Cambridgeshire & Peterborough
Integrated Care System

C&P ICS H1 2021/22 Operational Planning Submission Summary

28 May 2021

This document summarises the C&P ICS response to NHSEI operational planning guidance for H1 of 2021/22

The C&P ICS H1 2021/22 Operational Planning Submission Summary encapsulates our system's submissions to NHSEI, including the following templates:


Narrative


Activity and performance


Workforce


Mental health


Finance


Cancer

This summary captures our high level response to the specific asks of the 21/22 planning guidance and therefore does not include all of our planning work across the system. Our full submission expands on the detail in this summary. Our submissions to NHSEI will be further developed into a comprehensive 21/22 operational plan that incorporates all of our planning and ambitions as a system.

To deliver our plans, we will work locally in neighbourhoods, in places, across our system and across ICSs.

The structure of this summary follows the six priorities in the Operational Planning Guidance 21/22.

A. Supporting the health and wellbeing of staff and taking action on recruitment and retention

B. Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19

C. Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services

D. Expanding primary care capacity to improve access, local health outcomes and address health inequalities

E. Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay

F. Working collaboratively across systems to deliver on these priorities

Supporting our workforce is a core component of our system operating plan

- Our ICS Operating Plan submission sets out the work in train to develop and implement our Local People Plan which will be further developed through the System Workforce Improvement Model (SWIM) methodology
- The SWIM methodology focuses on supporting the development of plans to accelerate ICS workforce development and the SWIM themes align to our People Plan themes and plans which are summarised below

Looking after our people

We have developed a system-wide programmes for system staff including:

- System-wide **Staff Mental Health Service** that delivers rapid access multi-disciplinary mental health support for staff from our NHS Trusts
- ICS **Covid-19 Staff Support Hub**, launched in February 2021 to engage staff in hard to reach groups
- 12 month pilot of **enhanced Occupational Health and Wellbeing service** offer to all 85 GP practices and 65 small community pharmacies

Through H1 these programmes will be sustained to ensure continued support to maintain and improve staff wellbeing.

Belonging to H&SC

Specifically over the next six months we will focus on three priority areas with agreed plans:

- **Talent management**, including providing access to development opportunities for BAME staff and overhauling our recruitment to reduce bias and discrimination
- **Learning and development**, running a Stepping Up Programme for C&P staff and undertaking a review of ED&I training provided
- **Tackling bullying and harassment** through implementation of a Cultural Ambassadors programme

All of NHS partner organisations have established BAME and Disability staff networks to support staff.

New ways of working

The system has agreed four actions to transform workforce ways of working:

- Develop a **system workforce plan** which maps to our population needs
- Challenge the infrastructure in each of our organisations to explore **become leaner** over coming years
- Innovate to **create new roles**; and career pathways across NHS, primary and social care
- Recruit to a Director of System Workforce Transformation and Culture post by July 2021

All Trusts are reviewing and embedding changes to flexible working arrangements for staff and plans are in place to improve the coverage and level of attainment for e-rostering

Growing for the future

As a system we are working together on shared programmes to recruit and retain staff. The projects include:

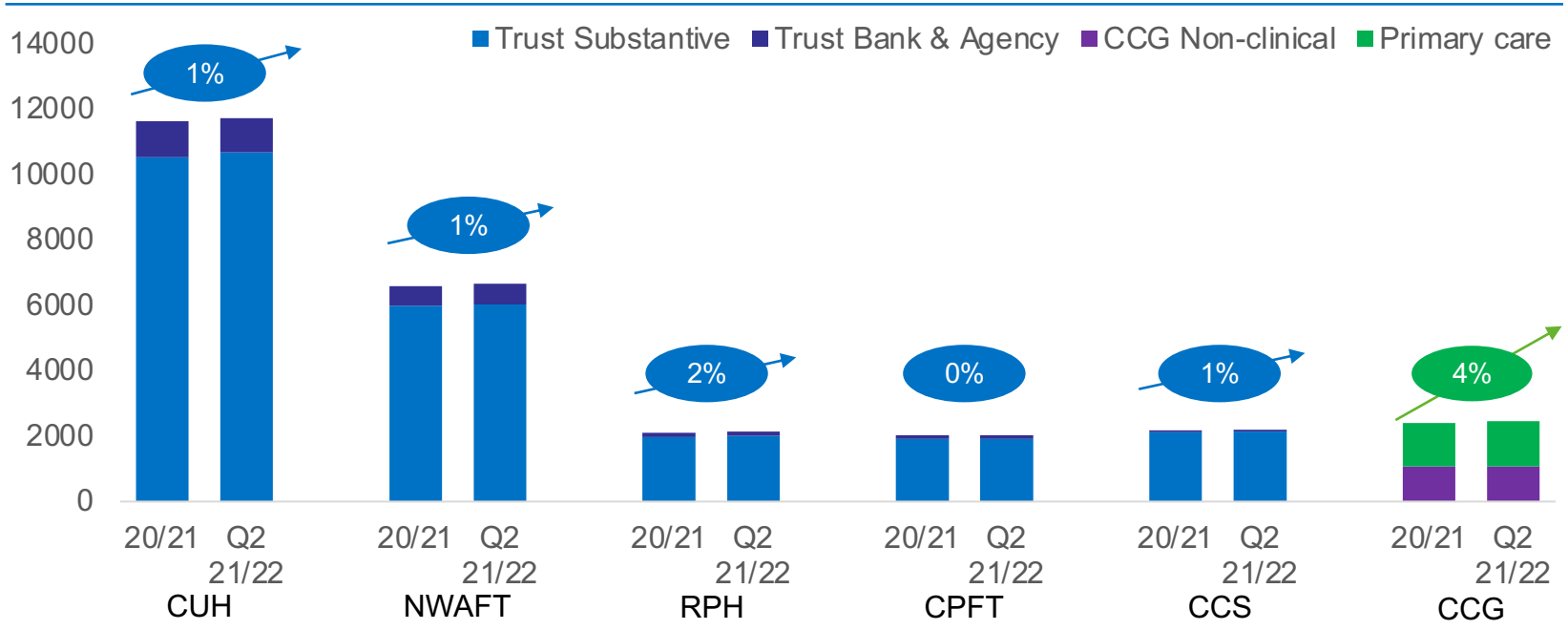
- International recruitment
- Health and Care Academy
- Apprenticeships Collaborative
- Clinical placement expansion scheme
- Continued employment of new Large Scale Vaccination Workforce across our system
- Regional Retention Programme

