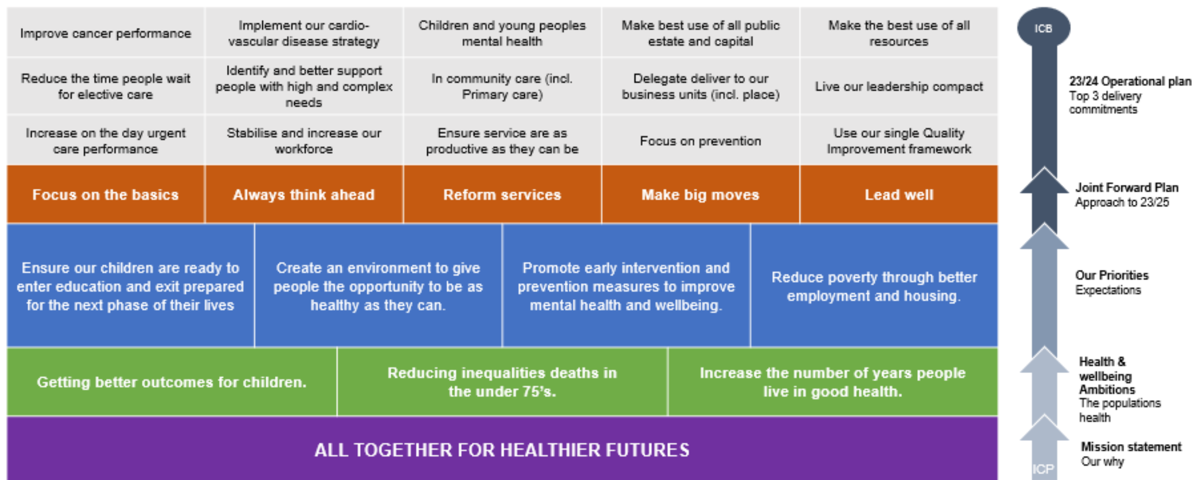
Delivery Plans

Introduction

Our delivery plans aim to provide clarity for our key priority areas for NHS and system commitments, a core element of our 5 year Joint Forward Plan in Cambridgeshire and Peterborough. They describe an overview of each plan and objectives for each area within the plan, including key deliverables and milestones, leadership and governance over the next 5 years.

The delivery plans we have developed demonstrate the clear alignment with our overarching vision, ambitions, and priorities across the integrated care system. This is described in the figure 1 below:



There is more work to be done in this first year of our joint forward plan to refine many of deliverables and actions. The delivery plans are working documents which will continue to evolve and be reviewed on a regular basis.

The full list of plans is detailed here:

Focus on the basics:

- Cancer services – improve cancer performance
- Planned care – reduce the time people wait for elective care
- Urgent and emergency care – increase on the day urgent care performance
- Maternity and neonatal services – also referenced in the babies, children and young people delivery plan

Always think ahead:

- CVD – implement our cardio-vascular disease strategy
- Population Health Management
- Identify and better support people with high or complex needs (high intensity users, advanced illness, end of life care - in development)
- Workforce – stabilise and increase our workforce

Reform Services:

- Babies, children and young people
- Mental health, learning disabilities and autism
- Diagnostics and Community Diagnostic Centres – ensure services are as productive as they can be

- Primary care transformation
- Ensure services are as productive as they can be is also a theme throughout our delivery plans (in progress)

Make big moves:

- Estates – make best use of all public estate and capital
- Digital
- Cambridgeshire South Care Partnership – delegate delivery to partnerships
- North Cambridgeshire and Peterborough Place Partnership – delegate delivery to partnerships
- NB Our children's and maternity and mental health, learning disability and autism delivery plans above also cover delegate delivery to partnerships
- Four strategic priority action plans - Focus on prevention

Lead well:

- Green plan (sustainability) – make the best use of all resources
- Procurement – make the best use of all resources
- Organisational Development – live our leadership compact
- Quality improvement – use our single Quality Improvement framework

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Cancer services

Overview

C&P ICS continues to prioritise cancer services across the system with a key focus on optimising access and improving outcomes, recovery, and patient experience, whilst reducing potential harm. During 2022/23, work across the system has been undertaken to develop robust recovery action plans at the provider and system level, including reviewing care pathways, undertaking deep dives into referrals, and implementing new pathways or services such as the Rapid Access Pathway for Lower GI to embed FIT tests within the referral and breast pain pathways. Key challenges to delivery have been workforce availability, diagnostic and histopathology capacity, coupled with an increase in demand.

Cambridge University Hospital NHS Foundation Trust is the largest provider of specialist cancer treatment in the East of England, and the provider in the region that can offer cellular therapies and genomics. The proposed Cambridge Cancer Research Hospital (CCRH) aims to accelerate improvements and contribute to improved outcomes through bringing together scientific and clinical expertise within pathways bringing the lab bench to the patient bedside, whilst working with other providers across the system and wider region to support improved outcomes. The CCRH offers the system and our local population a unique opportunity and will be critical in the continued transformation of how cancer services are delivered in the future. The CCRH will work with all cancer providers both within Cambridgeshire and Peterborough and the wider region.

With The Royal Papworth Hospital NHS Foundation Trust providing specialist services for people with lung cancer and Northwest Anglia NHS Foundation Trust receiving one of the highest volumes of cancer referrals in the Alliance, the system is well positioned to deliver wide reaching changes for people affected by cancer.

The ICB has developed, with all system partners, a Cancer Delivery Vision and key objectives which aim to improve patient experience, outcomes, and access, looking at care closer to home where possible. Within the delivery we want to address health inequalities as well as provide sustainable models of care that improve current workforce recruitment/retention challenges.

Our C+P ICS vision is to:

- Improve access and waiting times across all our cancer services.
- Be the first ICS in the country to achieve 75% faster diagnosis at stage 1 and 2
- Recover 62-day backlogs to pre-pandemic levels (or better) by March 2024
- Co-develop personalised care, psychological support and community provision with our patients living with cancer and beyond.

Our key objectives of the Cancer Delivery Vision are:

- To improve early diagnosis through improvements in screening, earlier access to diagnostics, patient education, and primary care pathways
- To improve recovery rates by implementing best practice and reducing unwarranted variation in services; expanding tele dermatology services and ensuring diagnostic capacity to meet needs.
- To improve the experience for people living with cancer and beyond, through better support in the community, a strong personalised care approach, psychological support, and access to high quality palliative care.

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- To maximise the opportunities and expected benefits of the Cambridge Cancer Research Hospital for our patients and our local workforce.

There are a number of key principles that will be considered when developing services and detailed deliverables:

- Workforce – maximise opportunities to jointly develop new roles, explore opportunities for joint appointments, training to support recruitment and retention.
- Health Inequalities – to ensure that C&P ICS have accessible services across the system and that development/service improvement plans address health inequalities.
- Innovations– to identify opportunities to maximise digital services and other innovations to support services and increase capacity for example through the use of Artificial Intelligence (AI), Robotic Process Automation (RPA) and Machine Learning (ML)
- Patient engagement – we will work closely with our partners across the VCSE and closely involve our local patient participation groups as we develop plans to ensure that they meet local needs.
- Communication – ensure timely and robust communication is available to all system partners and our population on our developments advising how to access appropriate and timely cancer services.

The ICB will work with all partners across the system and the Cancer Alliance to deliver the vision and the objectives. This will be monitored through the System Cancer Board.

Delivery plans:

Improve access and waiting times across all cancer services key deliverables.

Across the system there is ongoing work to improve access and waiting times across all cancer services. The key objective in 2023/24 will be to reduce our current 62-day backlog to pre-pandemic levels or better and successfully achieve the Faster Diagnosis Standard (FDS). This will support patients without cancer being confirmed and advised of this sooner, reducing their anxieties whilst waiting for a diagnosis, whilst also improving the journey of patients confirmed with cancer to be treated in a timely way improving their outcomes, and experience. Longer term we want to continue to improve waiting times and improve access, providing care closer to home where possible and addressing current health inequalities. Areas of focus will be:

- Delivering cancer diagnostic tests and routine imagine within Community Diagnostic Centres
- A non-specific symptom service to be embedded across the system.
- Improving direct access for primary care into diagnostic service leading to faster diagnosis (CT and MRI)
- Delivering against the optimal timed pathways for each tumour site
- Introducing new pathways of care, maximising digital opportunities including a teledermatology solution and the use of AI in histopathology services

The delivery of the improvements is also co-dependent on workstreams within the wider Planned Care and Community Diagnostic delivery plans.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Deliver and sustain Faster Diagnosis Standard of 75% at a system level	End of March 2024	Kate Hopcraft, Director of Performance and Delivery	Cancer Board and Planned Care Board
Achieve 62-day backlog target	End of March 2024	Kate Hopcraft, Director of Performance and Delivery	Cancer Board and Planned Care Board
Achieve 90% of lower GI suspected referrals with an accompanying FIT Result	End of March 2024	Kate Hopcraft, Director of Performance and Delivery	Cancer Board and Planned Care Board
100% population to have access to Non-Specific Symptom service by 31 March 2023 and to embed referral processes during 2023/24	End of March 2024	Kate Hopcraft, Director of Performance and Delivery	Cancer Board
Improve direct access to diagnostics leading to faster diagnosis (CT, US & MRI)	End of March 2025	Kate Hopcraft, Director of Performance and Delivery	Cancer Board and Diagnostic Board
Ensure sustained delivery of the optimal timed pathway for prostate cancer including mpMRI	End of March 2025	Kate Hopcraft, Director of Performance and Delivery	Cancer Board
Ensure at least 65% of urgent cancer referrals for suspected prostate, colorectal cancer meet timed pathway milestones	End of March 2025	Kate Hopcraft, Director of Performance and Delivery	Cancer Board
Delivery / expansion of Community Diagnostic Centres (Ely and Wisbech, and Peterborough) including access for suspected cancer referrals, incorporating the Rapid Diagnosis model	End of March 2026	Kate Hopcraft, Director of Performance and Delivery	Cancer Board and Diagnostic Board

To achieve faster diagnosis of stage 1 and 2 cancers key deliverables

The ambition of the system is to be the first in the country to deliver 75% of cancers being diagnosed at Stage 1 and 2 by 2028. Through earlier diagnosis there are improved outcomes and survival rates. To deliver this ambition we will work with all system partners and our local population to:

- Improve access to screening programmes through:
  - Rolling out additional programmes and age extensions in line with national expectations for example Targeted Lung Health Checks
  - Identify current health inequalities within screening programmes across Cambridgeshire and Peterborough and work with partners to improve access to programmes
  - Work with the Cancer Alliance and Public Health England on campaigns and promoting the benefits of screening and promote access.
  - Maximising opportunities for opportunistic screening services when accessing other services for example cervical screening when accessing other women's health services.
- Work with primary and secondary care to improve access to specialist advice, information, and training.
- Improving information and patient education to support earlier identification of suspicious symptoms.

