APPENDIX 1

C&P UEC Improvement Plan

Progress update

UPDATED SEPTEMBER 2024

PURPOSE

This document provides an update on performance and progress against Cambridgeshire and Peterborough's Urgent and Emergency Care (UEC) improvement plan, which includes considerations for winter preparedness.

As presented to the Integrated Care Board in September, the plan builds on the existing UEC strategy (Appendix 1) and Improvement Plan, reflecting progress and learning year to date, has utilised data and evidence to identify high impact areas and aligns to our existing agreed priorities, both locally and nationally, across urgent and emergency care. The half 2 (H2) priorities are clearly defined to ensure momentum on performance improvement is maintained through winter. This document provides an update on progress to date, current risks, mitigations and how the governance structure will ensure oversight and assurance of delivery of the plan and schemes within it.

NHS England have outlined the national winter and H2 priorities in their letter sent on 16th September (Appendix 2). Following review, the schemes within the C&P plan clearly align to the priorities outlined within it:

- ✓ National Flu immunisation programme and Covid 19 vaccination rollout
- ✓ Focus on optimisation of SDEC, SPOA and virtual wards
- ✓ Hospital avoidance and provision of alternatives to ED, providing high quality, safe care to patients in their own home
- ✓ Community frailty services
- ✓ Pro-active management of Long-term Conditions
- ✓ Collaborative working with community partners, local government and social care

C&P does not have a separate plan for winter. This has been the case for the last two years and is based on the principle that while winter may require some additional preparedness for seasonal surges in demand, continuous improvement is the preferred methodology for creating sustainable change in performance and improved outcomes for our population. This approach has been welcomed by stakeholders as it ensures consistency and reduces the need for additional short-term interventions which consume resources and often do not have the intended impact on outcomes.

While the principles, outcomes and approach to the plan will remain fixed, there will be ongoing work to refine and adapt specific actions and interventions over the coming weeks and months ensuring we remain flexible in our response to risk.

SUMMARY

- UEC improvement plan revised and updated for ICB Board in September. Delivery against revised plan shared with QPF monthly thereafter. This builds on and is in addition to individual provider improvement plans.
- Performance continues to improve (month on month and year on year). Benchmarked performance remains middle of pack nationally for most indicators. 5/11 indicators on plan and 6/11 behind plan year to date. Detailed performance data shown slides 4-9.
- Tier 2 arrangements for C&P have not yet commenced. The ICB has written to NHSE setting out the actions already being taken by the system to support performance improvement.
- Additional planned interventions to support performance improvement in various stages of development, shown slide 10 onwards.

OCTOBER LOOK AHEAD

- 20 additional beds opening on PCH site (modular ward) which should support flow and occupancy.
- Rapid improvement programme, with national hands on support, commences at both CUH and PCH sites.
- Finalising delivery plans for additional actions and interventions for November go live.
- Commence new winter task force governance arrangements.

PERFORMANCE

Data: August 2024

	ACTUAL	PLAN	MOM MOVEMENT	ON TRAJECTORY
C2 RESPONSE TIME (MINS:SECS)	29:33	30:00	-4:50	✓
AVERAGE HANDOVER TIME (MINS:SECS)	22:30	30:00	-9:42	✓
URGENT COMMUNITY RESPONSE <2 HOURS	85%* (June)	70%	+4%	✓
A&E ATTENDANCES	182,739 YTD	175,376 YTD	-2,397	✗
A&E FOUR HOUR PERFORMANCE	73%	74%	+1%	✗
G&A BED OCCUPANCY	94.0%	92%	-0.7%	✗
ZERO DAY LENGTH OF STAY	27% (July)	40%	-1%	✗
NON-ELECTIVE ADMISSIONS	9,391	9,127	-310	✗
NON-ELECTIVE LENGTH OF STAY	5.8* Days (June)	6.60 Days	-0.16	✓
NOT MEETING RESIDE CRITERIA (DAILY AVG)	298 (July)	127	-7	✗
VIRTUAL WARDS OCCUPANCY	87%	80.0%	+4%	✓

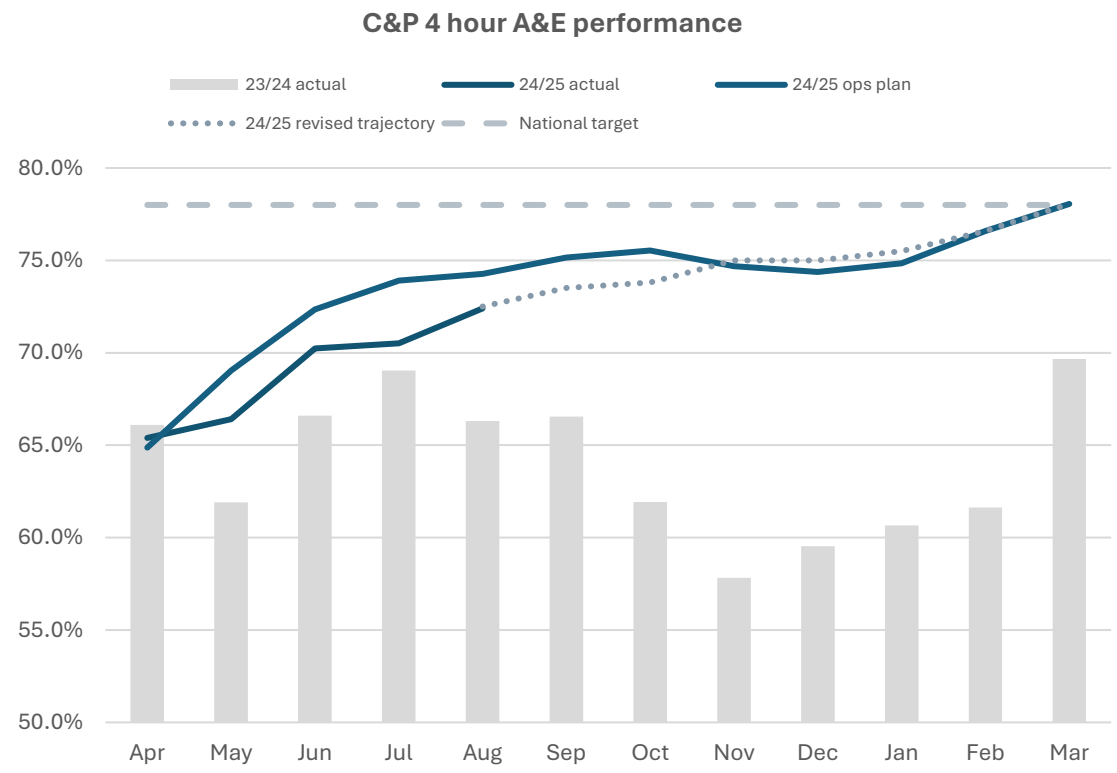
Year-to-date, the performance of the C&P Urgent and Emergency Care (UEC) system has fallen below plan across several areas, following a challenging start to the 2024/25 period.

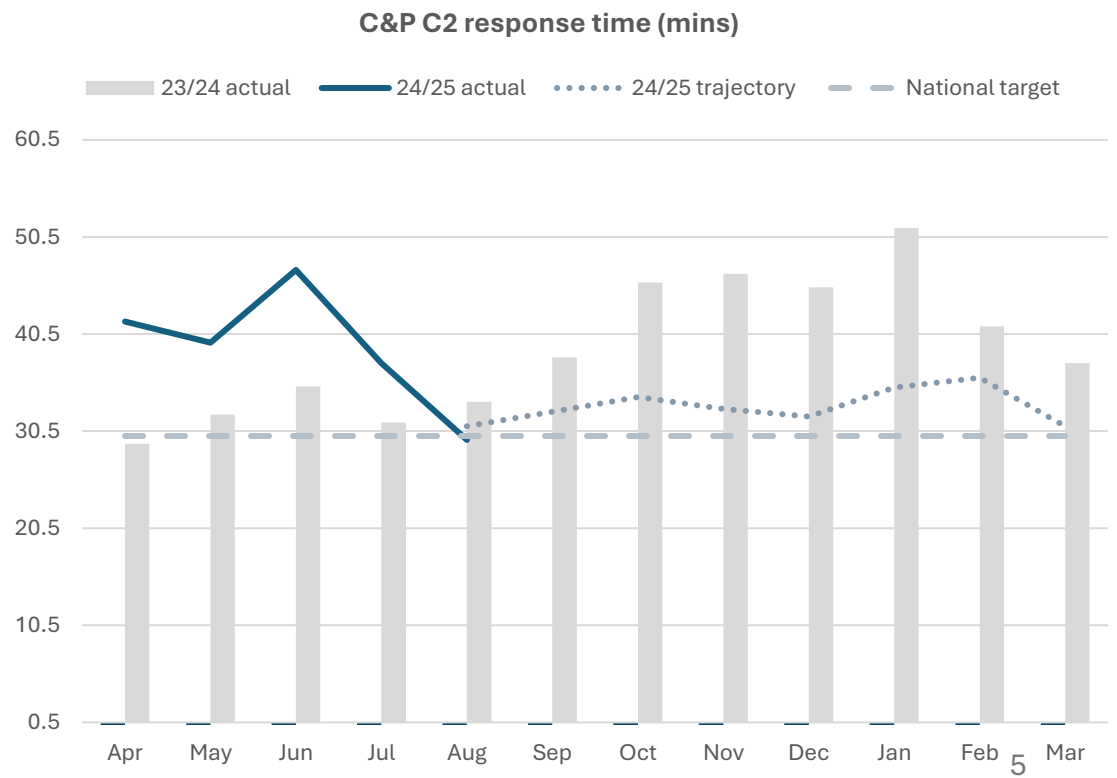
However, improvements were observed across all metrics listed in the table to the left for August compared to previous months. C2 response times reduced by 4mins50 sec to below the 30 min planned response. Average handover times saw a significant improvement with average handovers of 22.3 mins. Virtual ward occupancy continues to increase with further opportunities being identified, this coupled with greater alternatives to ED and hospital continues to support a reducing length of stay.

