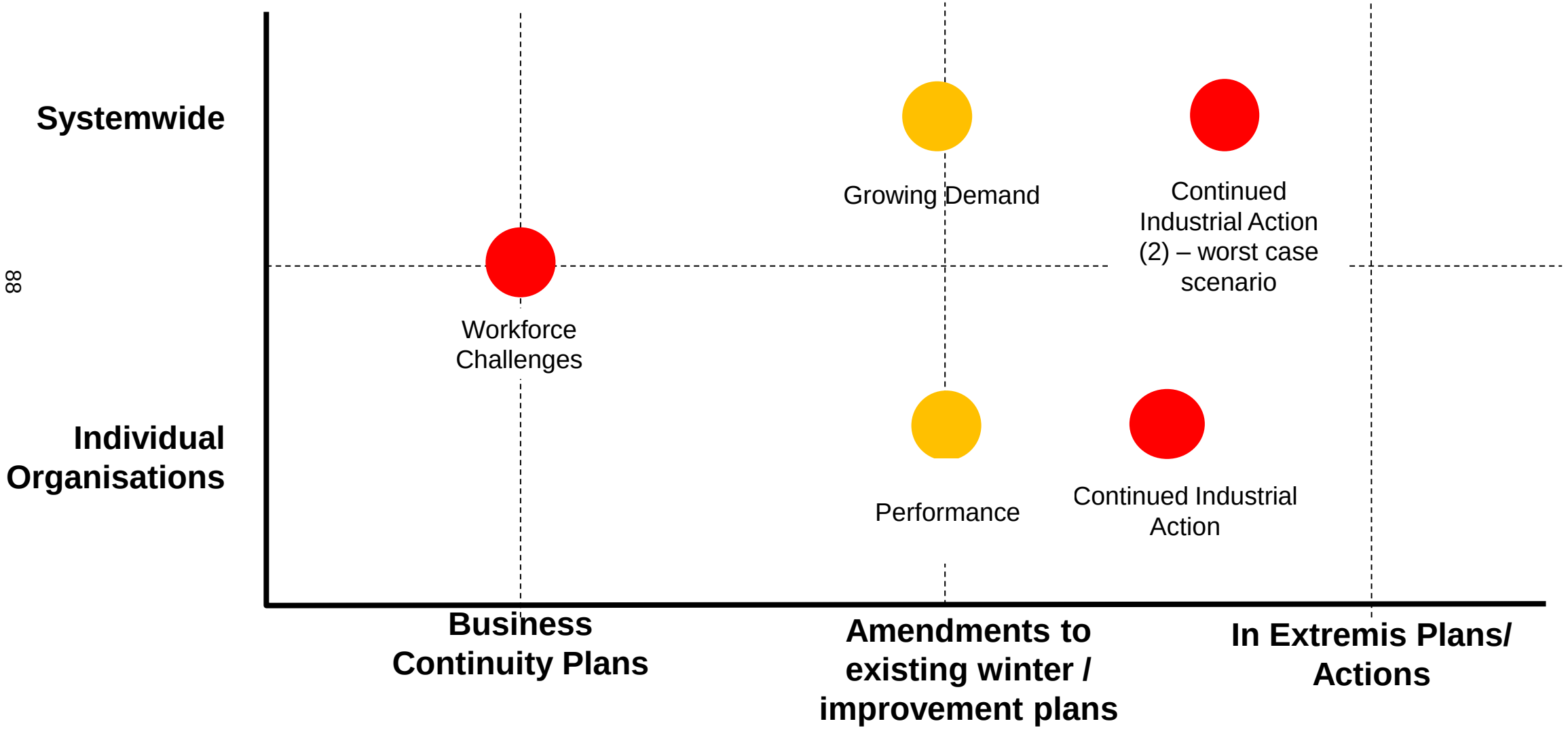
The actions in this plan set out how system partners are trying to mitigate unacceptable levels of patient risk particularly if continuing growing demand outstrips capacity under sustained pressure. Underlying this increase in risk is the challenged posed by a population whose profile is ageing and where the growth in patients with multiple comorbidities creates greater patient acuity.

A lot of time and effort has been dedicated to improving our collective planning and anticipate challenges based on previous experiences to reduce the amount of time and resource spent on crisis management. However, notwithstanding system efforts, proactive planning, and additional investment across services to enhance our winter preparedness, there are still residual risks driven by wider factors that could, should the worst case scenario realise, have a significant impact on the ability of system partners to deliver safe and effective care.

It is worth noting that developments of lower impact in any of these residual risk areas might be addressed by individual organisations and or the system through the development and deployment of effective Business Continuity Plans, or amendments to existing delivery plans. System leaders will need to judge the severity of the challenge, and therefore the appropriate response required, exploring all avenues before resorting to in extremis actions.



System Response



Appendix 3: Monthly Highlight report EXAMPLE UCR

Period: 1 to 31st August 2023

Exec SRO / SRO
NAME

Programme Lead
NAME

Area	Metric	National Target	Local Target	Performance	Trend	Comments
UCR	2hr UCR response time	70%	90%	TBC	TBC	TBC

Workstream Overall RAG

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