In addition to these system-wide measure, our providers are progressing some specific initiatives to address their individual needs around recruitment and retention, and are sharing the learning from these across our system

Staff capacity is a key determinant of the system's delivery of restoration and recovery but remains difficult to forecast due to ongoing effects of the pandemic

- We expect this year to be more uncertain than previous years in terms of the stability of our workforce assumptions. For example, it is more difficult to predict staff turnover in the context of lower than normal turnover and other impacts over the last 12 months
- Workforce plans could be impacted by further Covid surges, continued support to Large Scale Vaccination sites, challenges in delivering our health and wellbeing support to staff, and staff recruitment and availability of candidates to fill vacancies
- To support delivery of workforce plans, the system will work together to support staff health and wellbeing, deliver the recruitment and retention strategy, and embed new ways of working and delivering care

Workforce baseline of NHS providers in C&P vs Q2 plan (% change shown is for substantive staff only)



- Increase in CUH substantive is driven by staffing of 20 surge beds and other service growth
- NWAFT growth is driven by TUPE of UTC staff and recruitment into maternity roles
- RPH recruitment is across all services, reflecting current vacancies
- CCS is expecting TUPE of S&L services from Norfolk into the organisation and TUPE of school immunisation services out
- Increase in primary care workforce is driven primarily by increases in AARS-funded direct patient care roles

We will continue to meet needs of patients with Covid-19

We have resilience plans in place across the system to respond to future Covid surges. These plans are based on our experience and learning from previous Covid surges. The full plans are detailed in our Resilience plan which will be submitted to the regional team but a summary of plans in place are included below:

Preparations for future surge requirements

- **Workforce plans and protocols:** we will maintain system-wide workforce flexibility through training and maintenance of staff redeployment mechanisms, MOUs to enable inter-organisational staff deployment in acute settings with a similar agreement for primary care under consideration, and support measures in place for additional staff stress resulting from any future redeployments
- **Capacity plans:** we have critical care surge plans in place and escalation areas identified, ICS acute bed capacity allows dedication of Covid-specific capacity whilst maintaining non-Covid elective activity plans, and transformation underway to improve flow and provide maximum bed base flexibility
- **Community response:** We have established joint working arrangements across NHS providers, Local Authorities and wider system partners through the Health Protection Board to identify and respond rapidly to any increase in Covid-19 cases in the community
- **Infection prevention and control (IPC):** all acute providers have point-of-care testing available, IPC measures are embedded in UEC pathways, pre-admission Covid testing is in place for elective care, and established Covid/non-Covid pathways can be escalated and de-escalated as required

Post Covid Syndrome "Long Covid"

Delivered so far:

- We have in place a system-wide referral point for Long Covid, overseen by s system-wide steering group and have secured c£500k funding for 21/22 from NHSE for ongoing provision of Long Covid clinics
- We have established collaboration between our providers on consultant support and workforce capacity to meet demand across the system

Planned for 21/22:

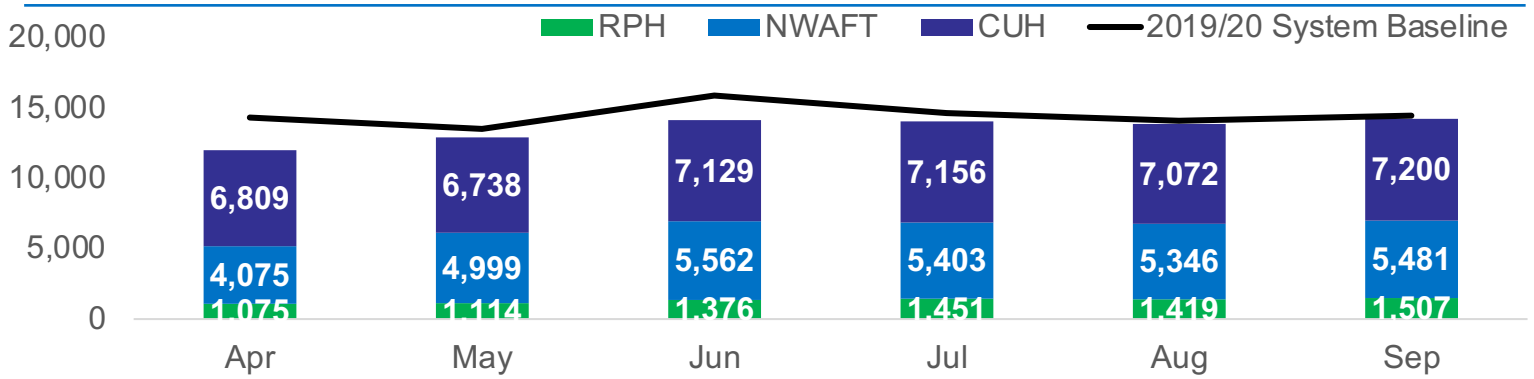
- We will go live with GP referral into integrated Long Covid services through a single point of referral by the end of April
- We will develop additional pathways into core services for patients post-assessment
- We will launch a Long Covid hub for face-to-face clinics in the north of the ICS and establish children's provision through existing clinics once we have completed an assessment of need

Risks

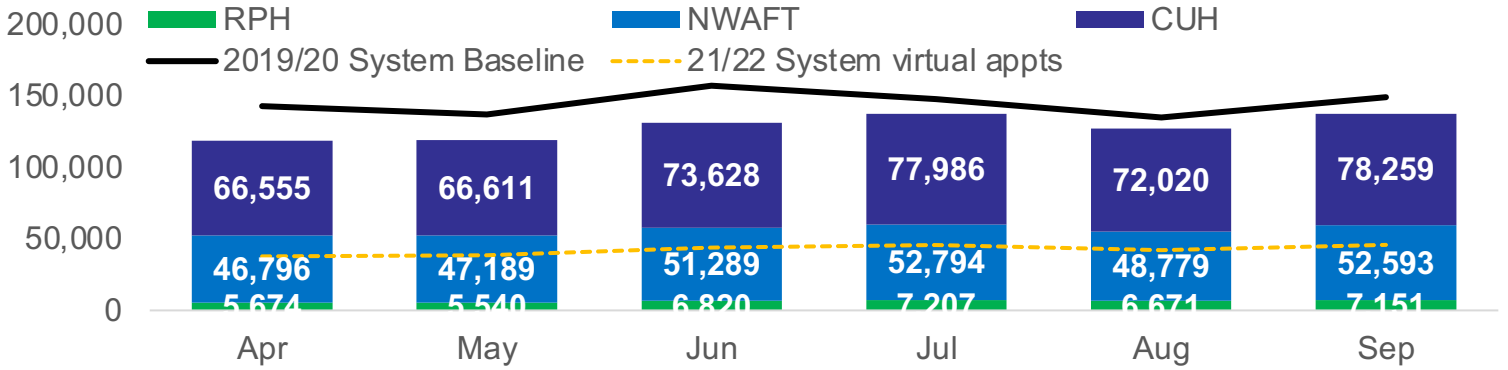
- A **surge beyond the assumptions** in our activity plans would require the allocation of further beds to Covid patients and negatively impact the elective and emergency bed base
- Development of additional ongoing pathways into core services for patients post-assessment is **dependent on funding** expected to be allocated from NHSE