Unfortunately, these improvements have not been sustained and since late August, pressures across the urgent and emergency care pathways have increased, resulting in adverse performance across several metrics in early September. System tiering meetings with acute providers remain in place where drivers, recovery plans and wider actions are reviewed and discussed.

PERFORMANCE TRAJECTORIES

C&P ICS are expecting to achieve the 78% four-hour A&E target by March 2025 but have adjusted the trajectory originally submitted in the 2024/25 Operational Plan to reflect slightly slower than anticipated improvement month on month so far from April 2024, as indicated in the below graph. Some improvement was seen in August with four-hour performance increasing by 1% on the July position to 73%. C2 ambulance response time in August was 29:33 (mins:secs) against an annualised target of 30 minutes. Handover delays are a whole-system issue impacted by challenges with hospital capacity, patient flow and delayed discharges but also factors outside of C&P control such as EEAST resource availability . It is not expected that C&P will achieve the annualised 30-minute target for this year, although by a relatively small margin and demonstrable improvement can also be seen when compared to data from 2023/24.





PERFORMANCE – MONTHLY ICB RANKING

The table below shows C&P UEC performance when ranked out of 42 ICBs nationally. Augusts benchmarked data is not yet available.

Between June and July, C&P ICB moved out of the bottom quartile nationally for both ambulance hours lost due to handover delays and G&A bed occupancy. C&P remains in the bottom quartile for 2 standards though for A&E 4 hour performance our overall ranking has improved.

C&P		Jul-24		Jun-24		May-24		Apr-24		Mar-24		Feb-24		Jan-24		Dec-23		Plan 24/25
Metric	Metric Target	Value	Rank (/42)	Value	Rank (/42)	Value	Rank (/42)	Value	Rank (/42)	Value	Rank (/42)	Value	Rank (/42)	Value	Rank (/42)	Value	Rank (/42)	
111 calls received (calls offered avg per day)		885		888		914		899				1,146				1,264		December unique due to Measles demand post child deaths
% 111 calls abandoned	3%	5%	19	5%	21	5%	11	11%	30			29%				25%	31	Local plan = 5%
Ambulances Arriving at A&E (Avg per day)		214		206		214		213				209				202		Ambulance demand flat / below plan
CAT 1 mean response times (h:mm:ss)	7 mins	0:09:10		0:09:48		0:09:29		0:09:07				0:09:58				0:09:46		
CAT 2 mean response times (h:mm:ss)	18 mins	0:37:29		0:47:05		0:39:36		0:41:48		0:37:50		0:41:16		0:51:45		0:45:19		
Ambulance hours lost due to handover delays (per day)		40	23	85	34	64	27	85	33			56	22			90	27	
A&E attendances avg per day (all types)		1,205		1,230		1,225		1,185				1,173				1,069		Attendances increasing - walk ins 7% up YoY
A&E 4 hour performance (all types)	76%	71.5%	34	70.7%	35	66.6%	40	65.6%	41	69.7%	36	62.5%	39	60.8%	39	60.3%	39	Peformance below trajectory - 71.5% vs. 73.9% in July. Ranking based on unvalidated data.
% of patients waiting > 12 hours in ED from arrival		11.0%	30	12.1%	31	13.8%	35	15.3%	38	15.1%		15.2%	38	15%		15.2%	37	
Total G&A beds open (per day)		2,213		2,215		2,201		2,211		2,223		2,246		2,204		2,163		
Total G&A beds occupancy %		93.8%	29	94.6%	32	94.7%	26	95.5%	27	95.8%	23	95.8%	30	95%	17	92.3%	17	
% 21+ Day Stranded Patients		21.5%	32	21.9%	32	20.9%	28	21.5%	28	21.6%		20.3%	24	20.5%		21.1%	30	
% of patients with no criteria to reside remaining in hospital		18.6%	4	15.6%	4	5.2%	2	6.4%	2	7.9%	3	7.2%	3	7.97%	2	6.5%	3	National changes in reporting in June

PERFORMANCE – WEEKLY PROVIDER RANKINGS

The tables below show the weekly provider performance rankings when benchmarked against 121 providers with A&E departments. This is based on unvalidated data submitted daily via ECDS.

As shown, following a particularly difficult period in June and July for CUH, linked to IPC issues, performance has improved and CUH have been in the top quartile for some areas of performance. It is worth noting that NWAFT also experienced significant challenges during this period in June and we continued to balance risk across providers, with NWAFT taking ambulance diverts on 14 / 30 days in month.

For NWAFT, recent weeks have seen an improvement in ambulance handover times but wait times in ED have deteriorated.

Providers benchmarked out of 121 Trusts with A&Es		Bottom quartile	Top quartile			
		Rank				
		Ambulance handover over 60 min	4 hour performance	Average time spent in A&E (minutes)	12 hours from arrival in A&E (per day)	Patients no longer meeting criteria to reside who were not discharged (per day)
CUH	01/09/2024	16	81	43	47	12
	25/08/2024	30	66	28	44	16
	18/08/2024	27	85	43	54	18
	11/08/2024	57	78	36	66	20
	04/08/2024	101	79	64	92	30
	28/07/2024	58	84	56	85	40
	21/07/2024	66	76	54	86	33
	14/07/2024	66	76	54	86	33
	07/07/2024	102	89	102	74	41
	30/06/2024	113	63	67	86	39
	16/06/2024	114	92	101	88	20
	09/06/2024	71	85	51	80	26
	02/06/2024	88	87	51	76	25

		Rank				
		Ambulance handover over 60 min	4 hour performance	Average time spent in A&E (minutes)	12 hours from arrival in A&E (per day)	Patients no longer meeting criteria to reside who were not discharged (per day)
NWAFT	01/09/2024	89	71	81	96	23
	25/08/2024	83	79	65	97	11
	18/08/2024	86	48	65	84	16
	11/08/2024	93	94	71	92	14
	04/08/2024	80	57	12	64	0
	28/07/2024	98	58	14	86	12
	21/07/2024	61	34	20	73	12
	14/07/2024	61	34	20	73	12
	07/07/2024	94	40	11	77	18
	30/06/2024	98	74	27	90	18
	16/06/2024	103	80	20	75	13
	09/06/2024	88	99	23	99	7
	02/06/2024	97	60	66	82	7

TIERING

With performance against the national headline targets of: 78% of patients being admitted, transferred or discharged within 4 hours by March 2025 & Improved ambulance response times for Category 2 incidents to 30 minutes on average during 2024/25, continuing to remain challenged across the C&P ICS, in August 2024 the ICB were notified by NHSE that the system had been escalated to Tier 2 of the national UEC programme.

In addition to reviewing our UEC improvement plans, since receiving confirmation of a formal move to Tier 2, partners have come together to do the following:

- Reviewed our approach to tiering meetings, changing the membership and content, with a prescribed pack for completion and presentation to ensure focus on key areas of risk and variation to plan. To support this we have engaged with other ICBs already in tiering, including N&W ICB and HWE ICB
- Written to Regional NHS England colleagues asking for additional attendance at our UEC meetings from UEC subject matter experts, alongside the current relationship lead attendees
- Written to EEAST regarding their attendance at tiering meetings, reflecting that actions beyond ambulance handover times are needed to improve C2 performance
- Engaged with the new rapid improvement programme approach, with a focus for us on internal Length of Stay (LoS) within the two acute sites
- Consolidated reporting, so we are clear about our benchmarked position, relative to others on all indicators; both headline indicators (A&E 4 hour, C2) as well as some of the subset indicators ie type 1 performance.

The ICB has written to the regional NHS England team setting out the actions being taken as part of this move but we have yet to receive confirmation on NHS E approach to tiering or exit criteria as discussed at Augusts' QPF Committee. The following slide shows performance against the four metrics considered as part of tiering (unvalidated). As discussed previously, these are subsets of the overarching performance indicators that form the headline expectation.