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Deliverable/ milestone	Timeline	SRO	Oversight group/s
Commence Targeted Lung Health Check service as part of the national lung cancer screening programme	March 2024	Kate Hopcraft, Director of Performance and Delivery	Cancer Board
Delivery of national screening programmes including extension to NHS bowel screening	March 2025	Kate Hopcraft, Director of Performance and Delivery	Cancer Board
75% of cancer diagnosis to be at Stage 1 and 2	2028	Kate Hopcraft, Director of Performance and Delivery	Cancer Board

To develop personalised care, psychological support and community provision with our patients living with cancer and beyond key deliverables

For our population that is living with cancer and beyond we want to ensure that we offer services that provide a holistic, and personalised approach, support and care for people at each stage of their cancer journey; supporting them to manage the wider impact living with cancer can have on individuals physical and mental health, finances, and social and family aspects of their life. We will be working with our partners and patients with lived experiences to improve on the current services and models available through:

- Developing psychological support services that meet individual needs of cancer patients by improving:
  - Access and availability
  - Education and training within mental health services about the impact of cancer
  - Enhancing current services within hospital setting cancer services
- Providing personalised, holistic support for people by working with social prescribers, voluntary services and sign posting people to wider support services within communities and neighbourhoods
- Exploring opportunities to maximise community provision for cancer care through neighbourhood teams, community diagnostic centres and mobile care
- Ensuring people towards the end of their life are empowered to access the care and support they need, including choosing their preferred place of care

The delivery of elements of this plan are co-dependent and linked into the wider Community Diagnostic Centre and End of Life delivery plans.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Increased access to psychological support through bespoke and mainstream Mental Health services	2025	Kate Hopcraft, Director of Performance and Delivery	Cancer Board
Clear pathways to access personalised care through social prescribers, voluntary sector provision and cancer services	2025	Kate Hopcraft, Director of Performance and Delivery	Cancer Board

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To maximise the benefits of the Cambridge Cancer Research Hospitals key deliverables

The Cambridge Cancer Research Hospital (CCRH) will bring many benefits and opportunities for the population and workforce within C&P as well as the wider region. It will be focused on the early detection of cancer and novel precision medicine treatments, bringing together the clinical excellence of Cambridge University Hospitals, scientific expertise of the University of Cambridge and the Cancer Research UK Cambridge Centre, as well as industry partners under one roof. It will support with transformation of pathways, attract, and retain workforce into the region and improve patient cancer outcomes through early detection, and interventions.

Wider benefits for local patients will be through the improved environment and facilities. Plans are in place to increase digital offers to support patients for example through remote monitoring.

The ICB will work with the Cambridge University Hospital NHS Foundation Trust, the CCRH team, NHS England and wider system partners to maximise the benefits that the new hospital will bring for our local population. These include:

- New models of care and pathways improving access, patient experience and outcomes
- Increased telemedicine and virtual clinics reducing travel and appointment times for patients as well as supporting the ICB Green plan
- Greater use of ambulatory pathways for Bone Marrow Transplant patients, and cellular therapies supporting patients to return home earlier for ongoing care
- Increased capacity to reflect the predicted future needs of the services including the Cancer Assessment Unit (CAU) which provides access to emergency and urgent care for cancer patients who are deteriorating, decreasing the need for them to attend the Emergency Department
- Innovation being driven forward and accelerated through the collocation of clinical teams for both early detection and integrated cancer medicine research
- Greater access to regional trials, whole genome sequencing and wider research for patients from across the system and region through integrated working with local hospitals
- Workforce benefits both at Cambridge University Hospital NHS Foundation Trust and other hospitals in the system and region include.
    - Improved staff satisfaction through modern facilities and integrated working
    - Improved recruitment and retention through collocation with partners, research opportunities and potential models for joint working/appointments with other hospitals
    - First class education and training locally, across the system and region including specialist advice via telemedicine, digital pathology, and networking.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Full Business Case to be completed	2024	CCRH Exec Lead	CCRH Programme Board/Cancer Board
Construction to start	2025	CCRH Exec Lead	CCRH Programme Board/Cancer Board
Completion of build	2027	CCRH Exec Lead	CCRH Programme Board/Cancer Board

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Planned Care

Overview

C&P ICS is continuing to develop and address elective recovery by introducing and embedding new ways of working to further improve services, patient outcomes and increase productivity, and efficiencies to reduce overall waiting lists in line with national delivery standards. Through our work we aim to reduce identified health inequalities, embed personalised care, and look at opportunities to bring care closer to people's home.

Post covid waiting lists across the system have increased with wait times across multiple specialties at an all-time high. During 2022/23 excellent progress was made in reducing waiting times from over 2 years to under 18 months in most specialties. This has been through increased capacity, maximising resources across the system and looking at new ways of working together. We are committed to further reducing wait times and improving access to services for all our population.

Working with all system partners the ICB's Planned Care objectives are to:

- Improve access and waiting times, so no patients are waiting more than 65 weeks by the end of March 2024 and year on year improvements thereafter.
- Embed a personalised care approach across services.
- Support our population to access holistic care to improve their overall wellbeing and outcomes whilst they wait for treatment.
- Deliver planned care closer to home, through greater development of community pathways and provision.

We aim to deliver this through several programmes of work:

- Elective Recovery
- Health inequalities and improved access to elective care
- Personalised care and support
- Pathway improvements and redesign
- Increasing productivity and efficiency
- Outpatient transformation

Oversight for delivery is through the C&P ICS Planned Care Board, with clinical and operational representatives from across the system.

Delivery plans:

Elective recovery key deliverables:

Within this plan there is a continued focus to reduce the long waits within the system and reduce the overall size of the waiting list. Working closely with our secondary care providers we will maximise opportunities to increase and share capacity. There will be a focus on additional actions that need to be taken to reduce the wait times for our children and young people across the system to minimise the impact delays can have on their overall development. Key actions will be:

- Maximise mutual aid across the system to ensure equitable waits and reductions in waiting lists.
- Work with our independent sector providers to increase capacity for specialties under increasing pressure within our acute Providers.
- Work with clinical teams to provide additional capacity within secondary care providers.

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- Increase diagnostic capacity and reduce wait times through increasing capacity within community diagnostic centres and improve overall productivity of other diagnostic capacity

The delivery of the elective recovery plans is co-dependent on other elective delivery plans and the community diagnostic centre delivery plan.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Reduction of acute, community and mental health waiting lists to ensure no one waits more than 65 weeks by March 24	March 2024	Kate Hopcraft, Director of Performance and Delivery	Planned Care Board
Develop clear children and young people's services recovery plan and commence delivery. Paediatric ENT waiting lists for elective surgery reduced.	March 2024	Karlene Allen, Deputy Director of Maternity and Childrens Commissioning / Deputy Chief Nurse & Kate Hopcraft, Director of Performance and Delivery	Planned Care Board
Offer meaningful patient choice at point of referral and subsequent points in the pathway, using alternative providers to minimise waits, embedding mutual aid as routine practice	March 2024	Kate Hopcraft, Director of Performance and Delivery	Planned Care Board
Improve diagnostic wait times across the system	March 2025	Kate Hopcraft, Director of Performance and Delivery	Planned Care Board and System Diagnostic Board

Reduce Health Inequalities and improve access to elective care key deliverables:

C&P ICS are committed to reducing health inequalities across planned care services. Utilising local data, we will identify where we have current health inequalities and work with partners and communities to develop plans to address them. For example, during 2022/23 an MSK health inequalities project has commenced with an action plan to address the findings in development.

Within this delivery plan we will also look at opportunities to provide care closer to home through the development and utilisation of community pathways, identifying services or tests that can be carried out in different settings (Point of Care) for example the community diagnostic centres and neighbourhood teams.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Develop MSK Health Inequalities plan following data review	March 2024	Kate Hopcraft, Director of Performance and Delivery	Planned Care Board
Wider data review	March 2024	Kate Hopcraft, Director of Performance and Delivery	Planned Care Board
Engagement and plans developed	March 2025	Kate Hopcraft, Director of Performance and Delivery	Planned Care Board

Embedding personalised care within planned care pathways key deliverables:

We want to further embed a personalised care approach across our elective services; promote shared decision making and providing access to holistic services to support individuals' well-being.

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With the current increases in waiting times, we want to ensure that people are 'waiting well' for their treatment, being supported to access wider services that can support with finances, home, family, and isolation. We also want to provide people with access to information, education and services that will support them with other aspects of their physical or mental health that may cause further deterioration in their condition, impact their ability to have timely treatment or negatively impact their health outcome or recovery time. For example, helping people to stay active or managing another long-term condition (like diabetes). To do all of this we will work with partners across health, social care, local authority, and voluntary sector to promote current services, develop self-care information and sign post to national information. We will work with our population to co-produce information, and future services that meet the local needs.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Work with our population and system partners to develop wrap around services to ensure people 'wait well'	March 2024	Kate Hopcraft, Director of Performance and Delivery	Planned Care Board
Embed a personalised care approach across all planned care, including cancer services	2026	Kate Hopcraft, Director of Performance and Delivery	Planned Care and Cancer Board

Pathway improvement and redesign key deliverables:

There are opportunities across our current pathways to redesign and improve services for the benefit of both our population and our workforce. These include moving services out of hospital and into community settings as well as introducing more 'one stop' clinics, new models of care and new technology. The system will look at best practice pathways, Getting it Right First Time (GIRFT) recommendations and 'best practice' models as we develop our plans.

The ICB will identify pathway reviews through the Planned Care Board and establish system working parties with clinical, operational and patient representation to identify opportunities and develop impactful delivery plans. Pathways currently under review are:

- Dermatology
- ENT
- Cardiology
- MSK including Orthopaedics and Rheumatology
- Ophthalmology
- Urology

In addition to pathway improvements the system wants to protect secondary care elective work from being impacted by emergency care pressures, particularly through winter. To support this ambition the ICB will work with system partners to develop a strategy for a system wide elective hub, aligned to Hinchingbrooke theatres build and the Hinchingbrooke Hospital redevelopment programme. This will improve system access to elective services, reduce cancellations and disruption for patients and support recruitment and retention of staff through improved staff satisfaction.

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Deliverable/ milestone	Timeline	SRO	Oversight group/s
Pathway redesign on key specialties to achieve greater integration and outcomes (ENT, dermatology, Urology, MSK and Ophthalmology and cardiology)	2024-2026	Kate Hopcraft, Director of Performance and Delivery	Planned Care Board
Develop a strategy for the C&P ICS Elective hub, aligned to Hinchingbrooke theatres build and Hinchingbrooke Hospital redevelopment programme	2025	Kate Hopcraft, Director of Performance and Delivery	Planned Care Board

Increasing productivity and efficiency key deliverables:

To ensure that we are maximising all our current capacity across Planned Care services several productivity and efficiency programmes will continue to run across our providers utilising national best practice, and GIRFT. We will ensure that there is shared learning across the system and where there are opportunities for joint working across providers we will develop joint plans.

Areas of focus are:

- Theatre productivity
- High volume low complexity procedures (HVLC)
- Outpatient productivity
- Right Procedure, Right Place
- Day Case optimisation

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Productivity and efficiency focus to maximise existing capacity, implementation of national benchmarking and best practice including GIRFT	2024-2025	Kate Hopcraft, Director of Performance and Delivery	Planned Care Board and Diagnostic Board
Achieve 85% Theatre Productivity	March 2024	Kate Hopcraft, Director of Performance and Delivery	Planned Care Board
Achieve 85% Day case optimisation	March 2024	Kate Hopcraft, Director of Performance and Delivery	Planned Care Board

Outpatient transformation key deliverables:

Working with system partners the ICB will continue to improve our outpatient services. Good progress has already been made with rolling out Patient Initiated Follow Ups (PIFU), which supports patients to access services post discharge if needed, but reducing attendance of any unnecessary appointments. Work will continue to increase the use of PIFU across specialties.