Our ICS is working to maximise elective activity to meet the clinical needs of patients and best utilise national funding

C&P provider elective admissions for H1 21/22 compared to 19/20 baseline



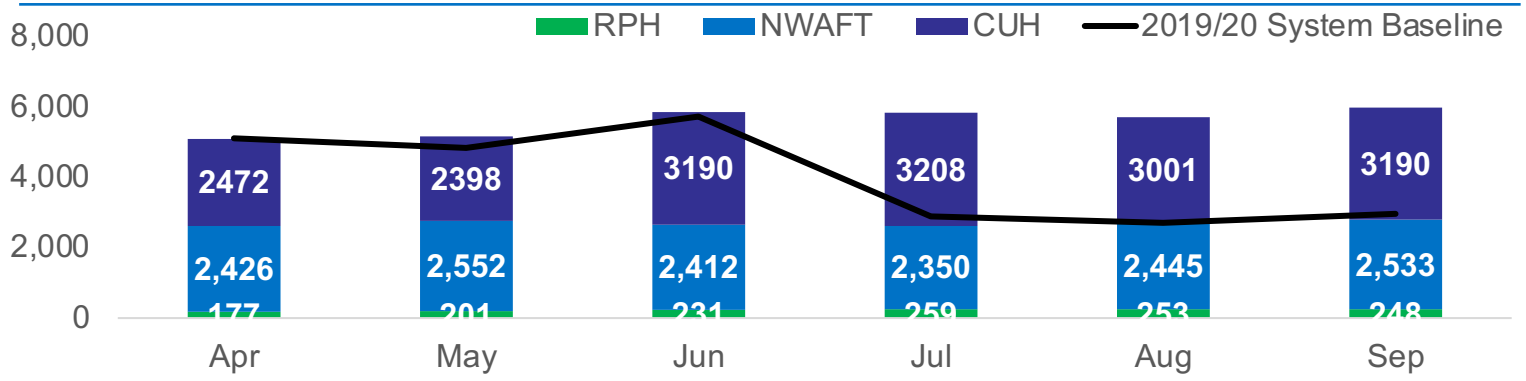
C&P provider total outpatient attendances for H1 21/22 compared to 19/20 baseline



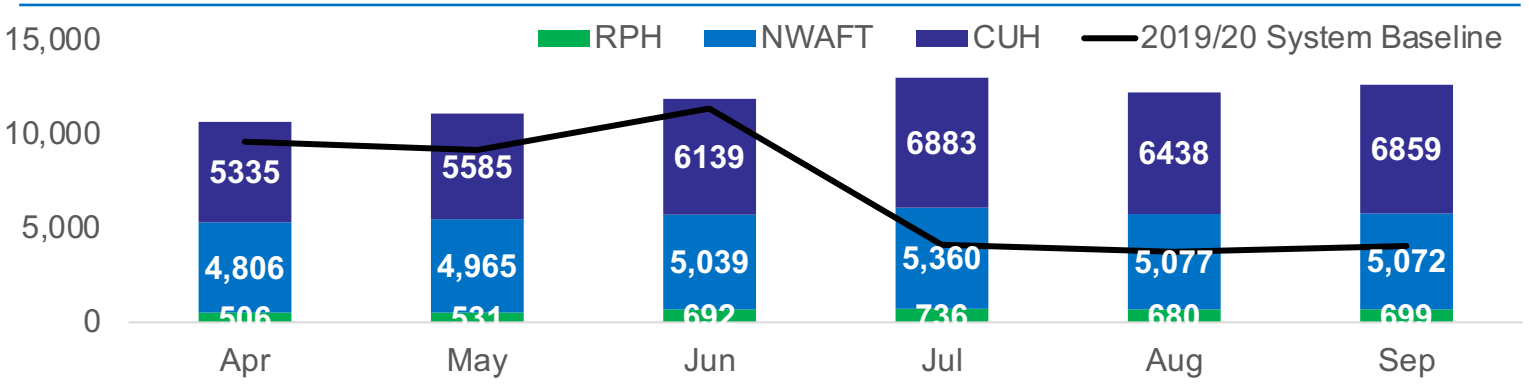
- Providers have forecasted activity based on workforce and physical capacity
- 2019/20 baseline has been adjusted for working days
- Recovery has been facilitated by the uptake of virtual appointments (appx. 35% across system)
- Risks include rise in Covid-19 or non-elective patients above assumed baselines, workforce turnover, and closure of theatres at HH due to RAAC survey
- The value of system activity will be used to calculate Elective Recovery Fund income. Initial finance forecast based on activity returns suggests will be approximately £14Mm (more detail is provided on slide 19)

We have ensured diagnostic capacity is in place to support restoration and recovery of services

C&P provider MRI for H1 21/22 compared to 19/20 baseline



C&P provider CT for H1 21/22 compared to 19/20 baseline



- Providers have forecasted activity based on workforce and physical capacity
- 2019/20 baseline has been adjusted for working days
- Community Diagnostic Hubs will reduce footfall at our specialist centres and streamline patient pathways through joined up diagnostics, direct primary care referrals and improved interactions
- Risks include workforce shortages, changes in IPC guidance, greater acuity, and rise in Covid-19 patients above assumed baseline
- The baseline numbers provided by NHSE/I show a significant drop in diagnostic activity for Q2 due to a reporting issue after NWAFT implemented the new PAS system, which resulted in the Trust not submitting diagnostic data between July 2019 and June 2020

We are restoring services and working towards full operation of all cancer services

We are working towards a position of fully restoring operation of all cancer services across the system, and we have articulated the high-level actions over the next 6 months to achieve this below:

Urgent cancer referrals

We will take the following actions to support delivery against the planning guidance over the next 6 months:

- Improve 2 week wait (2ww) referrals by streamlining forms to support equity and identify 'straight to test' pathway opportunities
- Working with GPs on agreed priority areas by implementing targeted comms to increase referral rates on underutilised pathways and interrogating non-2ww referral outcomes identify tumour sites with high conversion to cancer rates
- Improve diagnostics by ensuring equal access to diagnostic tests within primary care through targeted patient comms and analysing local system data, and implementing 'bundle tests' packages for appropriate tumour sites
- Develop enhanced system-wide communications to support patient confidence and service utilisation

Cancer treatment volumes

We anticipate 5-9% treatment volume growth between CUH and NWAFT, with recovery expected to be achieved by Feb 2022 through the following actions:

- Further develop our 'system first' approach, including backlog management by developing and implementing a centralised Cancer PTL during 2021/22, and utilisation of independent sector endoscopy and diagnostic capacity across the ICS
- Achieve earlier, faster and more timely diagnosis by implementing related projects, processes and innovations
- Ensure PCFUp compliance for Breast, Prostate and Colorectal, and achieve establishment of 3 other tumour site PCFUp compliant pathways by September 2021
- Ensure CWT standards compliance across all providers

Patients waiting 63 or more days

To improve against the 62+ days 85% national performance standard, we will:

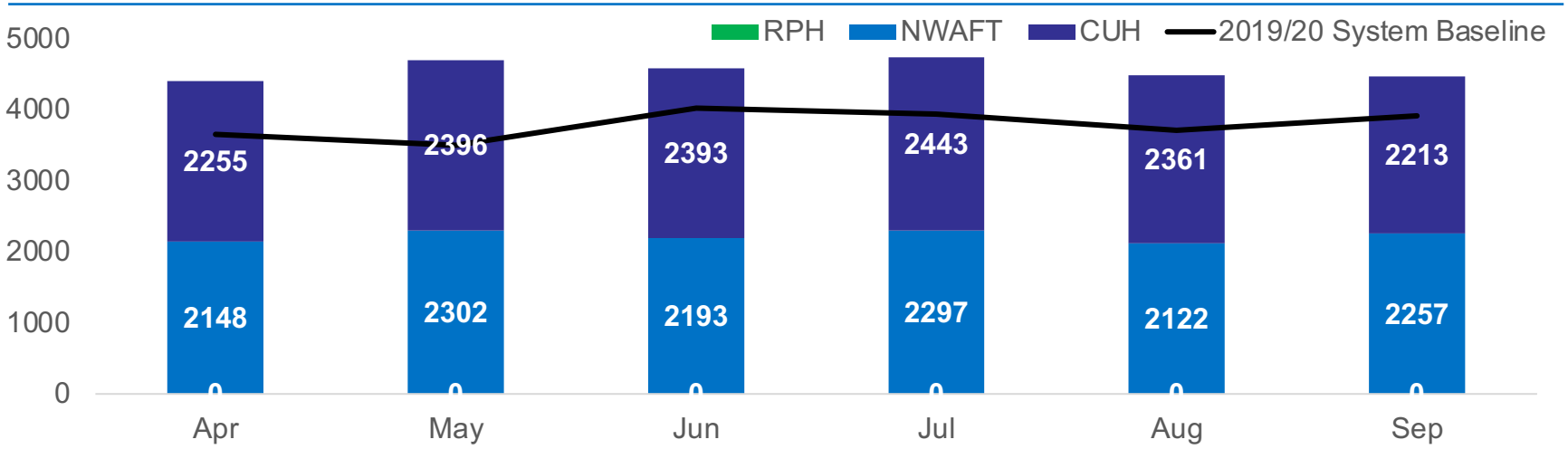
- Hold regular capacity and demand reviews aligned with ICS-wide methodology and an agreed tumour type prioritised table
- Agree tolerance levels and escalation procedures for mutual aid requirements
- Reduce care variation and identify opportunities through systematic review of current pathways

Risks to delivery of our actions include:

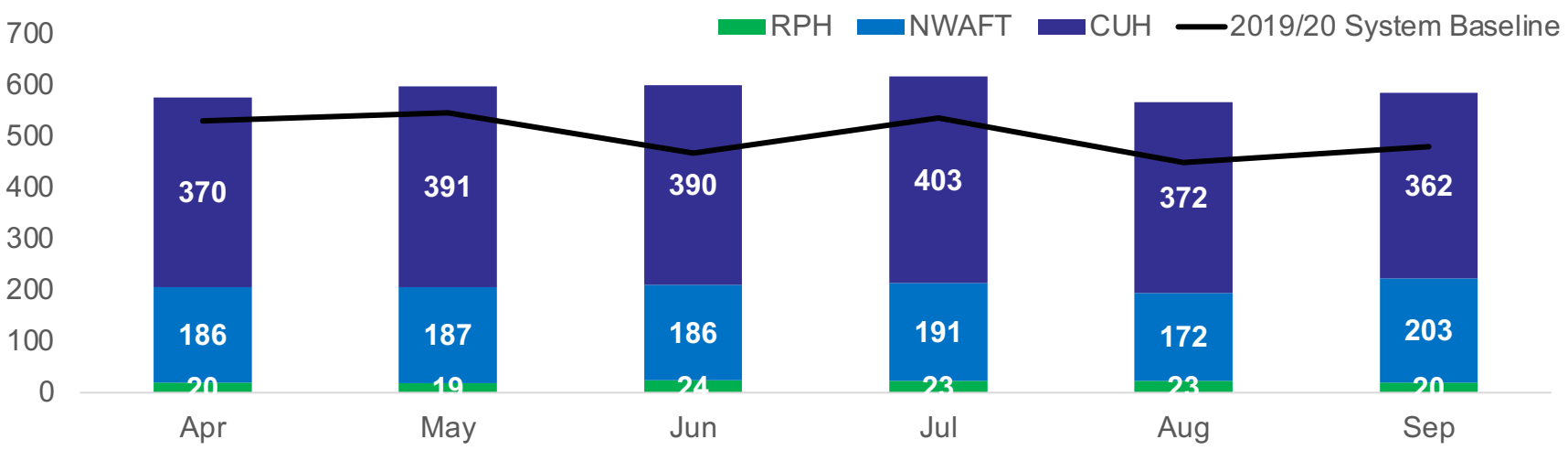
- Our plans depend on achieving current expectations of Service Development Fund allocations for H1 and H2
- Our plans depend on continued development and access to rapid diagnostic services
- Further wave(s) of Covid-19 would impact on our ability to deliver due to impact on workforce, facilities and/or patient engagement

Urgent cancer referrals for H1 2021/22 are planned to exceed historic activity levels