PERFORMANCE - TIERING INDICATOR SUBSET

Type 1 4 hour performance (attendances not admissions) >70% | =<70% >60% | =<60% | *C&P system March 2025 operational plan target 70.2% (NWAFT 73.6% and CUHFT 66.0%)*

Trust & Site	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024
CUHFT	**49.0%**	**40.1%**	**42.7%**	**43.9%**	**42.3%**	**41.9%**	**54.5%**	**47.1%**	**48.6%**	**49.2%**	**49.6%**	**54.0%**	**50.5%**
Addenbrooke's	49.0%	40.1%	42.7%	43.9%	42.3%	41.9%	54.5%	47.1%	48.6%	49.2%	49.6%	54.0%	50.5%
NWAFT	**59.1%**	**53.5%**	**45.0%**	**49.2%**	**50.1%**	**53.7%**	**58.8%**	**55.0%**	**55.5%**	**64.1%**	**64.5%**	**64.3%**	**60.4%**
Hinchingbrooke	75.8%	70.9%	60.6%	65.9%	63.8%	75.2%	72.1%	69.4%	73.4%	83.6%	84.0%	86.5%	82.4%
Peterborough City Hospital	45.6%	40.3%	33.2%	37.1%	40.5%	38.4%	49.3%	44.8%	43.1%	50.6%	50.9%	49.0%	44.8%
Total	**54.6%**	**47.5%**	**44.0%**	**47.0%**	**46.7%**	**48.6%**	**56.9%**	**51.6%**	**52.5%**	**57.8%**	**58.2%**	**59.8%**	**56.1%**

Latest Data: Thursday, September ...

Current Month System Performance: 56.1%

Patients in ED for 12+ hours as a proportion of type 1 attendances =<6% | >6% =<10% | >10% | *Green top third ICBs. Red bottom third ICBs. July 2024 data*

Trust & Site	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024
CUHFT	**7.2%**	**15.0%**	**13.8%**	**15.1%**	**17.1%**	**17.9%**	**12.9%**	**15.6%**	**14.2%**	**13.7%**	**12.4%**	**8.3%**	**10.1%**
Addenbrooke's	7.2%	15.0%	13.8%	15.1%	17.1%	17.9%	12.9%	15.6%	14.2%	13.7%	12.4%	8.3%	10.1%
NWAFT	**12.0%**	**14.6%**	**16.4%**	**15.6%**	**15.7%**	**14.7%**	**13.1%**	**15.1%**	**13.3%**	**10.9%**	**10.5%**	**10.9%**	**11.7%**
Hinchingbrooke	0.8%	2.6%	5.3%	5.4%	6.0%	3.9%	3.4%	5.2%	2.9%	1.2%	1.4%	1.0%	1.2%
Peterborough City Hospital	21.0%	23.6%	24.7%	22.9%	22.6%	22.3%	20.0%	22.1%	20.5%	17.7%	16.9%	17.8%	19.2%
Total	**9.9%**	**14.8%**	**15.2%**	**15.4%**	**16.3%**	**16.1%**	**13.0%**	**15.3%**	**13.7%**	**12.1%**	**11.3%**	**9.8%**	**11.0%**

Latest Data: Thursday, September ...

Current Month System Performance: 11.0%

Ambulance handover delays over 30 minutes as a proportion of arrivals at ED =<19% | >19% =<30% | >30% | *Green top third national performance. Red bottom. July 2024*

Trust & Site	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024
CUHFT	**4.4%**	**9.2%**	**8.7%**	**25.5%**	**27.4%**	**24.2%**	**15.2%**	**28.3%**	**28.7%**	**43.8%**	**21.1%**	**8.7%**	**5.6%**
Addenbrooke's	4.4%	9.2%	8.7%	25.5%	27.4%	24.2%	15.2%	28.3%	28.7%	43.8%	21.1%	8.7%	5.6%
NWAFT	**27.5%**	**43.1%**	**52.1%**	**42.7%**	**37.2%**	**34.3%**	**28.8%**	**46.6%**	**39.1%**	**33.8%**	**34.1%**	**28.3%**	**40.8%**
Hinchingbrooke	8.7%	20.4%	34.3%	31.0%	20.4%	12.8%	11.0%	16.2%	11.4%	11.0%	18.0%	12.4%	16.3%
Peterborough City Hospital	36.8%	55.2%	61.6%	48.7%	45.6%	45.6%	38.0%	63.6%	52.9%	45.4%	42.1%	36.0%	54.4%
Total	**18.6%**	**28.9%**	**33.7%**	**35.7%**	**33.4%**	**30.3%**	**23.4%**	**39.0%**	**34.9%**	**37.5%**	**28.9%**	**20.8%**	**26.5%**

Latest Data: Thursday, September ...

Current Month System Performance: 26.5%

% beds occupied by patients with a length of stay of 14+ days =<26% | >26% =<30% | >30% | *Green top third ICBs. Red bottom third ICBs. July 2024 data*

Trust & Site	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024
CUHFT	**29.1%**	**29.4%**	**30.2%**	**30.7%**	**31.8%**	**31.5%**	**33.3%**	**31.5%**	**32.3%**	**34.8%**	**33.3%**	**30.5%**	**30.2%**
Addenbrooke's	29.1%	29.4%	30.2%	30.7%	31.8%	31.5%	33.3%	31.5%	32.3%	34.8%	33.3%	30.5%	30.2%
NWAFT	**30.0%**	**29.8%**	**29.7%**	**30.4%**	**28.5%**	**29.0%**	**29.6%**	**29.5%**	**27.6%**	**27.3%**	**27.9%**	**27.1%**	**27.2%**
Hinchingbrooke	28.2%	30.1%	28.1%	26.6%	25.3%	27.8%	29.3%	29.1%	31.9%	28.1%	28.4%	26.0%	24.9%
Peterborough City Hospital	30.8%	29.7%	30.4%	32.1%	30.0%	29.5%	29.7%	29.7%	25.7%	26.9%	27.6%	27.6%	28.2%
Total	**29.5%**	**29.6%**	**30.0%**	**30.6%**	**30.2%**	**30.3%**	**31.5%**	**30.5%**	**30.0%**	**31.2%**	**30.7%**	**28.8%**	**28.8%**

Latest Data: Thursday, September ...

Current Month System Performance: 28.8%

Ambulance Cat 2 response time (system monthly average mins) =<18mins | >18 mins =<30mins | >30mins | *Requirement to reach 30mins by end of FY. 18mins is the KPI*

September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024
33.9	42.4	41.1	39.9	42.8	36.0	33.2	37.3	34.6	39.7	33.3	30.5	32.3

Latest Data: Wednesday, September 18, 2024

Current Month System Performance: 32.3

UEC RECOVERY PLAN UPDATE

C&P ICS have had a live UEC Improvement Plan in place since 2022/23, centered on the principle of continuous quality improvement, developed in collaboration with system partners and agreed at Unplanned Care Board. System discussions through the summer based on extensive data analysis of quantitative and qualitative evidence identified a detailed list of interventions for focus over the next six months, most likely to have a high impact on improving UEC performance and transforming service delivery as set out in the New Care Model.

The key areas of focus were highlighted as:

Health Optimisation with a focus on respiratory, care homes and seasonal illness.

Expansion of the **C&P Acute Illness and UEC Hub**, supported by a Trusted Assessor model and single point of access for all healthcare professionals.

Demand and capacity planning, specifically the introduction of additional GP capacity and delivery of robust streaming models in ED.

Home First, building on the programme already established to enhance voluntary sector support and expand into community and mental health settings.

To support the delivery of these four key themes, several schemes have been identified, some already being delivered within existing resources through a continuous improvement approach and some which will require additional funding in the first instance. The delivery plans, implementation timelines, expected impact and outcomes, including defined KPI's and associated costs for each of these schemes can be seen in the slides below.

The winter schemes were discussed at Commissioning and Investment Committee (CIC) and the Integrated Care Board in September 2024. All were supported in principle with agreed delegated authority for executive sign off for those schemes where there was a financial requirement. Funding for schemes has currently been agreed on a non-recurrent basis. The investment overview is outlined in Appendix 3 (attached).

PROGRESS AGAINST SCHEMES TO DATE

Scheme Name	Delivery Plan	Milestones on target	KPI's developed	PMO paperwork completed *	Risks R/ Mitigations M escalated
High Impact Users	Completed	In Progress	Completed	Started	R outcomes not realised until March 25, effective evaluation of the model
Covid & Flu vaccination	Completed	In Progress	Completed	Started	R Provider resource to support delivery
Frailty Services	In Progress	In Progress	Completed	Started	R Geriatrician and physiotherapy support
Care home proactive intervention	In Progress	In Progress	Completed	Started	
UEC Hub development	Completed	Completed	Completed	In Progress	R Staff Recruitment, physical space and IT M phased roll out
Targeted Respiratory interventions	In Progress	In Progress	In Progress	Started	
Additional GP capacity	Completed	Completed	In Progress	Started	R Staff Recruitment and physical space M phased roll out
111 ED Streaming	Completed	Completed	Completed	In Progress	R HUC capacity to support and IT requirements
Pathway one capacity	Completed	Completed	Completed		R High LoS impacting on ED and ambulance flow
Personalised discharge budgets	Completed	Completed	Completed	In Progress	R Low utilisation in early stages M extensive comms plan proposed ro raise awareness of service
Extended VSA support	Completed	Completed	Completed	Started	R Staff recruitment M mirroring previous successful recruitment approach
Maximising discharge medicines service	Completed	Completed	Completed	Started	R Staff shortages, integrated referrals system not implemented

*PMO paperwork due for submission on 27/09/2024

NEXT STEPS

Next steps for implementation of the schemes:

Each provider responsible for delivering a scheme is required to submit a final proposal document outlining their delivery plan including milestones, timescales for implementation and KPI's. This needs to be completed and returned to the ICB by the end of September 2024.