We will utilise the GIRFT outpatient specialty guidance to develop specialty-based outpatient transformation plans. We will work with clinical and operational teams from primary, community and secondary care to develop these; exploring how we easily provide more specialist advice and guidance to primary and community care, move more services into a community setting, improve

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communication to patients, introduce new pathways/models and ultimately improve patient experience.

This work will be closely linked and embedded into the pathway redesign.

Deliverable/ milestone	**Timeline**	**SRO**	**Oversight group/s**
Achieve >5% of outpatients being discharged to a PIFU pathway	March 2024	Kate Hopcraft, Director of Performance and Delivery	Planned Care Board
Increase the use of specialist advice and guidance	March 2025	Kate Hopcraft, Director of Performance and Delivery	Planned Care Board

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Urgent and Emergency Care

Overview

Our UEC Delivery Strategy sets out the priority areas for C&P ICS. Our focus is on keeping people safe and well, and we will deliver this through preventative initiatives, action to deliver services quickly and close to home where possible, and when hospital treatment is required, by ensuring the delivery of safe care, minimising time spent in hospital thus supporting people to return home at the earliest opportunity. We also recognise the ongoing pressure and challenges our staff face, and we want to enhance their ability to work efficiently, effectively, and safely with confidence and full system support. Our plan maps to the national strategic aims and actions.

C&P ICS invested winter funds into a range of scheme to deliver discharge support, enhanced urgent community response and admission avoidance, support for High Intensity Users, as well as additional bed capacity. Where these schemes have demonstrated impact, the system has agreed to sustainably fund these schemes through the additional capacity funding in 2023/24.

In addition, we aim to improve and maintain our grip on daily UEC operations to manage peaks in demand and effective escalation processes through our C&P Surge & Escalation Plan, working together with all ICS partners, and implementation of our System Coordination Centre operating 7 days a week.

The ICB will work with all partners, but in particular via our North and South Place-based Partnerships, and two Collaboratives to deliver the UEC strategic aims and objectives outlined in the following sections.

The C&P UEC delivery strategy objectives are summarised as ensuring that:

1. Patients experience a well-coordinated integrated community urgent care service which enables them to be supported at home where it is clinically safe, instead of attending emergency hospital services. This includes Call Before You Convey as part of our Care Coordination hub model and boosting our Urgent Community Response services including Falls Cars. It also covers continuing work with our 111 service to improve timely access, and to integrate more effectively with on the day urgent care services in line with the Fuller Stocktake vision.
2. Ambulances reach patients in line with national target response times and are able to handover their patients over to appropriate hospital services quickly. This includes the Cat 2 30-minute response time for 2023/24 and improving further in subsequent years, and implementing our handover improvement plan.
3. Patients who do attend hospital Emergency Departments are assessed, treated, and discharged or admitted with 4 hours, delivering the 76% target by March 2024, and improving further in subsequent years in line with national expectations.
4. Patients who are admitted to hospital do not experience delays at any stage in their stay. The net effect of all of our system flow work will reduce hospital bed occupancy which supports delivery of the ED 4 hour wait target, improved handovers and also elective recovery.
5. When their acute care is completed, patients are transferred home first for assessment, or to virtual wards or other intermediate care services to complete their rehabilitation.
6. The system as a whole is well coordinated with tight day to day grip on flow and effective escalation as required. This includes embedding and refining our System Control Centre model and implementing our System Assurance Framework.
7. Making it easier to access the right care – ensuring healthcare works more effectively for the public, so people can more easily access the care they need, when they need it.

The UEC Recovery Plan is dependent on successful recruitment and retention to improve capacity and resilience of existing UEC services and to develop new services such as virtual wards. Our aim is to reduce UEC vacancies and reliance on agency staffing over time. There will be a focus on identifying opportunities to improve productivity and stabilising the workforce in terms of supply, retention and wellbeing following the impact of Covid-19. We will maximise the efficiency and effectiveness of our workforce focusing on a revised temporary workforce model, shared resources and rostering efficiencies.

Delivery plans:

Emergency Department 4 hour wait performance

We will work with our acute providers to reduce demand, improve ED processes and overall flow to deliver at least 76% patients being treated, admitted or discharged within 4 hours by March 2024, and deliver further improvements in subsequent years.

Key actions:

- **Increasing sustainable capacity within hospital:** Sustaining additional capacity funded through 22/23 to increase overall bed availability, reducing occupancy and improving flow, specifically on the PCH site. Creating additional capacity for ambulance offloads, increasing Same Day Emergency Activity capacity and new models of care at the front door to accelerate patient journeys such as Frailty models.
- **Improving operational processes, clinical decision making and flow:** Focus on implementation of best practice site management models, effective surge and escalation plans at provider level, appropriate utilisation of escalation spaces and full capacity protocols, including adaption of North Bristol continuous flow model, supported via the ICB SCC. Investment and development in operational and clinical teams, recognising the challenging nature of these roles.
- **Increasing community capacity and alternative models:** Maximising occupancy of virtual wards, expanding available pathways to address core population requirements (i.e. falls, CVD). Ensure front door and inpatient pull and push model into this additional capacity. Sustainable additional investment in falls vehicles and overall increase in our UCRT provision to increase admission avoidance, facilitated through our care coordination hub. Right care first time should reduce number of patients conveyed into hospital and reduce avoidable admissions, supporting better flow and reduced bed occupancy within acute footprints.

Deliverable/ milestone	Timeline Y1-5	SRO	Oversight group/s
76% 4 hour wait performance	31.3.24	SC	Unplanned Care Board
95% 4 hour wait performance (subject to national guidance)	TBC	SC	Unplanned Care Board

Expand new services out of hospital and avoid admission to hospital

As set out in the UEC Recovery Plan Objectives above, our aim is that patients experience a well-coordinated integrated community urgent care service which enables them to be supported at home where it is clinically safe, instead of attending emergency hospital services. This includes Call Before You Convey as part of our Care Coordination hub model and boosting our Urgent Community Response services including Falls Cars. It also covers continuing work with our 111 service to improve timely access, and to integrate more effectively with on the day urgent care services in line with the Fuller Stocktake vision.

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Key actions:

- Expand the Care Coordination Hub scope and capacity, moving beyond the current focus on ambulance services to care homes and primary care, provide coordination across a wider range of UEC services, and reach out beyond C&P boundaries to help manage the impact of border system demand.
- Develop the Urgent Community Response (UCR) service. Our UCR service delivers clinical assessment, treatment and care at home, avoiding unnecessary hospital admissions. We will work to ensure a UCR response which is consistently under 2 hours where clinically appropriate for at least 70% of patients. We will work with referring services and clinicians to increase use of UCR to avoid hospital admissions and reduce ambulance conveyances. We will develop a more integrated and multi-disciplinary approach to UCR which will provide effective care coordination. This will include simple options and rapid response for referring clinicians. We will develop our Falls Programme, which will include enhancing the UCR offer to encompass more patients who have fallen, reducing the incidence of 'long lies', and supporting multi-agency falls prevention work. We will also develop integrated response pathways Frailty and for specific conditions such as Urinary Tract Infections.
- Develop an ICS-wide frailty strategy in 23/24 to deliver greater consistency in patient experience, integration across community and acute settings and effective multi-disciplinary team working. This will link with work on prevention and proactive primary care to identify frail residents earlier and reduce the risks of hospital admission.

Deliverable/ milestone	**Timeline Y1-5**	**SRO**	**Oversight group/s**
2-hour response for >70% patients needing UCR	2023/24	Stacie Coburn, Director of Performance and Assurance, ICB	Unplanned Care Board
Sustained reduction in conveyance to ED rate	2023 - 28	Stacie Coburn, Director of Performance and Assurance, ICB	Unplanned Care Board

Increase bed capacity

C&P has consistently overperformed against national targets for increased bed capacity against expected winter demands. We will continue to plan to meet surge demand through a hybrid model, to include:

- General & Acute Hospital beds
- Other beds (i.e., intermediate care)
- Virtual ward beds
- Reduction in demand (admission avoidance schemes)
- Improvements in length of stay and reduction in Criteria to Reside numbers through increased community capacity and improvement in processes to manage patient flow

Deliverable/ milestone	**Timeline Y1-5**	**SRO**	**Oversight group/s**
92% acute bed occupancy sustained	2024-28	Stacie Coburn, Director of Performance and Assurance, ICB	Unplanned Care Board

Improving discharge from hospital

C&P ICS is committed to the principles of Home First and to support this we will continue to develop our ICS transfer of care hub. We recognise that as a system our developments in this area are not as mature as we would like them to be and are behind other systems who have established models, accelerated through COVID. We have an extensive programme of activity in place for 23/25 to deliver the following outcomes:

- Reduction in number of patients who do not meet criteria to reside for reasons related to Pathway capacity;
- Reduction in length of stay from Clinically fit for discharge date to actual discharge date for complex discharge patients;
- An overall reduction in Emergency Medicine length of stay
- Improved patient outcomes and reduction of Harm events associated with extended LOS once clinically discharge ready - reduction in number of Harm events related to extended length of stay.

Our core work streams within this programme are:

- Implementation of a single ICS wide digital solution for patient discharge data. This will aid patient pathway management, visibility of progress, scrutiny, and accuracy of data to drive both operational and tactical efficiencies in how we work as a system and also inform future care models.
- Sustainably investing in additional discharge resources both at a provider and collective Transfer of Care Hub level.
- Reviewing current discharge pathways (delirium/ neuro rehab/ stroke/ IPR) to identify pathway challenges and opportunities to deliver care more effectively and efficiently.
- Building on the Pathway 1 Trusted Assessor principles
- Full system capacity and demand review to inform future focus areas

Deliverable/ milestone	Timeline Y1-5	SRO	Oversight group/s
Increase in Pathway 1 capacity (ref Operational Plan 23-24)	31.3.24	Stacie Coburn, Director of Performance and Assurance, ICB	Unplanned Care Board
Reduction in discharge delays (method work in progress)		Stacie Coburn, Director of Performance and Assurance, ICB	

Virtual wards

C&P ICS have completed demand and capacity modelling to develop a Virtual ward model of approximately 160 beds by 1st April 23, and we will work towards the national target over the next 2-3 years. We are now focussed on increasing utilisation of the available capacity. In line with NHSE's Virtual Ward scaling up plan(s), the priority specialty areas have been:

- Frailty, Respiratory and Heart Failure (North & South)
- Additional pathways have been created for admission avoidance (North) and multi-general specialties within CUHFT

- Papworth Hospital (RPH) has been developing two pathways, one for Respiratory and the other for pre-cardiothoracic surgery high-risk diabetic patients, although comparatively these are smaller numbers

Deliverable/ milestone	Timeline Y1-5	SRO	Oversight group/s
>80% bed occupancy for VW	31.3.24	Stacie Coburn, Director of Performance and Assurance, ICB	Unplanned Care Board
Trajectory to national VW bed target	2024-28	Stacie Coburn, Director of Performance and Assurance, ICB	Unplanned Care Board

Ambulance Response Times and Handover Improvement

The ICS has made good progress in reducing ambulance handover delays and accelerating ambulance response times, specifically for Category 2. The net effect of all of the interventions described above feed into the Ambulance Handover Improvement plan, and joint work with EEAST and EMAS to improve ambulance response times.