C&P provider total urgent cancer referrals for H1 21/22 compared to 19/20 baseline



C&P provider total cancer treatment volumes for H1 21/22 compared to 19/20 baseline



- Providers have forecasted activity based on workforce and physical capacity
- The system 2019/20 baseline is charted in black – the baseline has been adjusted for working days
- For urgent cancer referrals, key assumptions include:
  - CUH activity growth based on average of 3 pre-covid years is 9%
  - NWAFT activity growth based on 5% growth plus 50% of backlog
  - Provider assumptions have been triangulated and aligned with CCG level activity assumptions

We have plans to support the restoration and recovery of mental health services

- We have established governance to support collaboration in mental health across our system and through our primary mental health provider CPFT (third largest mental health research organisation in the UK) we are contributing to national policy on mental health transformation
- Below we've included a high level summary of our main priorities (full plans are included in our full mental health submission)

	Children mental health	Adult mental health
Business as usual	• Continued achievement of access and waiting times targets • Continued focus on eating disorders pathways • Continued progress on digital solutions through Kooth	• Enhancing IAPT provision through Trust and third sector providers • Enhancing existing perinatal model • Increasing proportion of people with SMI receiving physical health checks • Enhancing MH access and treatment for older people
Covid recovery	• Joint working with system partners to understand increasing health inequalities • Addressing increased wait times • Support neurodevelopmental and MH comorbidities pathway	• Continued multi-agency wellbeing support programmes • Addressing increased waiting times • Progressing local recovery plans
Operational transformation	• Development of an integrated MH Hub • Progression of crisis pathways and separating out planned and unplanned care to manage waiting lists • Development of home treatment team • ARFID pathways developed with neurodevelopmental service • Roll out of MH support across schools • Development of inpatient pathways with provider collaboratives	• Delivery of behavioural insights programme with IAPT provision • Enhanced access to psychology to reduce length of stay through pathway development and admission avoidance through community provision • Development of local liaison psychiatry provision to meet need • Continue with Community Mental Health Transformation, and work with Primary care on the ARRS investment through a joint working group • Restart Expansion of EIP Service • Development of Eating Disorder pathway to include medical monitoring and alignment to NCM
Strategic transformation	• Establishment of MH and LD/ASD Collaborative • Establishment of a CYP Collaborative	• Establishment of MH and LD/ASD Collaborative • Developing opportunities to integrate services OOH and with acutes

Our plan for H1 assumes no further Covid wave, the availability of expected allocated funding, and expected progress on workforce recruitment as set out in our MH workforce plans in our full MH workforce submission.

We will expand and improve services for people with LD and autism

Below we've included a high level summary of our main priorities for people with Learning Disabiltiies and autism (full plans are included in our full mental health submission)

Business as usual

- Progress on delivery of annual health checks and improved GP Learning Disability Registers accuracy
- Implement 100% of LeDeR reviews within 6 months of allocations
- Review of the Partnership Arrangements with the Local Authorities

Covid recovery

- Continue delivery of vaccination programme
- Maintain community bed and crisis bed capacity

Operational transformation

- Implement Community Forensic Services
- Continue expanding CYP keyworkers programme
- Expansion of Adult Autism Diagnostic and postdiagnosis services – link with MH plan
- Expansion of CYP Neurodevelopmental Pathways – link with MH plans
- Resume Community LD Integrated Model
- Resume redesign of LD inpatient model
- Enhance local LD Crisis Response service - towards 24/7
- Review of the s75 contract with LDP + PCC incl Lyons Gardens

Strategic transformation

- Review the local infrastructure or delivery of LD /ASD services inline with the local MH, LD/ASD Collaborative Work

Our LD Partnership:

Our Learning Disability Partnerships has been in place since 2002 and plays a central role in delivering integrated specialist health and social care for people with a learning disability. The LDP works on behalf of the system to both commission and provide services with some staff employed by the Council and others by the Cambridge and Peterborough NHS Foundation Trust - but all working together and managed under the LDP.

The LDP model and pooled funding arrangement is managed through a Section 75 Agreement which delegates the lead responsibility to deliver and commission community health and social care provision to the Council. The integrated arrangements and pooled budget arrangements ensure that service users, their families and providers experience a seamless approach to assessment, care and support planning, commissioning, procurement and payments.

The integrated model proved critical to managing the challenges arising throughout the pandemic enabling delivery of integrated crisis case management to avoid admission and delivery of commissioned services able to meet increases in demand. The Council believes it provides a robust basis from which an integrated provider collaborative could be further developed.

In response to NHSEI priorities, we have developed plans to transform maternity services

Recovering the full maternity pathway

- All services suspended due to Covid-19 have been reopened, with escalation through the Local Maternity & Neonatal System Board as required
- Supporting staff to recover from pandemic pressures is central to organisational development plan of providers across ICS
- Limits on birthing partners and visiting are under review to increase women's access to support
- To minimise additional risk of Covid-19 to ethnic minority women and their babies, a plan is in place to improve issues with face-to-face appointments and BMI recording, and an audit will be conducted on progress against implementation
- Progress, updates & escalations made regularly to LMNS board, regional maternity programme board, and Maternity Clinical Network

Strengthening governance

- C&P CCG's Chief Nurse is the SRO for the LMNS board and seeks assurance on the maternity safety agenda
- LMNS governance is being aligned within the ICS to ensure clear accountability and escalation
- Transition plans are being finalised for 2021/22 with full implementation from April 2022

Delivery of 2021/22 maternity transformation priorities

Ockenden report:

- We are supporting Trusts to implement the 7 immediate actions from the Ockenden report, with updates shared at LMNS board and regional maternity programme board
- We are on track to deliver a plan by 3 June 2021 on how their LMNS delivers its functions including governance arrangements with implementation by 1 April 2022
- To improve the culture of services for safe, personal & equitable care, OD work is underway at both Trusts with oversight and support from the LMNS board
- A vision for maternity and neonatal services will be co-designed with the Maternity Voice Partnerships to incorporate recent national changes, with finalisation at LMNS board

Maternity transformation priorities:

- Every woman will be offered a Personalised Care and Support Plan by March 2022
- We are in the process of implementing the Saving Babies' Lives care bundle
- We are developing pathways as part of a hub for Maternal Medicine Networks for the East of England with Norfolk & Norwich for specialist advice for patients with acute & chronic medical problems to support people with pre-existing conditions
- System Equity Action Plans aligning with the national Perinatal Equity Strategy will be delivered by 31/12/21
- We will continue to implement local neonatal improvement plans through LMNS and regional partners, and a Neonatal Voice Partnership has been established at CUH, with implementation at NWAFT scheduled
- Plans in place to ensure continuity of carer is the default model of care offered to all women by March 2023, with ICS community partners to prioritise those most likely to experience poorer outcomes

Supporting children and families:

The agencies and organisations across Cambridgeshire and Peterborough who work with children, young people and families (social care, education, health, police, voluntary sector) have worked together between 2019 – 2021 to develop three key strategies: Best Start in Life (pre- birth – 5) Early Help (five – adulthood) Special Educational Needs & Disabilities. (0 – 25). These strategies have comprehensive delivery plans that are regularly monitored to ensure they achieve the defined outcomes in the strategies.