The ICB is currently establishing a Winter Task Force. The remit of this group is to report on progress against delivery for 'Go Live' for each of the winter plans. The Task Force meetings will be fortnightly, but attendance will be targeted to align to delivery plans and ensure efficient use of individual's time.

Once schemes have gone live, ongoing performance and delivery monitoring will be through the ICB PMO process with provider submission of monthly highlight and KPI reports which will be fed back into the Winter Task Force Group.

SCHEMES

Health Optimisation
Covid and Flu Vaccinations
Care home proactive intervention
Targeted Respiratory Interventions
Frailty Services

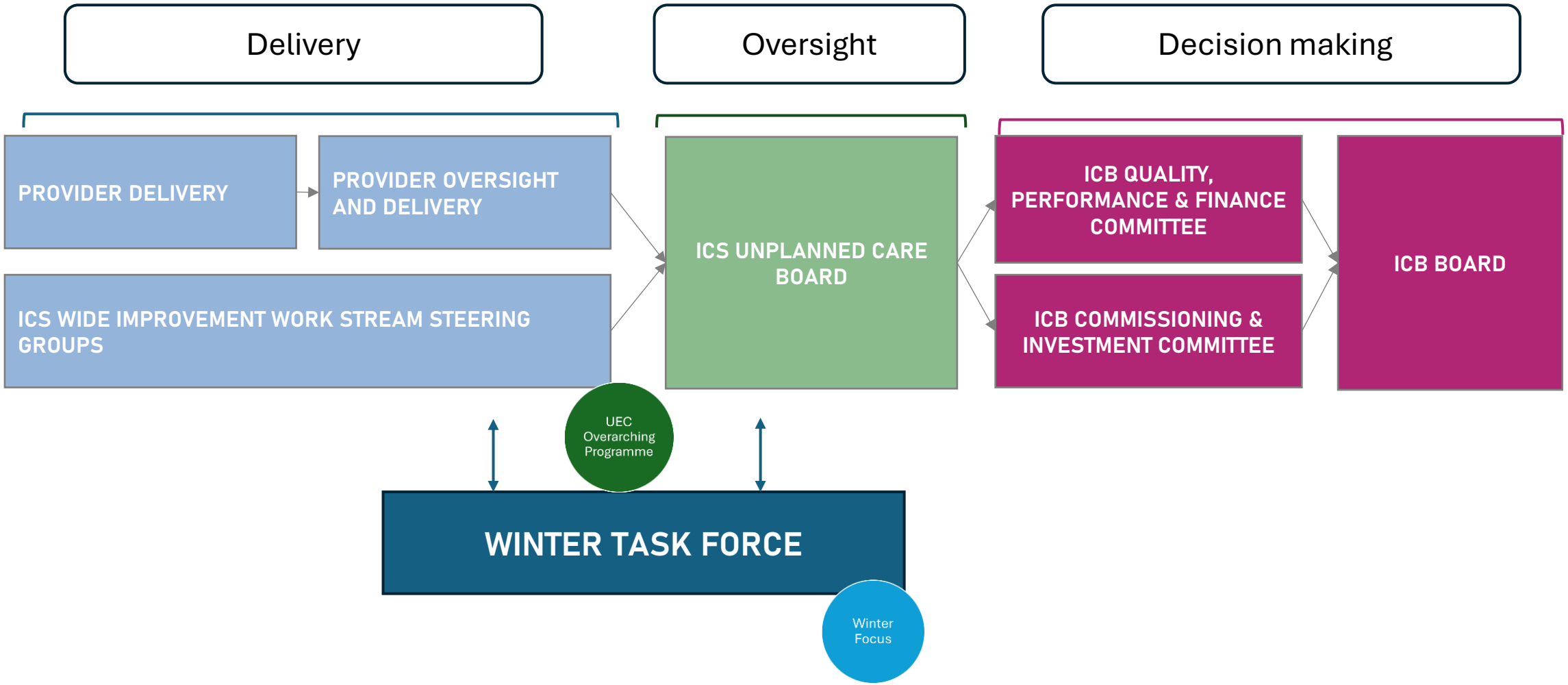
Acute Illness and UEC hub
UEC Hub development

Home First
Personalised Discharge Budgets
Extended Voluntary Sector Alliance (VSA) Support
Pathway One capacity
Maximising discharge medicine service

Demand and Capacity
Additional GP Capacity
111 ED Streaming
High Impact Users

Progress against scheme deliverables, KPI's, risks and mitigations will be presented to the Unplanned Care Board. Evaluation and assessment of each of the schemes will be undertaken between February and March 2025, the results of which will form the basis of determining a case for sustainable funding going forwards.

GOVERNANCE



The governance arrangements around UEC improvement, including winter preparedness and delivery, are well embedded across the ICS. These are kept under constant review to ensure that they are adaptable to changing needs, particularly relating to delivery work streams and in line with performance risks.

C&P UEC Improvement Schemes 24/25

46

HIGH IMPACT USERS

WHAT IS IT?

A specialist service that focuses on those people who are the highest users of A&E services through the recruitment of dedicated HIU leads, life coaches and MDT teams to deliver personalised care to those individuals.

WHY?

High use of unplanned care services indicates that we have missed opportunities to intervene earlier

STP: Cambridgeshire and Peterborough

Patients with 20+ A&E attendances	Minimum	Maximum	Average	Totals
People				102
Attendances	20	372	28.3	2891
Emergency admissions via A&E *	0	34	7.6	771
11-19 Attends				
Patients with 11-19 A&E attendances	Minimum	Maximum	Average	Totals
People				340
Attendances	11	19	13.2	4503
Emergency admissions via A&E *	0	18	4.2	1444
5-10 Attends				
Patients with 5-10 A&E attendances	Minimum	Maximum	Average	Totals
People				4555
Attendances	5	10	6.0	27437
Emergency admissions via A&E *	0	10	2.1	9668

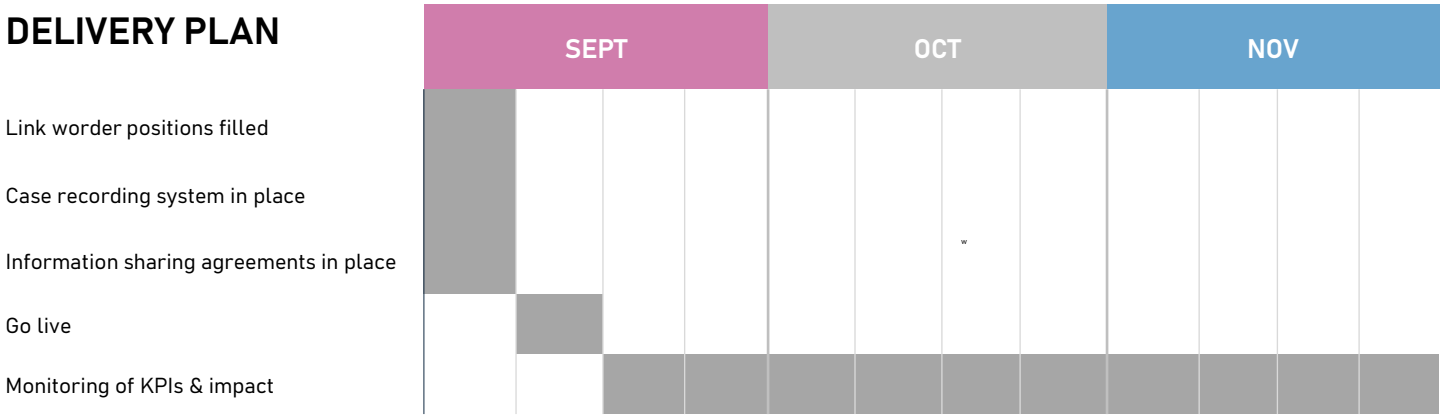
IMPACT EXPECTED

40% decrease in A&E attendances in the selected patient cohorts

RESOURCES

£900,000 to cover the whole of C&P to recruit an operational team hosted by the local authority (an additional £1,675,800 has been invested at Place level to support a complimentary targeted service focused on proactive case finding at neighborhood level)

DELIVERY PLAN



RISKS

R1	The anticipated outcomes from the Tier 1 service will not be realised by the March 2025 target date due to delays in the 'go-live' date as a result in delays with identification of a host organisation; contractual delays and subsequent approval timeframes; and anticipated delays in the recruitment of HIU staff	M1	Recruitment of HIU Team almost completed. Evaluation of the service required to support ongoing investment as well as alignment to other ICS-wide programmes of work (e.g., mental health student service pilot, MH discharge buddy scheme etc.)
R2	Effective evaluation of the HIU Tier 1 and 2 models is not possible because no standardised reporting processes exist to track the journeys of the specific patient cohorts/caseloads and the impact of the Tier 1 and 2 services in terms of patient experience and outcomes.	M1	Discussions in progress re: longer term evaluation partner for HIU. Further direction expected in relation to this within the context of new care models and establishment of internal evaluation function within ICB.