Deliverable/ milestone	Timeline Y1-5	SRO	Oversight group/s
Category 2 response <30 mins	2023/24	Stacie Coburn, Director of Performance and Assurance, ICB	Unplanned Care Board
Category 2 response <18 mins in line with nat guidance	2024/25	Stacie Coburn, Director of Performance and Assurance, ICB	Unplanned Care Board
Ambulance handover average <15 mins	tbc	Stacie Coburn, Director of Performance and Assurance, ICB	Unplanned Care Board

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Maternity and Neonatal services

Overview

The national, regional, and local maternity and neonatal aim is to provide safer, more personalised, and more equitable care achieved through the following objectives:

- Reduction in stillbirths, neonatal mortality, maternal mortality, and serious brain injury.
- Increase fill rates against funded establishment for maternity staff.
- Improvements to physical and mental health outcomes.
- Reduce health inequalities for pregnant people and babies through an integrated approach to providing care.

The Local Maternity and Neonatal System (LMNS) is the maternity and neonatal arm of the ICS. Cambridgeshire and Peterborough Local Maternity and Neonatal System (LMNS) brings together providers, commissioners, local authorities, service user voice representatives and other local partners to deliver a system plan. To support Cambridgeshire and Peterborough Local Maternity System (LMNS) in delivering the national, regional, and local aims, a three-to-five-year strategy is being coproduced. It is due for completion in September 2023. The overarching objective of the strategy is to follow the national direction of travel through utilisation of local intelligence. This will address maternity and neonatal service challenges and inform the Local Maternity and Neonatal System (LMNS) where to prioritise, integrate and maximise resources.

Key work programmes

Providing safe care is the basis to all maternity and neonatal restoration and service transformation. The key work programmes identified to enable safety improvements are the implementation and embedding of:

- Ockenden and East Kent report actions.
- NHS Long Term Plan.
- Maternity Programme.

Maternity and neonatal services Three-year delivery plan (also known as the Single delivery plan was published in March 2023. This delivery plan sets out clear responsibilities and measures of success across services and systems. The Three-year delivery plan sets measures for what “good will look like” within the focus areas identified below.

Within the key programmes of work the following areas are to be focused upon:

- Listening to and working with women, birthing people, and families with compassion.
- Growing retaining and supporting our workforce with the resources and teams they need to excel.
- Developing a culture of safety, learning and support.
- Standards and structures that underpin safer more personalised and more equitable care.

It has been indicated that equity and equality must be the prioritised when planning, monitoring, and responding to the key work programmes, priorities and focus areas. This is because indicators are that health inequities continue to increase.

Governance and reporting

The Revised Perinatal Surveillance Model has been implemented and embedded as recommended by the Ockenden Immediate and Essential Actions. The Local Maternity and Neonatal System

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Programme Board provides safety, quality and transformation oversight and assurance. Its objective is to establish and embed a robust feedback mechanism to ensure that actions and progress against the 4 objectives shared by the Local Maternity and Neonatal System to the ICB Board are acknowledged and responses are fed back.

Key interdependencies:

- All partners and departments working together to progress the maternity and neonatal safety and improvement agenda.
- Recognition of the lifelong benefits and social care outcomes resulting from good health during pregnancy.

Delivery Plans:

Reduction in stillbirths, neonatal mortality, maternal morbidity and mortality, and serious brain injury

Deliverable/ milestone	**Timeline**	**SRO**	**Oversight Group**
Preterm birth clinics (included in LTP) - Ockenden & East Kent response	2024	LMNS SRO – Chief Nurse ICB CUH – Meg Wilkinson, Director of midwifery NWAFT – Melissa Davis Director of midwifery	LMNS Board
Perinatal Pelvic Health Services (included in LTP) - Ockenden & East Kent response	2024	LMNS SRO – Chief Nurse ICB CUH – Meg Wilkinson, Director of midwifery NWAFT - Melissa Davis Director of midwifery	LMNS Board
Saving Babies Lives Care Bundle (SBLCB) focus upon pre-term birth clinics - NHS Long Term Plan	2023-24	LMNS SRO – Chief Nurse ICB CUH – Meg Wilkinson, Director of midwifery NWAFT - Melissa Davis Director of midwifery	LMNS Board
Maternal Medicine Networks (MMN) - NHS Long Term Plan	2023-24	LMNS SRO – Chief Nurse ICB CUH – Meg Wilkinson, Director of midwifery NWAFT - Melissa Davis Director of midwifery	LMNS Board
Clinical Negligence Scheme for Trusts (CNST) - NHS Long Term Plan	2023-24	LMNS SRO – Chief Nurse ICB CUH – Meg Wilkinson, Director of midwifery NWAFT - Melissa Davis Director of midwifery	LMNS Board
Midwifery Continuity of Carer- focus upon building blocks and areas of inequity and inequality - NHS long Term Plan & Maternity Programme	2024-25	LMNS SRO – Chief Nurse ICB CUH – Meg Wilkinson, Director of midwifery NWAFT - Director of midwifery	LMNS Board
Health Safety Investigation Branch (HSIB) - NHS long Term Plan & Maternity Programme	2024-25	LMNS SRO – Chief Nurse ICB CUH – Meg Wilkinson, Director of midwifery NWAFT - Melissa Davis Director of midwifery	LMNS Board
Perinatal Mortality review Tool (PMRT) - NHS long Term Plan & Maternity Programme	2024-25	LMNS SRO – Chief Nurse ICB CUH – Meg Wilkinson, Director of midwifery NWAFT - Melissa Davis Director of midwifery	LMNS Board

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Deliverable/ milestone	Timeline	SRO	Oversight Group
Neonatal critical care Review (NCCR) - NHS long Term Plan & Maternity Programme	2024-25	LMNS SRO – Chief Nurse ICB CUH – Meg Wilkinson, Director of midwifery NWAFT - Melissa Davis Director of midwifery	LMNS Board
Maternity and Neonatal Safety Improvement Programme - NHS long Term Plan & Maternity Programme	2024-25	LMNS SRO – Chief Nurse ICB CUH – Meg Wilkinson, Director of midwifery NWAFT - Melissa Davis Director of midwifery	LMNS Board
Reduction in smoking during pregnancy - NHS long Term Plan & Maternity Programme	2024-25	LMNS SRO – Chief Nurse ICB CUH – Meg Wilkinson, Director of midwifery NWAFT - Melissa Davis Director of midwifery	LMNS Board
Reducing avoidable admission of full-term babies - NHS long Term Plan & Maternity Programme	2023-24	LMNS SRO – Chief Nurse ICB CUH – Meg Wilkinson, Director of midwifery NWAFT - Melissa Davis Director of midwifery	LMNS Board

Increase fill rates against funded establishment for maternity staff

Deliverable/ milestone	Timeline	SRO	Oversight Group
Increase Obstetric Leadership Capacity - Ockenden & East Kent response	2023-26	LMNS SRO – Chief Nurse ICB CUH – Meg Wilkinson, Director of midwifery NWAFT - Melissa Davis Director of midwifery	LMNS Board
Bereavement provision - Ockenden & East Kent response	2023-26	LMNS SRO – Chief Nurse ICB CUH – Meg Wilkinson, Director of midwifery NWAFT - Melissa Davis Director of midwifery	LMNS Board
Accelerate the implementation of the NMC Principles for Preceptorship - Ockenden & East Kent response	2023-26	LMNS SRO – Chief Nurse ICB CUH – Meg Wilkinson, Director of midwifery NWAFT - Melissa Davis Director of midwifery	LMNS Board
Unit based retention leads - Ockenden & East Kent response	2023-26	LMNS SRO – Chief Nurse ICB CUH – Meg Wilkinson, Director of midwifery NWAFT - Melissa Davis Director of midwifery	LMNS Board
Increase Maternity Support Workers numbers - Ockenden & East Kent response	2023-26	LMNS SRO – Chief Nurse ICB CUH – Meg Wilkinson, Director of midwifery NWAFT - Melissa Davis Director of midwifery	LMNS Board
Increase numbers of midwives (training, recruitment and retention) - Ockenden & East Kent response	2023-26	LMNS SRO – Chief Nurse ICB CUH – Meg Wilkinson, Director of midwifery NWAFT - Melissa Davis Director of midwifery	LMNS Board
Capacity and Capability Framework - Ockenden & East Kent response	2023-26	LMNS SRO – Chief Nurse ICB CUH – Meg Wilkinson, Director of midwifery NWAFT - Melissa Davis Director of midwifery	LMNS Board

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Deliverable/ milestone	Timeline	SRO	Oversight Group
Develop expert neonatal nursing workforce – NHS Long term plan	2023-26	LMNS SRO – Chief Nurse ICB CUH – Meg Wilkinson, Director of midwifery NWAFT - Melissa Davis Director of midwifery	LMNS Board

Improvements to physical and mental health outcomes

Deliverable/ milestone	Timeline	SRO	Oversight Group
Implementation and improvement of access to Perinatal Mental Health services - Ockenden, East Kent & NHS Long Term Plan	2023-26	LMNS SRO – Chief Nurse ICB CUH – Meg Wilkinson, Director of midwifery NWAFT - Melissa Davis Director of midwifery	LMNS Board
Midwifery Continuity of Carer- focus upon building blocks and areas of inequity and inequality - Ockenden, East Kent & NHS Long Term Plan	Timeframe paused for complete roll out	LMNS SRO – Chief Nurse ICB CUH – Meg Wilkinson, Director of midwifery NWAFT - Melissa Davis Director of midwifery	LMNS Board

Reduce health inequalities for pregnant women and babies through an integrated approach to providing care

Deliverable/ milestone	Timeline	SRO	Oversight Group
Utilising the Service User voice to ensure services are coproduced and accurately capture the experiences of the population they represent - Ockenden, East Kent & NHS Long Term Plan	2023	LMNS SRO – Chief Nurse ICB CUH – Meg Wilkinson, Director of midwifery NWAFT - Melissa Davis Director of midwifery	LMNS Board
Digital transformation (Access to digital records) - NHS Long Term Plan	2023	LMNS SRO – Chief Nurse ICB CUH – Meg Wilkinson, Director of midwifery NWAFT - Melissa Davis Director of midwifery	LMNS Board
Personalised Care and Support Plans (PCSPs) - NHS Long Term Plan	2023	LMNS SRO – Chief Nurse ICB CUH – Meg Wilkinson, Director of midwifery	LMNS Board
Midwifery Continuity of carer - focus upon BAME and most deprived 10% of neighbourhoods - NHS Long Term Plan & Maternity Programme	2025	LMNS SRO – Chief Nurse ICB CUH – Meg Wilkinson, Director of midwifery NWAFT - Melissa Davis Director of midwifery	LMNS Board
Midwifery Continuity of carer - focus upon BAME and most deprived 10% of neighbourhoods - Maternity Programme	2023-26	LMNS SRO – Chief Nurse ICB CUH – Meg Wilkinson, Director of midwifery NWAFT - Melissa Davis Director of midwifery	LMNS Board
Equity and Equality framework implementation - Maternity Programme	2023-26	LMNS SRO – Chief Nurse ICB CUH – Meg Wilkinson, Director of midwifery NWAFT - Melissa Davis Director of midwifery	LMNS Board
Midwifery Independent Senior Equity Advocate (MISEA) - Maternity Programme	2023-26	LMNS SRO – Chief Nurse ICB CUH – Meg Wilkinson, Director of midwifery NWAFT - Melissa Davis Director of midwifery	LMNS Board

Cardiovascular disease

Overview

Cardiovascular diseases (CVD) are a group of disorders that affect the heart and blood vessels and are the leading cause of death globally.