Delivery of primary care services has been transformed through the pandemic and we will continue to provide good care to patients

While the acute sector was managing the pressures of the covid pandemic, primary care continued to support patients remotely and face to face when clinically necessary, managing their conditions within primary care and will continue to do so as the system recovers. As lockdown eases, demand has increased and appointments in general practice rose 18% between February and March 2021. Through the Strategic Primary Care Group and System Leaders we are ensuring that our recovery takes place as a system, with acute, community and primary care cognisant of the parts they all play in recovery.

Our plans for primary care are as follows:

Getting practice appointment levels to appropriate pre-pandemic levels

Supporting practices with access challenges:

- We are working with the Local Medical Committee (LMC) and practices to identify demand, appointment and communications issues; engaging practices with low extended access services referrals; and working on relationships with populations less likely to access primary care, such as eastern European and homeless people, building on learning from the Covid-19 vaccination programme
- We will also improve patient communications in allied health professionals' services, and enhance our system-wide wellbeing and occupational health offer for primary care staff to reduce absence rates

Supporting access to GP appointments:

- We will engage with practices to increase online appointment presence, improve telephony systems infrastructure, and support management of patient expectations with partners including Healthwatch & the LMC

Ensuring capacity is in place:

- We will invest £1.9m using the Covid-19 Capacity Fund to increase GP numbers & appointments, continue to utilise surge hubs which have provided 3,500 to 5,000 additional monthly appointment capacity during Covid-19, and utilise an informatics solution to free up clinical time
- We will introduce effective flexible working patterns, improve workforce recruitment and retention, continue to invest in workforce training and support staff in practice leadership roles

Prioritisation

- We will support **Post Covid Syndrome** (Long Covid) patients needing direct access to clinical pathways for community care, including home monitoring machines (oximetry & blood pressure), which will reduce the need for additional GP appointments
- We have extended commissioning of the primary care engagement officer for **mental health & learning disabilities** to focus on engaging patients with severe mental illness (SMI) and LD to receive appointments at ease
- We are identifying patients potentially at risk due to **high-risk polypharmacy**, and utilising PCN and community pharmacy clinical pharmacists to target patients with polypharmacy for structured medication reviews

We have plans in place to address the LTP objectives for prevention and personalised care

Progress against the LTP high impact actions to support stroke, cardiac and respiratory care

Stroke care

PCNs are identifying and support people with AF, high blood pressure, high cholesterol and obesity. C&P are part of the North ISDN. We are increasing our scan capacity and improving our stroke and neuro rehab pathways system-wide

Respiratory care

We will develop a system Respiratory network, building on existing joint working through Covid. The network will drive progress on system wide pathways for Respiratory SDEC diverts from 111, asthma pathways and pulmonary rehab

Cardiac care

We will start delivering our agreed cardiovascular strategy which includes implementing a prevention programme in primary care for shared CVD risk factors and a network approach for imaging, treatment and community care.

Social prescribing & personalised care

Our PCNs have successfully recruited 48 Social Prescribing Link workers (SPLWs) through the Additional Role Reimbursement Scheme (ARRS), during 20/21 – significantly more than forecast in our LTP submission. Our PCN workforce plans demonstrate the importance of embedding not only the SPLWs into the workforce, but also other key specific personalised care roles such as Care Co-ordinators (CC) into PCNs over the coming years. Our plans will ensure that as a system we meet our trajectories for Personal Care and Support Plans in line with national guidance over the next year.

Expanding smoking cessation

- We are expanding and strengthening the membership of the System Tobacco Control Alliance
- We will establish a multiagency steering group to support initiation and delivery of the NHS funded Tobacco Dependency Treatment services
- We will continue to develop our Stop Smoking Services
- We will ensure clear smoke free pathways are in place at all acutes and maternity until by March 2022
- We will ensure smoke free pregnancy pathways are available for up to 40% of maternal smokers by March 2022

Improving uptake of diabetes prevention

- We have developed text and templates for increasing uptake of National Diabetes Prevention Programme (NDPP) and established 5 pilot PCNs focussed on NDPP uptake and have seen increased uptake of approx. 30%
- We will use Eclipse to identify pre-diabetic patients and link with a text communication campaign to patients through a ‘batch’ process involving mass texting to identified patients
- We will appoint NDPP uptake support to work with PCNs to improve uptake across the system

NHS digital weight management services

- We will work with University of Cambridge on digital diabetes programme for increased virtual weight loss applications use
- We have purchased a DDM weight management App
- We will go live with the Very Low Calorie Diet in Wisbech in Q1 with further roll out to central Peterborough in Q2

We have an agreed Health Inequalities strategy overseen by our system HI Board to progress national and local priorities

Through our Health Inequalities Board we have agreed a system-wide Health Inequalities Strategy and the recommendations from this strategy, together with the relevant LTP actions and recovery actions from NHSE are in an overall system action plan (included as an Appendix to our submission).

The priorities in our plan align with our planning to achieve the national must dos for addressing health inequalities which are summarised at a high level on the right.