COVID AND FLU VACCINATIONS

WHAT IS IT?

A national vaccination programme in public health, commissioned by NHSE and delivered operationally by the ICB to deliver to eligible cohorts as directed by JCVI.

WHY?

Seasonal vaccination programmes are health prevention initiatives to ensure our patient population stay well and ability to fight off preventable illnesses.

IMPACT EXPECTED

Reduction in winter pressures, uptake on impact to equal or exceed previous campaign from 23/24 of covid delivery 201k and flu delivery 306k

RESOURCES

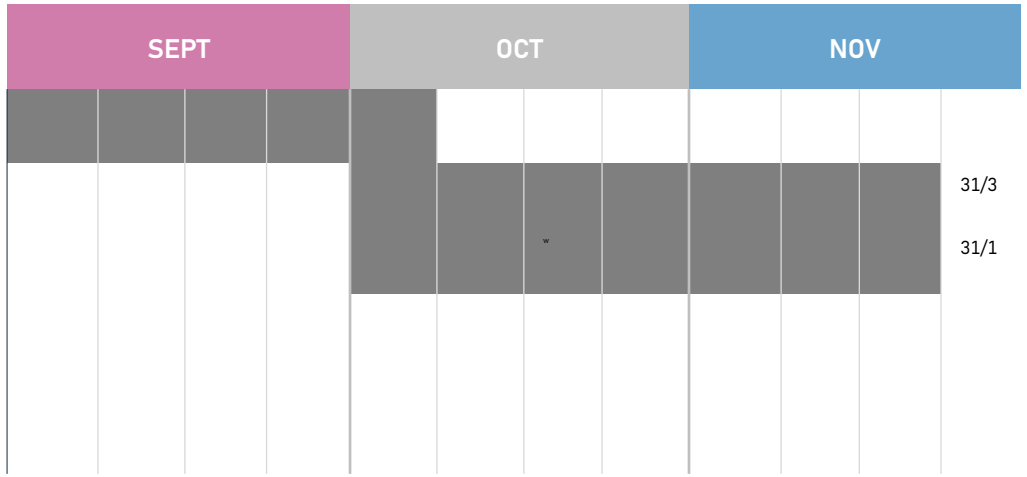
- Funded through NHSE vaccination progamme
- ICB Vaccination team in place
- Contracts to be established with GPs and Pharmacy
- Alternative delivery models being reviewed by NHS E

DELIVERY PLAN

Flu delivery 02/9 to 03/10 children and pregnant women

Flu delivery all cohorts 03/10 to 31/3

Covid delivery to all cohorts 03/10 to 31/1



RISKS

R1 Provider resource for delivery across system

R2 Primary care engagement

M1 Ongoing discussions and negotiation via NHSE

FRAILTY SERVICES

WHAT IS IT?

Provision of geriatrician led elderly care services across North and South to include:

- ✓ Falls clinics to include multi-factoral falls assessment and action plans
- ✓ Frailty rapid access clinics (outreach in community)
- ✓ Targeted support for care homes including A&G in UEC Hub

WHY?

Frailty costs UK healthcare systems £5.8 billion/year. 47% of inpatients 65+ years are frail, 3.2% are moderately to severely frail which occupies 36% of bed days (source: Clegg *et al*, Lancet 2013)
In C&P, 16.6% of GP registered population are aged 65 Of these, 3.7% have a dementia diagnosis

IMPACT EXPECTED

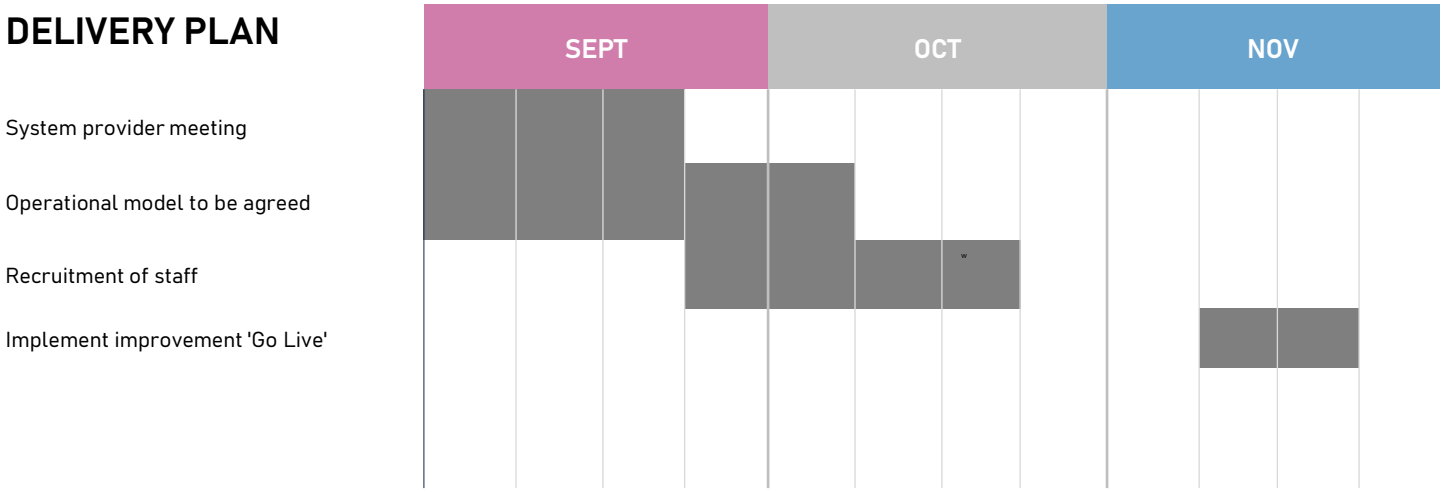
- Reduction in number of care home ED attendances and emergency call outs
- Reduction in number of unnecessary ED attendances for frail patients

Specific impact and outcome indicators to be finalised as part of operating model sign off and confirmed go live dates.

RESOURCES

Funding arrangements to be confirmed on agreement of models led by both CUHFT and NWAFT. £2.1m of ringfenced funding for all frailty interventions available.

DELIVERY PLAN



RISKS

R1	Recruitment, specifically of Geriatrician and physio support	M1	Exploring opportunities with all providers to look at collaborative approaches to provide geriatrician support from across the system
R2	Identifying physical space, centrally located with good access links for patients	M2	Exploring opportunities at Peterborough City Care Centre for the North
R3	Care home engagement		

CARE HOME PROACTIVE INTERVENTION

WHAT IS IT?

An outreach service to support care homes offering:

- Specialist geriatrician review of patients in care homes with a high frequency of hospital attendance
- Outreach into care homes for step down care & advance planning
- Education and support of care home teams
- Quarterly educational meetings
- Implementation of remote monitoring technology in high-risk care homes with proactive central monitoring to intervene prior to deterioration

WHY?

People residing in care homes are often living with frailty or multiple co-morbidities, needs that are more complex than that of the average older adult (British Geriatrics Society, 2012).
About 41% of emergency admissions from care homes are for conditions that are manageable, treatable or preventable outside of a hospital setting (The Health Foundation, 2019).

IMPACT EXPECTED

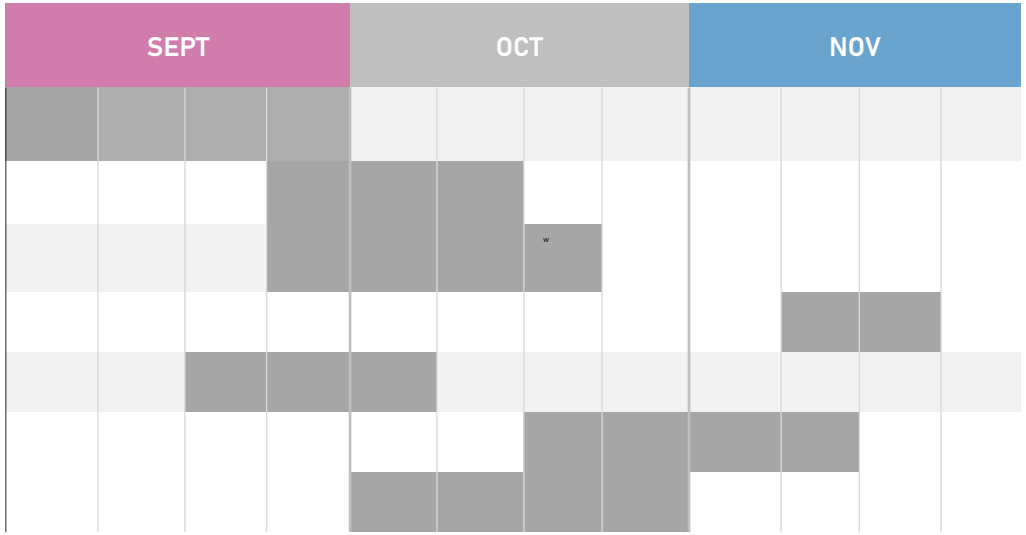
Reduction in number of care home ED attendances and emergency call outs

RESOURCES

Delivered with resources allocated to frailty

50

DELIVERY PLAN



RISKS

R1	Care home engagement/buy in	M1	Developing comms link and planned visits to care homes. Looking at opportunity to develop a Care Home Network group
R2	Geriatrician support/capacity	M2	Working with all providers to look at collaborative approaches to provide geriatrician support from across the system

UEC HUB DEVELOPMENT

WHAT IS IT?