According to the World Health Organization (WHO), 17.9 million deaths occur each year due to CVD, which is equivalent to 31% of all deaths worldwide. CVD can manifest as coronary heart disease (CHD), stroke, and heart failure, amongst others. Preventable under 75 years of age CVD mortality in Peterborough is significantly worse than England and regional average, ranked 26th highest district in England, with an increasing trend.

There are risk factors associated with a person's likelihood of developing CVD including age, family history, tobacco use, excess alcohol, excess weight, stress, diabetes, high cholesterol, and especially familial hypercholesterolemia. All these risk factors need to be identified, assessed, diagnosed, and treated to improve health outcomes.

CVD can be broadly prevented through lifestyle changes, such as following a healthy diet, being physically active, avoiding tobacco, and managing stress. Early detection and control of cardiovascular risk factors, such as high blood pressure and cholesterol, can also play a critical role in preventing CVD.

Implementing our cardio-vascular disease strategy is a priority as part of the CPICS ambitions to reduce health inequalities and improve health outcomes.

Our overall ambition for CVD is to reduce rates of CVD in Cambridgeshire and Peterborough through preventative lifestyle changes whilst optimising diagnosis and treatment.

The C&P ICS CVD strategy 21-26 aims to achieve the following outcomes:

- 5% reduction in deaths from cardiovascular disease by Dec 2026
- 5% reduction in acute admissions with heart failure by Dec 2026
- reduction in death from cardiovascular disease by 10% for PCNs within the worst quintile of death rates from cardiovascular disease by Dec 2026

Specific objectives and success measures to meet the 10-year cardiovascular disease ambition for England:

Atrial Fibrillation

- 85% of the expected number of people with AF are detected by 2029
- 90% of patients with AF who are already known as a high risk of a stroke to be adequately anticoagulated by 2029

High blood pressure

- 80% of the expected numbers of people with high blood pressure are diagnosed by 2029.
- 80% the total number of people already diagnosed with high blood pressure are treated to target as per NICE guidelines by 2029

High Cholesterol

- 75% of people aged 40-74 have received a formal validated CVD risk assessment and cholesterol reading recorded on a primary care data system in the last 5 years by 2029

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- 45% of people aged 40-74 identified as having a 20% or greater 10-year risk of developing CVD in primary care are treated by statins by 2029
- 25% of people with Familial hypercholesterolaemia (FH) are diagnosed and treated optimally according to NICE FH Guideline by 2024

Delivery plans

Optimising treatment of heart failure

Objectives:

- Enhanced joining up of care from integration of HF management pathways across hospital, community & primary care
- Enhanced patient and carer experience for people with HF
- Enhanced end of life care for people with HF
- Enhanced access to care via innovative digital models for delivery of care for people with HF - virtual clinics, remote monitoring, telemedicine

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Implement ICS wide Heart Failure pathway with one stop clinics	2025	Patrick Calvert, Consultant Cardiologist & CVD Clinical Lead	CVD Board HF sub-group
Develop heart failure hub to cover secondary, community and primary care staff.	2024	Patrick Calvert, Consultant Cardiologist & CVD Clinical Lead	CVD Board HF sub-group
Develop six monthly reviews by Heart Failure specialist team	2025	Patrick Calvert, Consultant Cardiologist & CVD Clinical Lead	CVD Board HF sub-group
Develop end of life and palliative training with the heart failure team and establish joined up working with palliative teams	2024	Patrick Calvert, Consultant Cardiologist & CVD Clinical Lead	CVD Board HF sub-group
Integrate HF hub with VCSE and service users	2024	Patrick Calvert, Consultant Cardiologist & CVD Clinical Lead	CVD Board HF sub-group
Develop virtual wards pathway for heart failure	2023	Patrick Calvert, Consultant Cardiologist & CVD Clinical Lead	CVD Board HF sub-group
Develop capacity and workforce plans to support Echocardiography including the option of hand-held devices	2025	Patrick Calvert, Consultant Cardiologist & CVD Clinical Lead	CVD Board HF sub-group & CDC board

Tackling behaviour risk factors, including smoking, exercise and weight management, and improving the management of clinical risk factors, including hypertension, AF, diabetes and hyperlipidaemia

Objectives:

- Increase primary care identification of high-risk groups.
- Deliver improved proactive care to high-risk patient groups, through integrated pathways across all services.
- Maximise digital interventions to support self-management.
- Targeted action to improve hypertension management to NICE recommended levels.
- Further implement the Tobacco Dependency Programme and increase referrals and quits.
- Increase the number the number of NHS Health Checks Programme through diversification and increasing access opportunities.

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Deliverable/ milestone	Timeline	SRO	Oversight group/s
Use of PHM, data extraction and monitoring e.g. System One, Eclipse, CVDPREVENT Audit to identify high-risk groups	TBC	Louis Kamfer, Dep Chief Exec Officer & Managing Director of Strategic Commissioning, Chris Gillings, Associate Director for BI	Strategic commissioning Group, ICB
Identification of high-risk groups through community pharmacy services	TBC	Sati Ubhi, Chief Pharmacist, ICB	TBC
Implement new model for CVD clinical risk management in primary care	TBC	Jessica Randall-Carrick, GP & CVD Prevention Lead	TBC
Evaluate the incentives programme for pregnant smokers and embed into wider services if positive	March 2024	Val Thomas, Deputy Director, Public Health & CVD Prevention Lead	Tobacco Control Alliance
Treating Tobacco Dependency Programme milestones and targets	March 2025	Jon Bartram, Programme Director, Strategic Commissioning Unit, ICB	Tobacco Control Partnership
Embedding integrated, proactive, and personalised care through place-based initiatives	TBC	South and North partnerships	South and North Boards
Embed NHS Health Checks into new Primary Care CVD LES, targeted pharmacies and other providers	TBC	Val Thomas, Deputy Director, Public Health & CVD Prevention Lead	TBC
Managed care team approach	2024	Simon Howard/North Place	HI Board

Governance and reporting

Objectives:

- Agree consistent baselines and measures and track progress towards system outcomes.
- Establish robust reporting, communication and governance arrangements to deliver the 10-year programme.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Agree and monitor CVD prevention KPIs at system level	Dec 2023	Louis Kamfer, Dep Chief Exec Officer & Managing Director of Strategic Commissioning	TBC
Ensure clear leads and governance for CVD prevention and interface with CVD treatment	May 2023	Louis Kamfer, Dep Chief Exec Officer & Managing Director of Strategic Commissioning,	TBC
Agree project/programme team to drive the systemwide changes	June 2023	Louis Kamfer, Dep Chief Exec Officer & Managing Director of Strategic Commissioning,	TBC
Engage with service users and staff	June 2023	TBC	TBC

Key interdependencies:

- Clinical strategy
- Primary care transformation and sustainability
- Quality, safety, and workforce strategies
- Public Health
- Health Inequalities Strategy

Population Health Management

Overview

Our joint health and wellbeing and integrated care strategy recognises that Population Health Management (PHM) is a key tool to support our goals on prevention of ill-health, reduced inequalities, improved outcomes, and quality of care.

Using a PHM approach drives a change in culture towards more integration, more prevention, and more provision, based on need rather than service use.

Our long-term vision is that all organisations within the ICS have the skills, resource and information they need to use PHM approaches.

Delivery plans:

There are 4 key elements of successfully delivering Population Health Management capabilities (NHS England PHM Flatpack):

- Infrastructure
  - The infrastructure is the set of basic building blocks that are core for a system to manage the health and wellbeing of a population.
  - This includes having shared and effective leadership, defining the population in question, having an agreed information governance and basic elements of digital and data infrastructure.
- Intelligence
  - PHM involves intelligence-led planning and delivery of services, aligning services with population need to improve outcomes.
  - Once the right infrastructure is in place, the first step in the intelligence process is to understand population need. This is then followed by use of tools and techniques to align need with effective interventions.
- Interventions
  - It is not sufficient to only have the right infrastructure and do the analytics.
  - The next step is to build from the learnings of the analytics to make decisions on the services provided to the public; identifying effective, evidence-based interventions and implementing them.
- Incentives
  - We need to incentivise stakeholders to undertake PHM based initiatives in line with health and wellbeing and integrated care strategies aims and individual patient needs.

Where we want to be by 2026 and how we will measure success:

Phase 1 is all about the data. We have a secure data warehouse that currently contains Hospital, Mental Health, Community and Social Care data. To carry out PHM we need to expand that to include General Practice data and information on the wider determinants of health e.g. Housing and the environment we live in.

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Deliverable/ milestone	Timeline	SRO	Oversight group/s
Talk to stakeholders and agree the data to be used and the Information Governance that supports its use.	January - April 2023	Louis Kamfer & Chris Gillings	Strategic Commissioning Group & Strategic Analytics Group
Submit Confidentiality Advisory Group application to use data for this purpose	May – July 2023		
Begin to collect the General Practice data and store it in our secure data warehouse.	August - December 2023		
Link that General Practice Data with the other data available e.g. A&E attendances, to understand patients needs.	August 2023		
Begin to carry out risk stratification and segmentation of our population to help redesign services.	September 2023		
Begin to share that analysis with system partners to enable change.	September 2023		
Pilot interventions and incentives using the PHM approach	2023/24		

Phase 2 is about building better intelligence using the data we pulled together in Phase 1. We will work with system partners to understand what we want PHM to do. We will build the use cases for PHM using all the points of view we have in the system, including that of patients. We will then look for the best solution to deliver that.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Procure a strategic partner to support the programme.	May 2023	Louis Kamfer & Chris Gillings	Strategic Commissioning Group & Strategic Analytics Group
Options appraisal	June – August 2023		
Develop specification	August - September 2023		
Shortlist suppliers using national framework and procure	September - October 2023		
Delivery phase	October 2023 – April 2024		

Phase 3 looks at what else we can do with the data and intelligence we have built during the earlier phases. Can we use it to forecast demand over the next 5, 10 and 15 years? Can we use it to build robust geospatial models of need? How can we use it to support research, making sure we do that in line with the views of our population? But overall it will be driving forward whole system analytics, bringing together system partners so we carry out analysis once but look at it from all angles. Not just health need but how that links to housing quality, air pollution, transport links etc.

Key interdependencies:

- Clinical strategy.
- Primary care transformation and sustainability.
- System and organisational Green plans.
- The system's Digital strategy (including virtual wards)
- Quality, safety and workforce strategies.

Source documents: CPICS PHM Delivery Roadmap, NHS England PHM Flatpack, CPICS Health and Wellbeing and Integrated Care Strategy

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High Intensity Use Service

Overview

The effective identification and management of those who utilise NHS services more frequently, also known as high intensity use, is vital in terms of reducing demand and increasing capacity across the system, while ensuring individuals receive the wider care and support they require.

High intensity use of services is linked to health inequalities. Those who frequently attend Accident and Emergency (A&E) departments are generally low in numbers, but their impact on the wider health system is significant[1]. For example, across the NHS Cambridgeshire and Peterborough ICS footprint, between November 2021 and December 2022, approximately 100 individuals (0.01% of the total registered population) attended A&E departments in the system 20 or more times, resulting in a total of 3,195 attendances (1.1% of the total A&E attendances).

Previous work to explore high intensity use has generally shown those who attend A&E most frequently are people living in the most deprived communities; are more likely to be admitted to hospital than people who attend less frequently; have poorer physical and mental health; and experience poorer than average health outcomes despite the high use of services.