Population Health Management as an enabler

- We currently have a basic population health management capability through “Eclipse Vista” which is used to identify and focus actions
- In December 2020 NHS Cambridgeshire and Peterborough's application was accepted for the wave 3 Population Health Management programme
- The population health management programme will ensure that every initiative addressed through a PHM methodology has a distinct Health Inequalities focus
- The PHM Wave 3 Development Programme will facilitate; working with each tier of the system to **link local data sets,** b**uilding analytics skills** across the system, identifying rising risk cohorts, risk stratification of elective backlogs and exploring alternative models of service delivery, care model design

Restore NHS services inclusively:

- Use monitoring of Sentinel Indicators for health inequalities (HIs) to support recovery planning and address any inequalities measured
- Further work to develop a single PTL and analysis to understand variation in access to services
- Conduct analysis of waiting lists to identify inequalities by IMD and ethnicity in healthcare access

Mitigate against digital exclusion:

- Provide low-cost digital support packages for patients with long-term health conditions
- Build on work by City Councils with libraries, VCS and providers to enhance digital access in communities
- Enhance access to services in multiple languages through joint work between PCNs, LAs, and VCS

Ensure datasets are complete and timely:

- Increase the range of inequality reporting by partner organisations, re-introduce inequalities surveillance metrics into the system IPR, and agree the most appropriate Sentinel Indicators to monitor health inequalities across the system
- Deliver the Shared Care Record programme to provide care professionals with a full patient record

Accelerate preventative programmes which proactively engage those at greatest risk of poor health:

- We have several prevention programmes being developed and delivered across the system
- The Health Inequalities team is working alongside prevention programmes to ensure that these programmes proactively engage those at greatest risk and so maximise inequality reduction

Strengthen leadership and accountability:

- Establish a new HI Operational Group of system partners, including Healthwatch, LAs and Public Health
- We will develop a communication plan to fully embed the health inequalities agenda and promote a whole-system approach to addressing inequalities for statutory, moral, and economic reasons.
- Review the CCG processes for conducting Equality and Health Inequality Impact Assessments, and review governance structures for system inequality reduction as part of the transition to ICS governance

Transformation in our community services will support better flow through the system

Delivering an improvement in average length of stay through discharge to assess and the intermediate care model

Over the next 6 months we will build on lessons learned (locally, regionally and nationally) to develop a sustainable, equitable and resilient D2A pathway and intermediate care model that incorporates our patient and service user feedback, is outcomes focussed and financially sustainable. We will work together to:

- Continue to simplify the processes in hospitals to reduce bureaucracy and support patients' discharge when they no longer meet the criteria to reside
- Develop a pooled and flexible staffing model for therapy/OT staff, with outreach from acutes and rotation of staff through acute and community setting
- Take forward recommendations for pathways 1 & 2 based on what worked well during Covid-19 and what is needed going forward for the next 6 months
- Continue to build on the Single Point of Access, multi-disciplinary working, whole system patient tracker and continue to manage patient flow as a system
- Review our system capacity for intermediate care and home first, to include a comprehensive review of wrap around services, e.g. therapy, social care, DPSNs and primary care support
- Use data to inform our understanding of health inequalities across our services and pathways and ensure that any future model is proactively addressing this through delivery at place and monitoring population health outcomes

Providing 2-hour crisis community health

We have implemented a system wide rapid 2 hour urgent care home response service which provides early supported discharge and front door streaming away from ED, with referrals accepted from a range of sources including healthcare professionals, 999, IUC, care homes, social workers, GPs and the third sector.

Over the next 6 months we will:

- Review demand and capacity to ensure a consistent 2-hour response and increase JET utilization by opening and additional referral routes to comply with national guidance
- Develop JET dashboard/links to SHREWD to allow a system view of available capacity and response/waiting times.
- Review JET workforce to ensure service can meet the requirements associated with the 2-hour response
- Undertake baseline activity modelling & forecasting 2021/22 activity including service costs
- Work with UEC Collaborative partners to further develop integrated 2 hour urgent community response services, using any available development funding as appropriate

Children's Community Services

- In September 2021 we will commence a whole system Children's Community Health Services review, with particular focus on children's physical, acute and complex healthcare needs to avoid admission and reduce length of stay, keeping care closer to home.
- We will continue work in development of care pathways between acute care and community as part of the Cambridge Children's Hospital programme.

We have plans to increase the use of NHS 111 and ensure the timely admission of patients from emergency departments

- Across C&P, we have been progressing UEC transformation through our UEC Collaborative group which brings together local provider organisations and the commissioner to deliver improvements in urgent care provision.
- We have made significant progress in improving 111 services in 20/21, such as increasing call handling capacity, establishing a Virtual Waiting Room pilot through consultant-led expansion of the CAS, and piloting practitioner support to manage NHS 111 injury dispositions

We aim to achieve three significant milestones in 21/22:

Establish the 'Super CAS'

- We envision the Clinical Assessment Service maturing to a multi-disciplinary function that supports access to senior clinical resources on 24-hour basis
- We will add access to a wider range of clinical specialties and utilise technology to provide direct referral for validation and consultation virtually
- The 'Super CAS' would form part of the core flow for patients through NHS 111
- It will also be expanded to provide timely access to referral pathways for healthcare professionals, especially 999 ground crews
- We aim to enable inter-operability between EEAST and HUC for transfer to super CAS

Relaunch Think NHS 111

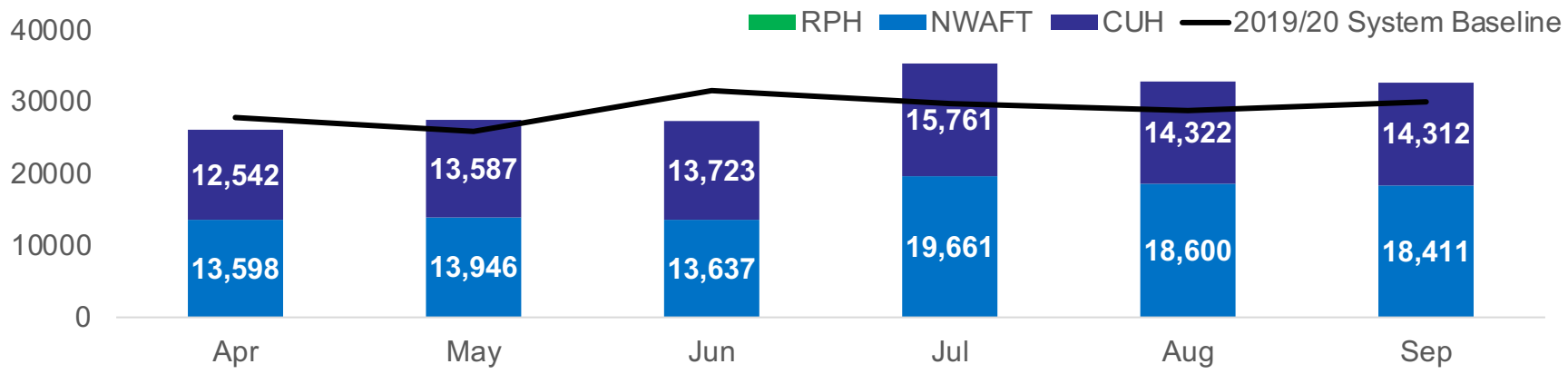
- Subject to clarification on national funding, we will relaunch an expanded Think NHS 111 First programme, which was halted due to the second wave of COVID