Integration & coordination of acute healthcare services to streamline patient care, reduce delays, and improve outcomes by integrated multidisciplinary teams, case managers, and same day care & virtual hospital infrastructure under a single service "Hub"

WHY?

Traditional beliefs that patients requiring urgent care are always safer in acute Emergency Departments rather than at home often lead to long waiting times in inadequate conditions. This approach also biases our risk assessment to those visible in ED neglecting a broader needs assessment perspective that standardises and improves access to care & ensures a smooth transition between services (estimated 20% of clinical time currently lost in handover between services)

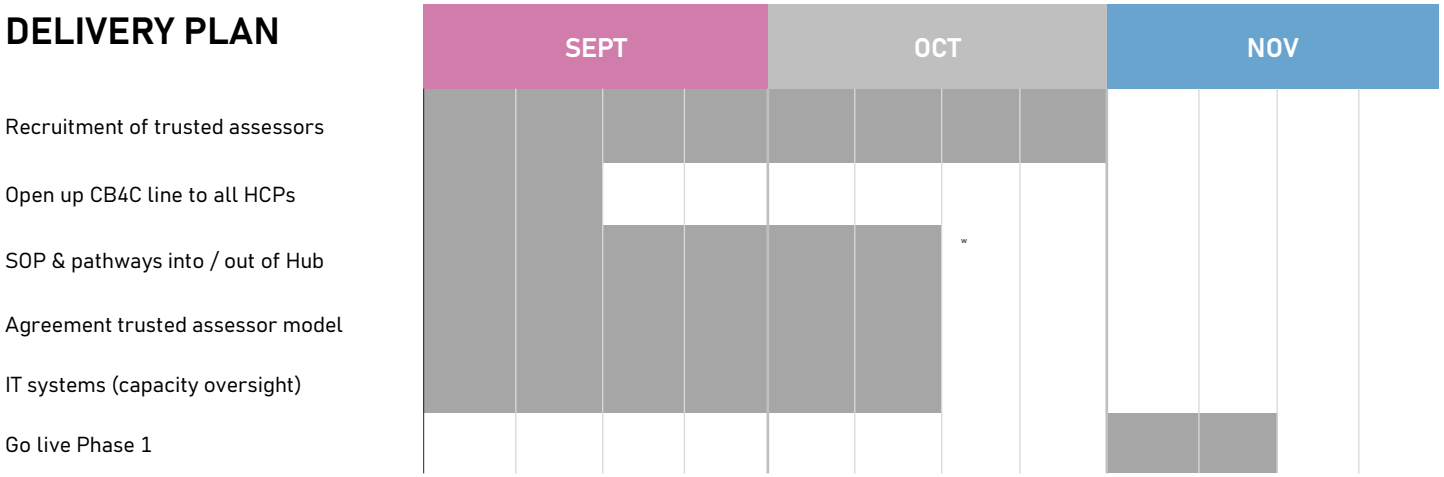
IMPACT EXPECTED

- Reduction of ambulance conveyances to ED.
- Reduction in AE attendances and unnecessary non elective admissions.
- Release of clinical time to deliver patient facing care.
- Delivery of UCR 2hr response standard target across all UCR pathways.

RESOURCES

£3.6m year 1 (split 50% to fund a senior clinician led advice and guidance service open 7 days a week to all healthcare professionals and 50% to fund a multidisciplinary 7-day trusted assessor service to manage access and flow through all urgent care system pathways)

DELIVERY PLAN



RISKS

R1	Delays in recruitment of trusted assessors
R2	UEC hub is not able to cope with demand / levels of referrals from the start
R3	Implementation of new IT packages to support hub processes take longer than anticipated and not ready by Nov

M1	Exploring early on opportunities for seconding staff currently doing triage in existing services into the roles short/medium term
M2	Phased approach to the transition from current arrangements to UEC hub incorporating a small number of services at a time
M3	Build short term alternatives in transition plan (ie use of nhs email, etc)

TARGETED RESPIRATORY INTERVENTIONS

WHAT IS IT?

Support for patients with COPD and asthma at risk of exacerbation through:
1) increased pneumococcal vaccination, 2) 48 hour follow ups for children post ED attendance with a diagnosis of Asthma, and 3) Proactive review of patients at risk of ED attendance/admission following an exacerbation 4) Targeted smoking cessation

WHY?

For every degree drop in temperature below 5C there is a 10.5% increase in primary care respiratory consultations and 0.8% increase in respiratory admissions.
Exacerbations of COPD account for 1 in every 8 admissions, growing at around 13% annually.

IMPACT EXPECTED

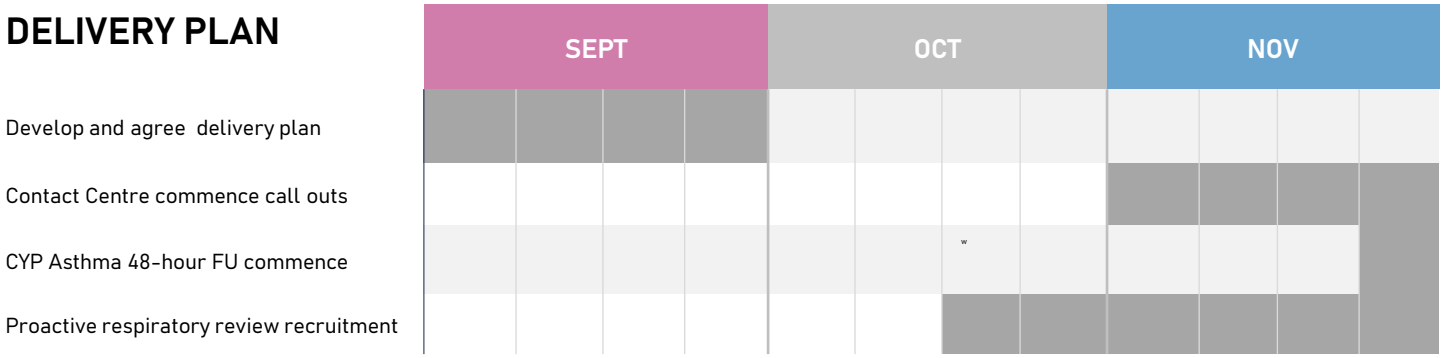
1) Reduce ED and GP attends due to pneumonia
Those that have had the vaccine results in 90% reduction in admissions with pneumonia[1]
2) Reduce reattendance rates for children with asthma exacerbations.
3) Equip at risk respiratory patients with the tools they need to live well at home and subsequently, reduce ED attendances/admissions.
4) Stopping smoking is associated with a significant reduction in the risk of hospital admission in COPD patients[2]

1https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6558731/pdf/12879_2019_Article_4119.pdf
2https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1746230/pdf/v057p00967.pdf

RESOURCES

£75,000

DELIVERY PLAN



RISKS

R1	Low take up of offered pneumococcal vaccination	M1	Vaccination programme will offer opportunistic pneumococcal jabs in existing clinics.
R2	Recruitment of appropriate PCNs is unsuccessful	M2	PCN order, by IMD and respiratory prevalence, will move to next in line.
R3	Recruitment of appropriately skilled staff is unsuccessful.	M3	Mitigation is mobilising option 4, smoking cessation.

GP ADDITIONAL CAPACITY

WHAT IS IT?

Overflow primary care capacity for 111, GP surgeries, acute emergency departments and UEC Hub operating 12 hours per day 7 days a week across three C&P locations. GP and AHP sessions to double up daily capacity to see patients.

WHY?

Average daily ED attendances where patients are discharged with no investigation or significant treatment is 38.6% across sites in C&P compared to 28.5% national average. There is significant scope for these patients to be seen by alternative services improving patient outcomes and experience, and ED flow.