Those who use NHS services on a more intense basis are likely to experience a host of wider socio-economic problems, including unmet social needs such as housing, loneliness, employment, debt, as well as having chronic health conditions, mental health issues and drug and substance misuse problems. Taking a targeted approach to supporting these individuals is an important part of improving health outcomes locally and in turn helping to reduce avoidable A&E attendances and admissions over time.

Vision and objectives

- To ensure a personalised care approach is central to the development and establishment of high intensity user services and thereby providing people with more control over their own health, and more personalised care when they need it.
- To better identify those at greatest risk of high frequent A&E attendances and non-elective admissions through existing and emerging data to get up-stream to provide early and more suitable interventions.
- To reduce demand on NHS services (A&E attendances, ambulance call outs, 111 services and GPs) and reduce avoidable non-elective admissions amongst the high intensity user cohort.
- To gain a comprehensive understanding of what is driving the high frequency of A&E attendances and non-elective admissions, thereby identifying specific patient needs which are not necessarily clinical.
- To coordinate links into other services provided by a local network of health and wellbeing support partners.
- To strengthen integrated neighbourhood approaches, through improved communication and partnership working.

[1] British Red Cross report, "Nowhere else to turn: Exploring high intensity use of Accident and Emergency services", November 2021: https://www.redcross.org.uk/about-us/what-we-do/we-speak-up-for-change/exploring-the-high-intensity-use-of-accident-and-emergency-services)

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- To contribute to the Core20PLUS approach by tackling inequalities for those living in more deprived areas and who experience poorer than average health outcomes.

Deliverables / Anticipated outcomes:

Based on the success of other services concentrating on those who utilise services more intensely both regionally and nationally, the following are assumed deliverables and anticipated outcomes:

- 40% Decrease in A&E attendances in the selected cohort(s)
- 40% Decrease in non-elective admissions in the selected cohort(s)
- Reduction in avoidable 999 and 111 calls
- Reduction in ambulance conveyances within the selected cohort(s)
- Reduction in GP attendances within the selected cohort(s)
- An increase in Quality of Life as measured by the EQ5D tool (or another validated tool) in the selected cohort e.g. Outcome Star
- Improvement in patient physical and mental health within selected cohort(s)
- Increased number of Personalised Care Plans produced within the selected cohort(s)

Delivery plans

Implementation of a High Intensity User Service (Tier 1 – 'Specialist')

We will work with our accountable business units (ABUs), acute providers, and wider system partners to establish an HIU service focussing on those who attend A&E services more frequently and who are more likely to non-elective admissions. This service will be modelled on the NHSE approach to addressing high intensity use and will build upon existing structures / partnerships in place which are already supporting those people who are utilising A&E services more frequently.

Milestone	Timeline Y1-5	SRO	Oversight group/s
Business case and service specification agreed and additional investment (if required) approved	Y1	Jon Bartram Programme Director SC	Health & Care Partnerships & SCU
Establishment and implementation of the Tier 1 HIU service	Y1	Jon Bartram Programme Director SC	Health & Care Partnerships & SCU
Initial evaluation and quality improvement of service through co-production and through embedding a personal	Y2	Jon Bartram Programme Director SC	Health & Care Partnerships & SCU
Integrate data from wider system partners and utilisation of population health management insights to better identify emerging HIU patients	Y3-5	Jon Bartram Programme Director SC	Health & Care Partnerships & SCU
Identify drivers (including behaviours, lifestyles, underlying social and emotional reasons) that lead to high intensity use of services to help identify gaps in existing services	Y3-5	Jon Bartram Programme Director SC	Health & Care Partnerships & SCU

Improving outcomes for those at 'rising risk' of utilising services more frequently (Tier 2 – 'Targeted')

Building upon what is included in the Urgent and Emergency Care (UEC) delivery plan and to contribute to the wider NHSE plan for recovering urgent and emergency care, we will develop and implement a Tier 2 'targeted' HIU service at the integrated neighbourhood level, which focuses on those patients who are considered to be 'at risk' of accessing services more frequently. A targeted population health management (PHM) approach will be adopted to identify persons 'at risk' of utilising services more intensely that the general population (i.e., aligning to higher than average A&E attendances, but not limited to this criteria alone) within each Integrated Neighbourhood footprint.

This service will build upon the work carried out over winter 2022/23 where integrated neighbourhood teams supported cohorts of people considered most vulnerable through personalised care approaches, including 'what matters to me' conversations and the development of personalised care plans.

Milestone	Timeline	SRO	Oversight group/s
Business case and service specification agreed and additional investment (if required) approved	Y1	Jon Bartram Programme Director SC	Health & Care Partnerships & SCU
Develop governance model for Targeted HIU Service and signed off	Y1	Jon Bartram Programme Director SC	Health & Care Partnerships & SCU
Work with Place to design, develop and implement a Tier 2 targeted HIU Service	Y1	Jon Bartram Programme Director SC	Health & Care Partnerships & SCU
Evaluation of progress, reporting metrics and outcomes at neighbourhood, place, and system levels	Y2	Jon Bartram Programme Director SC	Health & Care Partnerships & SCU
Refinement of the tier 2 HIU service, including evaluation of new approaches to financial allocations	Y3-5	Jon Bartram Programme Director SC	Health & Care Partnerships & SCU

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Key interdependencies:

- Delivery plan for recovering UEC services
- Partnership delivery plans
- Core20PLUS5 approach to tackling health inequalities
- Primary and secondary prevention programmes
- Cambridgeshire and Peterborough drug & alcohol strategy
- Mental health strategy and delivery plans

Advanced Illness (End of Life)

Overview

Our Integrated Care System's Palliative and End of Life Care Strategy 2022-26 was co-produced in recognition of the projected growth in the demand for palliative care, the challenges due to increasing complexity and diversity of our population's needs. Our aim is to build on our existing palliative and end of life care provision to develop services that are equitable, sustainable, informed, and integrated.

The Strategy identified 6 Objectives as priorities for the next three years to ensure that people of all ages will have fair access to personalised palliative and end of life care which is person centred, integrated, well led, and maximises comfort and wellbeing to meet, as far as possible, the individual's wishes and choices.

Objectives:

- Early identification and appropriate and accessible information provided.
- Individual's wishes are understood and respected, physical, emotional, social and spiritual.
- Care is coordinated by staff who are well trained and have access to resources.
- Access to end of life care, where possible in preferred place of care with empowerment to make decisions about that care.
- Early access to services for families and carers, including bereavement support.
- Communities are ready, willing, and able to provide support.

Where we want to be by 2026 and how we will get there: Many of the actions cross more than one objective but will not be duplicated in each in this document.

Objective 1

- Closer collaboration between all specialities, general health care and social care to ensure early identification of people with life limiting diagnoses
- Improved access to and experience of palliative and end of life care for those who are neuro-diverse.
- Improved access to, and experience of, palliative and end of life care for those with poor mental health or cognitive impairment
- Improved access to, and experience of, palliative and end of life care for those with poor mental health or cognitive impairment
- Improved access to, and experience of, palliative and end of life care for those from different cultural backgrounds and those who are socially isolated
- Improve the experience and support to families where there is maternal death, or death of a child

Deliverables/ Milestone	Timeline	SRO	Oversight group
Recognition of the role of General Practice and Community Health, while enabling specialisms to understand the value of palliative care and how to discuss it with patients and families. Use of Eclipse data from GPs and Gold Standard Framework	2023	P&EoLC Lead	ICB

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Deliverables/ Milestone	Timeline	SRO	Oversight group
Close working with the Sue Ryder Health Inequalities Lead to build on links and listen to the needs of hard-to-reach groups	2023	Safia Akram, Health inequalities lead	Sue Ryder
Work with LeDeR lead and the Learning Disability Partnerships to improve access to services and understanding of needs	2024	Isobel Wilkerson, Associate Director of Nursing and Quality (OPAC)	CPFT
Closer working between specialist services and generalist to provide holistic support and understanding	2024	Isobel Wilkerson, Associate Director of Nursing and Quality (OPAC)	CPFT
Review current provision and work with service users to agree improved processes where appropriate	2024	P&EoLC Lead	ICS

Objective 2

- Continued training on honest and difficult conversations, to be widened to other specialisms
- Improved information provision for public and professionals

Deliverables/Milestone	Timeline	SRO	Oversight Group
Improved local website with information, signposting, and advice in easy read and different languages	2023	P&EoLC Lead	ICB
Training Hub to look at rolling out training to specialisms	2025	Sara Robins, Clinical Services Director, Arthur Rank Hospice	Arthur Rank

Objective 3

- Shared Care Records to include all ICS partners
- Improved transition experience for you people and their families

Milestone	Timeline	SRO	Oversight Group
Joint working to improve protocols and provide clear guidance and expectations	2024	P&EoLC Lead	ICS
Extension of use of Systm1 to include partners not currently accessing	2026	P&EoLC Lead	ICS

Objective 4

- Improved understanding and delivery of patient's wishes
- Improved support to primary care and community health professionals to support them in maintaining patients at home

Milestone	Timeline	SRO	Oversight Group
Develop collaboration between generalist and specialist services. Implement System-wide anticipatory medicines approach. Improved out of hours provision	2023	P&EoLC Lead	ICB
Continued ReSPECT training and implementation with system wide process	2024	Sara Robins, Clinical Services Director, Arthur Rank Hospice	Arthur Rank

Objective 5

- Bereavement support is available to all in different languages, age appropriate and to those with sensory impairment

Milestone	Timeline	SRO	Oversight Group
Review current provision, ensure directory is accessible and identify gaps and how to fill them.	2024	P&EoLC Lead	ICS

Objective 6

- Engaging with communities and faith groups

Milestone	Timeline	SRO	Oversight Group
Working with Sue Ryder Health Inequalities Lead and North and South Partnerships to involve residents in the conversation and show how we respond to their feedback	2023	Safia Akram, Health Inequalities Lead	Sue Ryder

Key interdependencies:

- All partners and departments working together to progress the End of Life provision
- Recognition that Palliative and End of Life care touches all areas of health and social care
- Sharing of information and data to inform gaps and developments
- Continued development of the Palliative Care Hub

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Workforce

Overview

Working to our shared vision of 'All Together for Healthier Futures' and the four pillars of the NHS People Plan, our workforce plans aim to shape an integrated workforce that is inclusive, healthy, flexible and resilient.

We want to ensure our workforce has the right skills to provide the right solutions in the most appropriate setting to improve outcomes for our communities, using resources as effectively and efficiently as possible. We are committed to aligning people planning with the ever-changing needs of our community's health and wellbeing.

Our workforce plans are vitally important to help address the transformational priorities of the system and to mitigate the staffing risks which are facing due to national shortages in many sectors, the strain of prolonged post COVID impact, demographic change, tight local labour markets and lack of affordable housing for health and care workers.

Delivery plans:

Leadership and culture: Developing compassionate and high performing leadership to drive a just and learning culture.