Expand 111 pathways to SDEC services

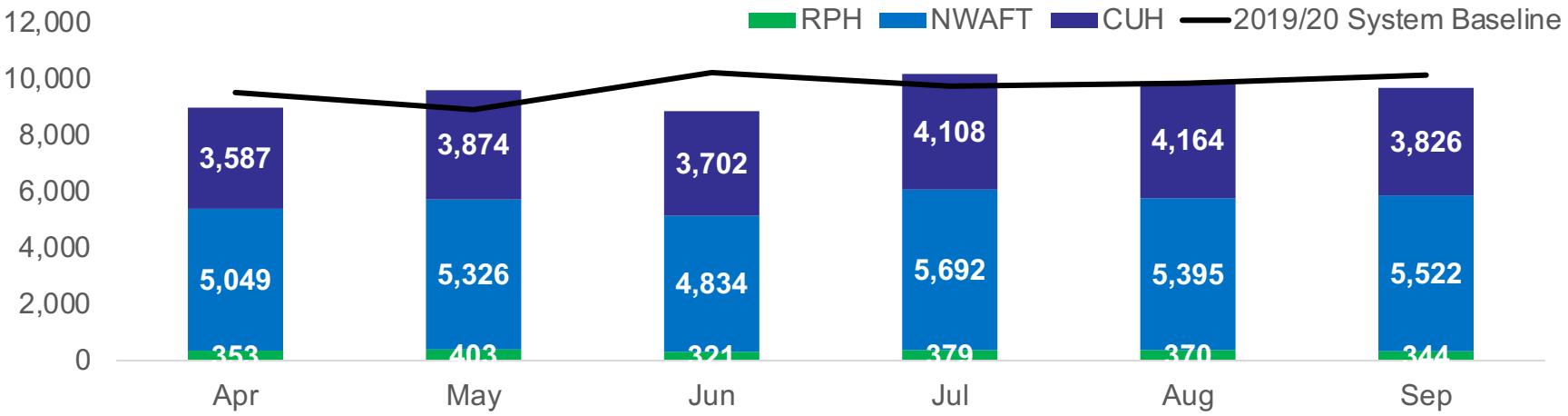
- We will continue to progress work underway to increase access to SDEC services
- We aim to deliver the full ambition of direct booking into a wider range of SDEC services
- We have piloted pre-booked appointments from NHS 111 or CAS to an SDEC service as part of Think NHS 111 First
- We have updated advice and specialty contacts on the DoS to facilitate direct booking by the 111 CAS (and ambulance service) to SDEC services
- We are analysing the number of patients with potential for direct booking from 111 into SDEC and have support from NHSX to trial use of EDDI functionality to enable this

C&P will continue to meet the urgent and emergency needs of patients while implementing transformation to ensure care is delivered in the most appropriate setting

C&P provider A&E attendances for H1 21/22 compared to 19/20 baseline



C&P provider non-elective admissions for H1 21/22 compared to 19/20 baseline



- These charts displays A&E attendances and total NEL activity, including small numbers of expected Covid-19 admission
- Providers have forecasted activity based on workforce and physical capacity
- The system 2019/20 baseline is charted in black
- 2019/20 baseline has been adjusted for working days
- The significant jump in NWAFT attendances in July-Sept is driven by the move of UTC to PCH (expect to be implemented 1st July 2021)

Delivery on these plans will be supported by a system financial plan

The financial template covers the 2021/22 H1 financial plans of the CCG and five NHS providers.

Allocations have been set for CCGs and the system on the basis that they will breakeven and there will be no retrospective allocation adjustments, such as those seen in the first 6 months of 20/21, to enable this.

The consolidated system position is breakeven, in line with a breakeven position in H2 20/21; we have also planned for individual system partners to breakeven. The underlying system position is a deficit of £18.4m, with breakeven being achieved through the following actions:

- Receipt of additional funding for lost 'other income' £6.6m (receipt confirmed via the national finance template).
- Inclusion of an estimated £14m ERF income, this is a risk-assessed value linked to our system activity plans for H1; whilst there remains a note of caution around the ERF calculation, NHSE independently have assessed the projected value for our system and the sum is greater (range £27m-£34m).
- The system has retained a contingency within the CCG of £3.3m
- Our financial plan is subject to the following conditions:
    - FPPG will continue to monitor performance against plan and will review system distributions as required to support delivery of breakeven across all system NHS partners.
    - Any ERF surplus income above that required to deliver the system plan will sit within the generating organisations, subject to system decisions on future investment

We have developed plans to ensure our ICS meets ERF Gateway criteria

Addressing health inequalities	• As a system we are committed to addressing health inequalities across the delivery of all health and care services • We have established a Health Inequalities Board at system level and developed a Health Inequalities Strategy to progress this agenda across the system • In order to plan and assess the restoration of services across our population, we have established monitoring and reporting of Sentinel Indicators to monitor health inequalities across key points of delivery over time to support our recovery planning
Transforming outpatient services	• Over the last 12 months we have accelerated outpatient transformation across the system to avoid unneeded referrals and increase the volume of remote consultations • Recent benchmarking suggests that as a system we perform in the upper quartile nationally in terms of Advice and Guidance utilisation, and all of our providers have Patient Initiated Follow-up (PIFU) schemes in place • All of our providers have plans for virtual outpatients that we are confident will meet the 25% virtual appointment target
System-led recovery	• Our system recovery will be led through our System Delivery and Transformation Group (SD&T) which will consist of our provider Chief Operating Officers, with one as Chair • The SD&T is responsible for rapidly agreeing and establishing arrangements to share data and elective activity plans as well as to manage PTLs at a system level – they will also develop and action plans for mutual aid and management of IS capacity
Clinical validation, waiting list data quality, and reducing long waits	• As a system, we have regular processes in place to undertake clinical validation of patients and we adhere to national guidance in terms of clinical validation and prioritisation • SD&T will provide system-level oversight of monthly waiting list data (WLMDs) and ensure effective and consistent validation across the system as well as monitor health inequalities across key points of delivery • We utilise shared decision making and treatments reviews between patients on waiting lists and clinicians
People recovery	• Our staff sit at the heart of our recovery and restoration plans • Our ambitious but achievable elective recovery plan balances potential clinical harm risks with staff restoration • We will ensure staff are given the opportunity to take annual leave, and we have reflected higher levels of leave in our activity and workforce planning