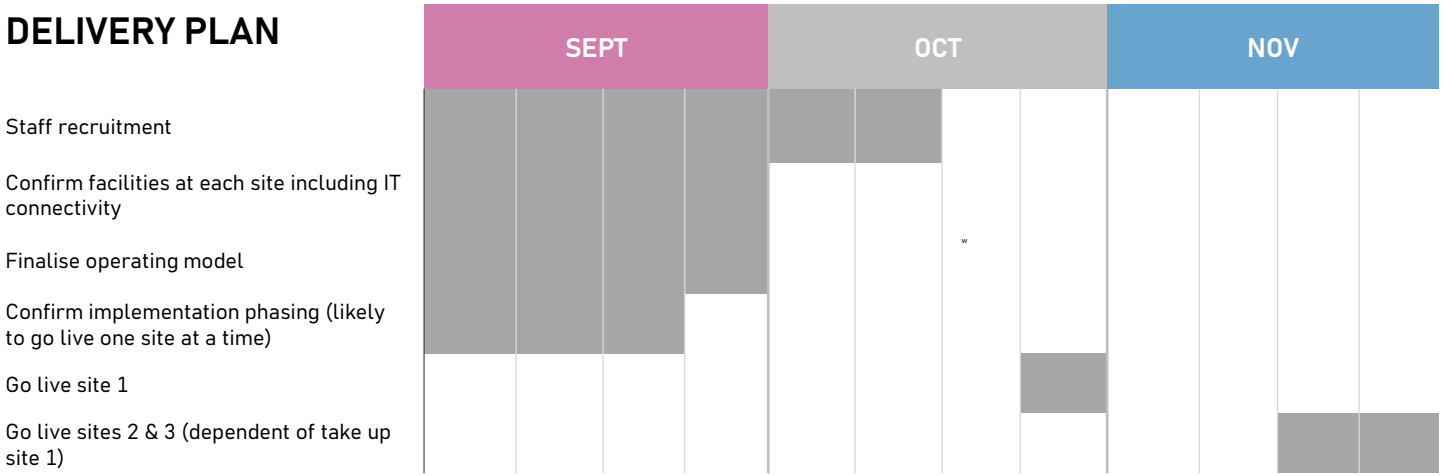
IMPACT EXPECTED

Up to 80 appointments per site per day (40 GP appointments and 40 AHP sessions). When all three sites are operational the system will have access to an additional 240 appointments per day.

RESOURCES

£3,750,000 for all three sites

DELIVERY PLAN



RISKS

R1	Recruitment of staff required to run 3 sites proves difficult	M1	Phase out roll out of sites and use a PDSA approach to explore optimal resource profile per site
R2	Suitable facilities not found in all preferred sites	M2	Alternative sites identified should preferred sites not be suitable / available
R3	Poor uptake / low utilisation of capacity	M3	Comprehensive comms before launch. Phased roll out will also enable adjustments to be made before further sites added.

111 ED STREAMING

WHAT IS IT?

Health Adviser navigators based at 3 acute EDs supporting public with self-triage using ED streaming tool. Re-direction/booking of clinically appropriate self-presenters through pathway routes outside of ED. Provided by HUC at CUH, PCH and HH EDs, 7 days per week based on demand mapping. EDs by appointment only for self-presenters

WHY?

Public behaviour has led to an increase in ED self-presenters despite AtED availability. Out of total ED attendances, self-presenters account for CUHFT 42% and NWAFT 68%, not all meeting ED suitable criteria

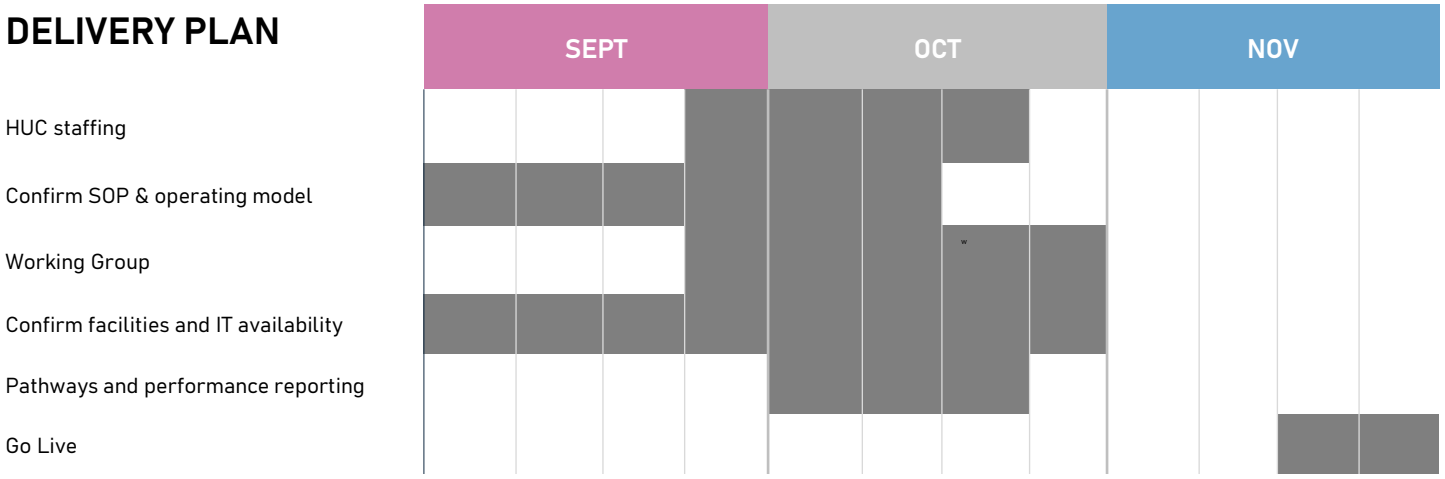
IMPACT EXPECTED

With Health Advisor navigators within the 3 C&P EDs – during peak hours, 7 days per week, up to 75% of self-presenters potentially can be redirected/booked into alternative to ED pathway routes. Reduction in ED booked patients and release in patient facing ED hours. Expected improvement in patient experience and outcomes.

RESOURCES

£270,000 to £300,000 across C&P all three locations

DELIVERY PLAN



RISKS

R1	HUC CA staff resources	M 1	Explore HA navigator model using self-service tablets & HUC control Centre
R2	IT not available/takes longer than go live date	M 2	Explore short term alternative to ensure go live
R3	Demand greater than ED streaming model capacity	M 3	Explore additional HA or acute staff resource

PATHWAY ONE CAPACITY

WHAT IS IT?

Additional capacity within the Intermediate Care Team service (CPFT) to support timely PW1 discharges home following an acute hospital stay or from a community inpatient bed.

WHY?

Following the end of the additional winter investment in 2023/24, C&P has experienced significant delays in discharging patients via Pathway 1 ICT (Health). This has had a notable impact on the overall flow of urgent and emergency care (UEC). Additionally, the latest Pathway 1 review has identified a gap between capacity and demand (C&D) within the ICT that requires mitigating and addressing long-term.

IMPACT EXPECTED

Using the ICT demand data from the past 12 months and the resources dedicated to this initiative, we expect minimal delays related to ICT pathway capacity between September 2024 and April 2025. The ICT pathway will be bolstered by the addition of private ICT vehicles and enhanced coordination resources.

The impact will be monitored daily by CPFT and the Transfer of Care Hub. Success will be reflected in a consistently low number of ICT cases awaiting start dates across Trusts, with the overall effect evaluated monthly based on reductions in Acute and Community lost bed days.

RESOURCES

£314k (23/24 funding – already with CPFT)
c.£1m (reinvestment of expected savings from PW2 D2A beds redesign and removal of Spot Purchase process)
c. £243k – to be funded from the C&D budget

Max Total of £1.58m

DELIVERY PLAN	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
CIC approval of reinvestment of PW2 savings to support PW1									
ICB letter to CPFT confirming funding agreed and reporting requirements									
CPFT mobilisation of additional cars as per demand									
Phasing down plan to be discussed/ agreed									

RISKS

R1	Length of stay remains too high within all settings impacting on ED and ambulance flow.
M	Ongoing work through Home First programme and wider LoS work within acute providers

PERSONALISED DISCHARGE BUDGETS

WHAT IS IT?

One off personal budgets to support discharge community inpatient beds and community mental health beds.
Used to pay for goods and/or services which without funding would delay patients being discharged.

WHY?

Personalised discharge budgets have been in place in C&P for over a year to support hospital discharges and have shown significant impact and return on investment. From Feb to June 2024, 94 referrals were managed with an estimated 332 bed days saved. The benefits will be increased by extending the offer to discharges from community and MH beds.