Objectives:

- Support local leaders to work together, learn and share knowledge from across the system with their teams and services to create public services that are more integrated based on the needs of the local population.
- Support inclusion and belonging for all and create a great experience for staff, using evaluation to better understand the needs of our workforce and improve leadership programmes.
- Raise awareness of the negative impact that incivility can have in healthcare, so that we can understand the impact of our behaviours.
- Enable and encourage all leaders to lead and drive these culture changes and address the challenges of leading across systems of care, as well as enable and encourage everyone to understand the new world that we are operating in, and their role in making it a success.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Ensure the sustainability of delivering system wide leadership offers	By 2025	Anita Pisani	Leadership and Culture
As a System work together to develop talent and succession plans	By 2025	Anita Pisani	Leadership and Culture

Equality, Diversity and Inclusion: Work towards driving out inequality, recognising we are stronger as a system that values difference and inclusion

Objectives:

- Develop and deliver EDI training for all staff, including senior leaders and managers.
- Utilise advanced models of culture change and establish a faculty to widen knowledge and reinforce the breadth of delivery across a wide range of leaders, to create a more supportive environment for staff from minoritized backgrounds, shifting away from the deficit model of EDI.

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- Develop targeted recruitment strategies to increase diversity within the ICS workforce, with a particular focus on underrepresented and marginalised groups.
- Develop a consistent approach to combating violence and aggression within the Cambridgeshire and Peterborough ICS and throughout provider organisations.
- Engage with local communities and stakeholders through consultation events such as Equality Delivery System (EDS) programmes, focus groups, and other engagement activities to ensure that their voices are heard and their needs are met.
- Develop and implement standards for policies and procedures that promote EDI and ensure that all staff and patients are treated fairly and with respect.
- Develop targeted initiatives to improve health outcomes for underrepresented and marginalised communities through the Health Inequalities programme.
- Provide support and development opportunities for staff from underrepresented and marginalised communities.

As a result of this plan we expect to see:

- Staff will feel valued, supported, and empowered to deliver services that are inclusive and accessible. Equalities data collected as part of the annual staff surveys and other feedback processes will show a trajectory of improvement after several years of decline.

Deliverable/ milestone	**Timeline**	**SRO**	**Oversight group/s**
Implement and build on the “Above Difference programme” to develop EDI leadership and EDI culture	Implementation March 2024 then ongoing	Oonagh Monkhouse	ED&I
Review and improve EDI training	By 2024	Oonagh Monkhouse	ED&I
System zero tolerance framework and actions to tackle violence and abuse against staff	By 2024	Oonagh Monkhouse	ED&I
We will review our policies through an anti-racist lens to ensure they reflect the needs our of people including the implementation of “fair recruitment” recommendations	By 2025	Oonagh Monkhouse	ED&I

Recruitment and retention: Developing a sustainable supply of staff to meet the health and care needs of our communities.

Objectives:

- Improve retention and progression across our system, increasing social mobility and access to careers in care and health.
- Increase supply of health and care staff, including through international recruitment ensuring we have pastoral support will strengthen and develop our workforce to remain part of our team and thus retaining essential skills and experience.
- Develop one clear, supportive and affordable accommodation process for IRN’s within C&P. We will identify the scale and profile of the housing needs amongst key workers, providing evidence of where the pressures are greatest, and work together to find affordable solutions.

- Develop clear system plans from providers, focusing on high-risk areas for workforce and to support integrated workforce planning, including data sharing agreements. Recruitment and retention initiatives to be focused against our C&P Operational workforce plans.

Deliverable/ milestone	**Timeline**	**SRO**	**Oversight group/s**
Development of new apprenticeship routes and expansion of the digital health & care academy	By 2024	Stephen Legood	Recruitment & Retention
Implementation of reservist model	By 2024	Stephen Legood	Recruitment & Retention
Build and implement an ICS retention plan	By 2024	Stephen Legood	Recruitment & Retention
Develop structure and governance to support integrated workforce planning	By 2024	Stephen Legood	Recruitment & Retention
Develop one clear, supportive and affordable accommodation process for IRN's within C&P	By 2025	Stephen Legood	Recruitment & Retention

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Babies, Children and Young People

Overview

The Children and Maternity Partnership are committed to work together to build strong families and communities, build capacity, and take a whole family approach, with early intervention to address specific needs. Our vision is to support children and young people to live their lives well and to achieve the highest possible levels of safety, happiness, education, training, physical health, and mental health.

Key strategies underpinning the work programmes:

- Joint health and wellbeing Integrated care strategy
- Special Education Needs and Disabilities Strategy (including early identification and prevention)
- The Maternity and Neonatal strategy will be available from September 2023.Cambridgeshire and Peterborough Equity and Equality plan, incorporating the infant feeding strategy.
- Strong Families, Strong Communities Strategy
- Best Start in Life Strategy (pre-birth to 5 years)/ Family Hubs
- Child and Young People Mental Health Strategy
- Contextual Safeguarding Strategy
- All age Autism Strategy

The programme of work is developed and overseen by the Partnership Executive Group, which includes the Director of Public Health, Director of Children's Services, the Chief Nurse from the ICB and Executive representatives from CPFT, CCS, NWAFT and CUH.

ICS outcomes:

- Reduce childhood overweight/obesity to pre-pandemic levels by 2026.
- Achieve 5% decrease in childhood overweight / obesity by 2030.
- Every child in school will meet the physical activity recommendations.
- Reduce inequalities in overweight / obesity.
- Increase the proportion of children who show a good level of development (GLD/School readiness) when they enter education and reduce inequalities in this outcome.
- Reduce the proportion of young people aged 16-17yrs who are not in Education, Employment or Training (NEET) and reduce inequalities in this outcome.
- Reduce inequalities in both these outcomes.
- Identify the blocks and enablers in the system pathways, especially in relation to investing upstream in prevention and supporting people while waiting for access to services.
- Reduce the proportion of children living in relative poverty.

Healthcare delivery KPIs:

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Efficiency	Quality of care	Inequalities
ED attendance Re-presentation in ED Number of unplanned admissions Percentage of outpatient appointments conducted virtually and in person (by LTC) Number of GP attendances Percentage of 111 triage appointments	Number of asthma deaths Reduction in Asthma admissions Number of unintentional injuries Waiting time in A&E with mental health as a primary admission factor Length of paediatric admission for CYP with mental health needs as a primary factor CYP mortality Number of tooth extractions	Number of children accessing specialist MDTs for severe obesity (CEW)and or prevention services Reduced prevalence of Y6 and Y8 obesity Developmentally appropriate care is in place. Access to speech and language support Access to fluoride varnish – dental appointments uptake

Public health deliverables

- Increase uptake of the Healthy Start Scheme
- Promote the Start for Life offer through health and community settings.
- Ensure local service providers including midwifery, health visiting, and community partners have an aligned approach to supporting new families with their mental health during the perinatal period and to develop good parent/infant relationships.
- Ensure all new parents & parents-to-be receive good infant feeding support.
- Provide families with the support and advice they need to access Early Years and Childcare opportunities.
- Ensure damp free accommodation for children with a respiratory condition.
- Increase apprenticeships through Anchor institutions (Councils, Combined Authority, NHS, commissioned services). Consideration to how this crossover with other sections in the JFP as it relates to the HWB Priority 3 as well.
- Improve Mental Health, Emotional Wellbeing and Resilience among the school aged population.
- Improve immunisation rates at entry into school and exit from school.
- Establish a mechanism to improve health outcomes for our school-aged population through a School-Aged Health Transformation Board

Delivery plans:

Perinatal and the Early Years

Aims:

- A whole system approach to improving health and wellbeing of infants, toddlers, parents/carers, and families.
- Improving health equity and supporting foundations for positive health later in life
- Deliver a range of transformation objectives to make maternity and neonatal care safer, more personalised, and more equitable.
- Continue to deliver the actions from the final Ockenden report (safe staffing; workforce training; learning from incidents; listening to families)
- Ensure all women receive personalised care and are supported to make informed choices.

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- Reduce inequalities in access and outcomes for the groups that experience the greatest inequalities (Black, Asian and Mixed ethnic groups and those living in the most deprived areas) Children in Care, Care leavers, young carers, young offenders, young parents, Children with SEND, Children in alternative education provision, LGBTQ+, certain Ethnicities, Socio-economic deprivation, Traveller communities.

Our local maternity and neonatal strategy, due to be completed in September 2023, will set out in more detail our approach to achieving these outcomes. The process will include engagement with the Maternity and Neonatal Voices Partnership and co-production activities with people who have lived experience.

More detail on key programmes and actions is set out in the separate delivery plan for maternity and neonatal services.

Family Hubs:

Objectives:
- Implementation of Parenting Support offer
- Parent-Infant relationships and perinatal mental health support
- Early language and home learning environment
- Infant feeding support

Deliverables/ Milestone	**Timeline**	**SRO**	**Oversight group/s**
. Employ Key Connectors . Baby Triple P training . Online Parenting Offer . Systemwide referral process	2023	John Peberdy, Service Director, CCS Helen Freeman, Commissioning Team Manager for Healthy Child Programme, Public Health	C&M Partnership Executive Group
Systemwide process for evaluation of parenting programmes to ensure impact	2024	John Peberdy, Service Director, CCS Helen Freeman, Commissioning Team Manager for Healthy Child Programme, Public Health	C&M Partnership Executive Group
. Systemwide antenatal education programme . Address inequalities and tackle stigma . Peer Support Programme . Parent-Infant pilot	2023	John Peberdy, Service Director, CCS Helen Freeman, Commissioning Team Manager for Healthy Child	C&M Partnership Executive Group
. Workforce training and supervision offer . Digital Parent Support offer	2024-2025	John Peberdy, Service Director, CCS Helen Freeman, Commissioning Team Manager for Healthy Child	
. Review HLE interventions access. . Review additional interventions in EIF guidebook . Enhance SLT offer to Early Years . Digital platform . Training Needs analysis . REAL training . 50 Things App	2023	John Peberdy, Service Director, CCS Helen Freeman, Commissioning Team Manager for Healthy Child	C&M Partnership Executive Group

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Deliverables/ Milestone	Timeline	SRO	Oversight group/s
. Website launch . Unicef Baby Friendly training . Family Hubs website & physical site . Breastfeeding friendly spaces . Equipment loan scheme . Introducing Solids support (2023-24)	2023-2024	John Peberdy, Service Director, CCS Helen Freeman, Commissioning Team Manager for Healthy Child	C&M Partnership Executive Group

CYP emotional wellbeing and mental health

Where we want to be by 2028 compared to where we are now and how we will measure success:

- A whole system approach to supporting positive wellbeing and mental health across childhood, adolescence and early adulthood.
- Increase year on year access rates to children and young people's mental health services for 0-25s year olds, for certain ethnic groups, age, gender and deprivation.
- Improve transition arrangements, as measured by defined processes for transfer of children to adult mental health support and improved user experience.
- Improve access and waiting times for eating disorders to achieve national metrics of 95% access for urgent and routine cases.
- Improve infant-parent mental health and align with family hubs. Improve perinatal mental health through increased access to perinatal and maternal mental health support.
- Developed needs-led 'risk support' offer for children and young people showing behaviours that are risky, challenging or misunderstood, because current solutions are often expensive yet not meeting the needs of children, young people and families.
- Improve knowledge and delivery of trauma informed approach across services to support a range of CYP including children in care, those in risk support.