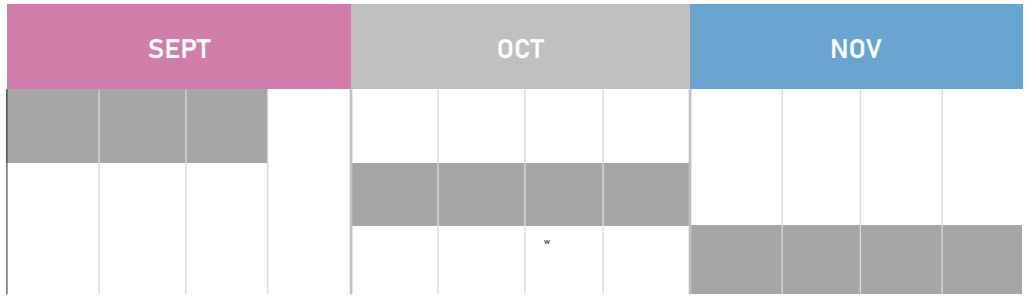
IMPACT EXPECTED

Reduced length of stay and improving patient flow through and out of the Trusts including community inpatients beds and mental health beds.
Providing a person-centred approach focusing on the best outcomes and care experience for the patient. Enabling a safe return home through provision of equipment and/or services, empowering patients to manage their own conditions.
Reduced risk of hospital acquired infections in the vulnerable groups.

RESOURCES

Included in resources for extended voluntary sector alliance support

DELIVERY PLAN



RISKS

R1	Low utilisation until service is well established
M1	Extensive communication with system partners ahead of go live to ensure patients that could benefit from this service are identified early on

EXTENDED VOLUNTARY SECTOR ALLIANCE SUPPORT

WHAT IS IT?

Increased community support to respond to referrals and requests for support from the UEC Hub. Additional dedicated capacity to focus on admission avoidance including support for the Early Intervention Team in the acute (facilitating discharges from ED prior to admission)

WHY?

VS Alliance already in place to support discharges and delivering an effective single point of access to key services to support older people with 84% of current referrals being for people over 70 years old. Expansion of this support for people in community will enhance opportunities to avoid unnecessary conveyances and admissions to hospital for target cohort.

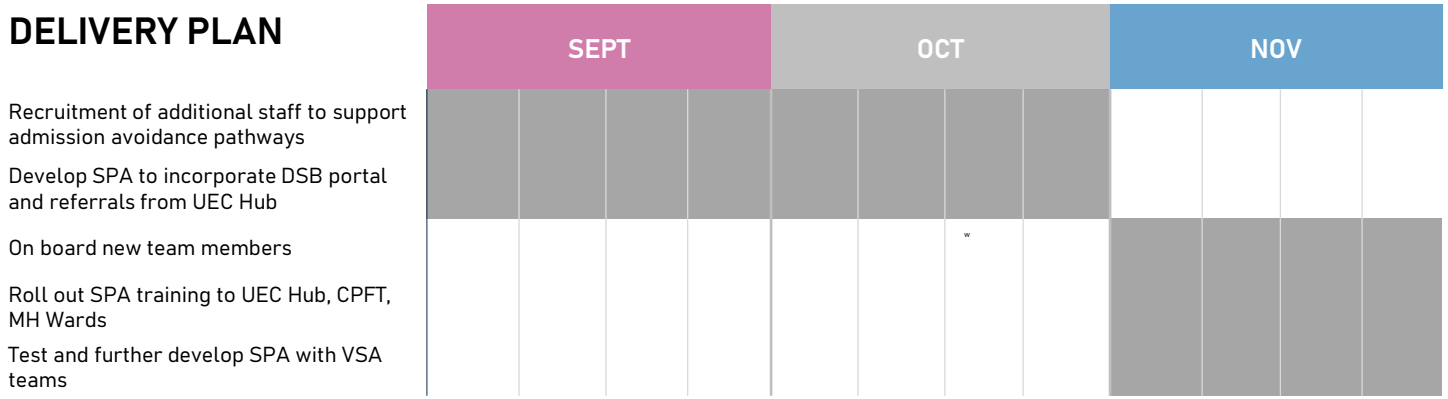
IMPACT EXPECTED

Increased referrals to voluntary sector services from acute ED, UEC Hub, and other community services to support patients in their own homes and avoid unnecessary hospital admissions.

RESOURCES

£233,076 up to March 2025.

DELIVERY PLAN



RISKS

R1	Challenges recruiting staff	M1	Plans in place to mirror previous recruitment approach for SPA posts which proved successful
R2	Low utilisation of vol sector services to support admission avoidance	M2	Proactive work from Trusted Assessor in UEC Hub to ensure vol sector services are considered whenever appropriate

MAXIMISING DISCHARGE MEDICINES SERVICE (DMS)

WHAT IS IT?

Using the DMS, hospital trusts send digital referrals to community pharmacies, where pharmacists assist with managing medication changes and provide guidance to patients on how to use their updated prescriptions.

WHY?

The Discharge Medicines services aims to reduce harm from medicines at transfers of care, identify medication errors and facilitate resolution in primary care and reduce hospital readmissions.
For every 10 patients referred through the DMS, 1 patient is prevented from hospital readmission. For those DMS patients that are readmitted to hospital, their stay is reduced by an average of 6 days.

IMPACT EXPECTED

- A 20% referral rate target by March 2025 has been agreed by respective Chief Executives of all four trusts within our system.
- The financial year average for the ICB is 2.07% with the highest performance rate at CPFT at 11.55% and lowest performance rate at NWAFT at 0.63%
- CPFT and RPH performance is above the national highest quartile average.
- System plans are in place to working with trusts to improve performance.

RESOURCES

- No resource implication at this stage

DELIVERY PLAN	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
ICB										
Inclusion of 20% target into Trust contact										
Monthly tracking and sharing of data										
CUH										
Implement Admin referrals system										
Develop integrated referrals system										
Expand target DMS cohorts										
RPH										
Add DMS consent to Meds Rec form as prompt										
All new staff to be trained on DMS										
NWAFT										
Identify DMS lead at each Trust site										
Explore Alternative working methods										
Increase staff awareness										
CPFT										
Increase staff awareness										
Identify DMS lead at each Trust site										

RISKS

R1	Staff shortages and workload pressures
R2	Integrated referrals system not implemented

M	Ongoing work with community pharmacies to review and mitigate if needed

59

APPENDICES

Appendix 1 : UEC STRATEGY

VISION

System partners working collaboratively to provide Cambridgeshire & Peterborough's population with high quality, safe urgent and emergency care by delivering preventative initiatives close to home, enhanced urgent community response and admission avoidance schemes to reduce ambulance conveyances and minimise time spent in hospital, whilst supporting continuous improvements in hospital pathways for those who require access to secondary care.

AIMS

- To deliver high quality, safe urgent and emergency care
- To develop and deliver preventative services closer to home
- To continue to develop and improve services to avoid unnecessary hospital admission or/and ambulance conveyances
- To develop effective post hospital and discharge services to minimise time spent in hospital, optimize patient flow, and ensure patients are discharged to the most appropriate setting
- To continue to improve urgent and emergency pathways in primary, community and secondary care

OBJECTIVES

1. Establishing a well-co-ordinated integrated community urgent care response service enabling patients to be supported at home where clinically appropriate
2. Ensuring ambulances reach patients in line with national target response times and can handover patients to hospital services quickly
3. Supporting Acute Trusts to deliver and sustain the 4-hour ED performance target
4. Minimising delays experienced by patients at any stage of their hospital stay thereby reducing average LOS and improving bed occupancy
5. Ensuring timely discharge and access to appropriate community-based services and intermediate support to complete rehabilitation
6. Embedding and refining our System Control Centre (SCC) model to ensure tight day to day grip on flow and effective escalation processes are in place
7. To improve patient experience, waiting times, and outcomes.

KPIS

1. C2 response times
2. Avg. handover time
3. Urgent community response
4. A&E attendances
5. A&E 4hr performance
6. G&A Bed occupancy
7. Zero-day Length of Stay
8. Non-elective admissions
9. Admissions from care homes
10. Length of stay 14+ days
11. Not meeting Criteria to Reside (daily avg.)
12. Virtual Wards occupancy

Appendix 2 : INVESTMENT OVERVIEW

The updated UEC improvement plan has four key themes, reflecting the data and known opportunities aligned to healthcare utilisation model (optimisation and acute illness) and removing duplication between individual provider owned plans and those which are system owned.

Many of the priority areas remain those identified at the beginning of the year, with schemes and services implemented to support more effective integrated UEC across C&P. There are several areas of additional investment expected in H2 as outlined in the table below, these will be supported by specific national funding for capacity and demand / UEC performance, with detailed schemes subject to Commissioning and Investment Committee review and expected to be finalised through September 2024.

Priority Area	April 2024	September 2024	Total
NWAFT & CUHFT (bed capacity & winter preparedness)	£21,424,000	£0	£21,424,000
Care of the elderly (North & South)	£0	£2,100,000	£2,100,000
UEC Hub**	£1,800,000	£1,800,000	£3,600,000
Urgent Wrap Around Care (UWAC /North & South)	£2,200,000	£0	£2,200,000
Virtual Wards	£3,552,470	£0	£3,552,470
GP Hubs and 111 ED streaming	£0	£4,100,000	£4,100,000
Discharge Support	£3,920,000	£0	£3,920,000
Voluntary sector (including EoL care)	£754,229	£233,076	£987,305
Targeted Respiratory Interventions	£0	£75,000	£75,000

This page is intentionally left blank