Objective:

- Deliver the 7 priorities of the Cambridgeshire and Peterborough Children and young people's mental health (CYPMH) strategy (2022 – 2025).
- CYPMH service improvement and transformation areas

Milestones	Timeline	SRO	Oversight group/s
1- Leadership, commissioning, and governance . Development of a data set for CYPMH system oversight and surveillance . Utilise information to inform future commissioning needs and facilitate joint commissioning of support as identified by the ICS	By 2024/25 Y 3 - 5	Karlene Allen, Commissioning Manager Children and Maternity, ICB Steve Bush, and John Webster, Medical Directors for ABU Partnerships	Children and Young People's Mental Health Board Children and Young People's Partnership Board Mental Health, LD and A Partnership board

Milestones	Timeline	SRO	Oversight group/s
2- Access to timely help and treatment . Primary care training pilot roll out . Development of plans to implement self-referral across services . Develop resources for parent/carers/families whilst waiting for support . Deliver Nationally set waiting times for MH	2023–2025 2023/2024 2023/2024 Y 3- 5	Karlene Allen, Commissioning Manager Children and Maternity, ICB Steve Bush, and John Webster, Medical Directors for ABU Partnerships	Children and Young People's Mental Health Board Children and Young People's Partnership Board Mental Health, LD and A Partnership board
3- Choice of help and treatment options . Implement Single session Thinking (Pilot, evaluate and system roll out) . Review digital options of support. . Deliver interventions based on population needs and updated guidance and research.	2023/24 2024/2025 Y 3 - 5	Elaine Deazley-Morgan YOUnited partners (CPFT, CCS, Ormiston Families)	Children and Young People's Mental Health Board Children and Young People's Partnership Board Mental Health, LD and A Partnership board
4- Meaningful voice and influence of children, young people, and their families (co-production) • Scope co-production activities • Define delivery model. • Utilise CYP/F voices in service developments. • Develop feedback processes to demonstrate involvement and impact of the voice of CYP/F. • Collation and dissemination of tools to embed effective coproduction practices.	2023/2024 End 2023/24 Year 1-5 2024 2024	Steve Bush, Medical Director for ABU Partnership, Karlene Allen, Commissioning Manager Children and Maternity, ICB ICB lead CYP/M ABU	Children and Young People's Mental Health Board Children and Young People's Partnership Board Mental Health, LD and A Partnership board
5- Reaching out to the most at risk • map available data of current service users • Review available support for high-risk groups. • Scope current inequalities work/projects and how links to COREPlus5 for CYP. • Delivery of identified requirements for our high-risk populations	2023/2024 2024 2024 Y 3-5	Karlene Allen, Commissioning Manager Children and Maternity, ICB Director of Childrens Services for PCC and CCC	Children and Young People's Mental Health Board Children and Young People's Partnership Board Mental Health, LD and A Partnership board
6- Confidence, knowledge and skills of the workforce • Implementation and evaluation of primary care training pilot. • Identify education sector need and adapt training options.	2023/2024 2024	Karlene Allen, Commissioning Manager Children and Maternity, ICB	Children and Young People's Mental Health Board Children and Young People's Partnership Board

Milestones	Timeline	SRO	Oversight group/s
• Support implementation of national MH roles (acute MH)	Y 1 - 5		Mental Health, LD and A Partnership board
7- Clarity about what is on offer and how to help yourself • Develop and implementation of communications strategy. • Redevelopment of Keep your head website.	Y 1 - 5 Nov 2023	Karlene Allen, Commissioning Manager Children and Maternity, ICB	Children and Young People's Mental Health Board Children and Young People's Partnership Board Mental Health, LD and A Partnership board
Transitions •Hold system event to identify workstreams and activities required to support transfer/transitions programme •Resource work streams • Carry out engagement activity •Deliver work programmes • Review changes required to commissioning and contracting •Implement new models and pathways	Year 1 – 2 Year 3 - 5	Steve Bush, and John Webster, Medical Directors for ABU Partnerships	MHLD/A ABU CYPMH Board? Cross reference with MH/LD A section for deliverables
CYP Eating disorders. • Revised front door process to enable timely access Achieve and maintain National 95% target. • Deliver wider CYP ED priorities and adherence to current guidance	2023/2024 Y 2-5	Elaine Deazley-Morgan, Service Director for CYP and Families, CPFT	MHLDA ABU
Perinatal and infant-parent mental health. • Develop and implement action plan. • Implement the Maternal Mental health service. (Loss and trauma service) • Refine and agree perinatal access targets for 23/24 and 24/25 • Deliver service enhancements in line with National guidance and population needs.	2023 2023/2024 2023/2024 Y 3-5	Karlene Allen, Commissioning Manager Children and Maternity, ICB Adele McCormack, Service Director for Adults and Specialist MH Directorate, ICB/CPFT	Children and Young People's Mental Health Board Children and Young People's Partnership Board Mental Health, LD and A Partnership board
Trauma informed support . Scope demand and provision of trauma support . Develop action plan to improve provision of support, awareness and understanding of childhood trauma	2024 Y 2 - 4	Karlene Allen, Commissioning Manager Children and Maternity, ICB	Children and Young People's Mental Health Board Children and Young People's Partnership Board

Milestones	Timeline	SRO	Oversight group/s
		Director of Children's Services, PCC and CCC Steve Bush, and John Webster, Medical Directors for ABU Partnerships	Mental Health, LD and A Partnership board
Access and outcomes . Ensure sufficient capacity available to annually increase numbers of children accessing mental health support, . Improve CYPMH outcomes through increased use of and flowing of clinical outcome data via MHSDS.	2023 Y 1-2	Karlene Allen, Commissioning Manager Children and Maternity, ICB Director of Children's Services, PCC and CCC Steve Bush, and John Webster, Medical Directors for ABU Partnerships	Children and Young People's Mental Health Board Children and Young People's Partnership Board Mental Health, LD and A Partnership board
'Risk support' offer . Thriving Partners 'Getting Risk Support' programme: More CYP will be able to continue working with the same helping person when risk changes in their lives rather than being referred on to someone else. . Ensure processes for oversight of high needs children including those eligible for S117 Mental Health Aftercare needs. . Scope need and impacts (outcomes, financial, system impacts) . Develop action plan to support CYP/F and ICS partners. . Review crises support and adapt delivery model based on guidance and population needs. . Collaborate with system partners to ensure effective delivery of CYPMH needs within wider Crisis, UEC, Acute inpatient, Tier 4 pathways. . Development of the CPICS Health & Social Care Protocol for the Support of Children and Young People in Crisis.	Y 1-5 Y 1 Y 2-3 Y3-4 Y 2 – 3 Y 1- 5 Y 1-3	Steve Bush, Medical Director for ABU Partnerships Karlene Allen, Commissioning Manager Children and Maternity, ICB Director of Children's Services, PCC and CCC Steve Bush and John Webster, Medical Director for ABU Partnerships	C&M Partnership C&M Partnership Executive Group Children and Young People's Mental Health Board Mental Health, LD and A Partnership board C&M Partnership

Milestones	Timeline	SRO	Oversight group/s
. Whole system approach to meeting the needs of CYP requiring support with high risk and complex behaviours			

CYP social communication, neurodevelopmental and Special Educational Needs and Disabilities

Where we want to be by 2028 compared to where we are now and how we will measure success:

- Improved understanding and support for children and young people who are neurodiverse or differently abled.
- Redesigning the help and support available to families when social communication or neurodevelopmental needs are identified because the current model is unsustainable and not tailored sufficiently to meeting the needs of children, young people, parents, and carers.
- Transformation of how acute hospital-based services are accessed for annual medical reviews by children with complex needs, building on existing pilot work to host these reviews within special schools.
- Integration with the LD MH Partnership/ABU for all age LD&A programme, including systemwide use of the "reasonable adjustment" flag as an early alert, implementation of Quality standards for Dynamic Support Register and all age S117 pathway.
- All young people who have ongoing healthcare needs to benefit from a good and safe transition into adult healthcare services.

Deliverable / Milestones	Timeline	SRO	Oversight group/s
Co-develop the next CPICS SEND Strategy to include requirements in line with the forthcoming SEND and Alternative Review National Standards and SEND workforce planning.	24-27	Carol Anderson, Chief Nurse, ICB ICB Designated Clinical Officer DCS for PCC and CC	SEND Exec Boards Children and Maternity ABU MH and LD ABU
Expand the implementation of Cambridgeshire and Peterborough Co-production in Commissioning principles by introducing the 'Are you Coproducing?' toolkit to ensure inclusion, participation and collaboration in design and quality improvements of services.	23 - 25	Carol Anderson, Chief Nurse, ICB ICB Designated Clinical Officer DCS for PCC and CCC Director of Education from PCC and CCC	SEND Exec Boards
Redesign the local offer to meet social communication and neurodevelopmental needs – a needs led model		Director of Childrens Services Director of Education	C&M Partnership Executive Group MH and LD Partnership
Review the Neurodevelopmental Diagnostic Pathway and introduce a range of evidence based diagnostic models to meet the diverse	23-25	Carol Anderson, Chief Nurse, ICB ICB Designated Clinical Officer	C&M Partnership Executive Group/LD&A Board

Deliverable / Milestones	Timeline	SRO	Oversight group/s
needs of children for early identification, diagnosis, and post diagnostic support.		DCS for PCC and CCC Director of Education from PCC and CCC	
Expand the Keyworker Collaborative to offer a Keyworker to all 0–25-year-olds with LD and/or Autism who are at risk of admission or out of area residential placement.	24-26	Karlene Allen, Commissioning Manager Children and Maternity, ICB	LD&A Board Children and Maternity ABU MH and LD ABU
Develop an All -Age NHS Continuing Care Pathway	24/25	Carol Anderson, Chief Nurse, ICB	QPF
Develop an All-Age S117 mental health aftercare pathway	24-26	Carol Anderson, Chief Nurse, ICB	QPF
Ensure quality and compliance with statutory timeframes for health services by implementing the SEND EHC Needs Assessment Improvement Plans.	23-25	Carol Anderson, Chief Nurse, ICB ICB Designated Clinical Officer DCS for PCC and CCC Director of Education from PCC and CCC	SEND Exec Boards
Develop a Learning from SEND Extended Appeal Tribunals and complaints programme to support continuous quality improvements and better communication for families.	24/25	Carol Anderson, Chief Nurse, ICB ICB Designated Clinical Officer DCS for PCC and CCC Director of Education from PCC and CCC	SEND Exec Boards
Preparation for Adulthood Programme: Create and adopt a systemwide communication tool for good and safe transitions so that young people with complex health needs feel safe, included, informed and in control of their transition. Implement systemwide Health Education England Transitions in Healthcare training quickly and effectively to ensure ICS workforce competency for improving good and safe transitions. Extend the Peterborough County Council Post-16 Education Offer Strategy to include the health and social care local offer for 16- to 25-year-olds with SEND.	23-25 23-25 24/25	Carol Anderson, Chief Nurse, ICB ICB Designated Clinical Officer DCS for PCC and CCC Director of Education from PCC and CCC	QPF SEND Exec Boards

Deliverable / Milestones	Timeline	SRO	Oversight group/s
Promote the 'SEND Pledge' by introducing a consistent set of self-evaluation measures to evidence commitment to improving the experience of children and young people with SEND	23 - 25	Carol Anderson, Chief Nurse, ICB ICB Designated Clinical Officer DCS for PCC and CCC Director of Education from PCC and CCC	SEND Exec Boards
Integrate SEND and CAMHs Quality Assurance measures into the ICB provider quality assurance visits.	23 - 24	Designated Clinical Officer, ICB	QPF SQG
Co-develop the next CPICS SEND Strategy to include requirements in line with the forthcoming SEND and Alternative Review National Standards and SEND workforce planning.	2024-2027	Carol Anderson, Chief Nurse, ICB ICB Designated Clinical Officer DCS for PCC and CCC Director of Education from PCC and CCC	SEND EXEC Board
Expand the implementation of Cambridgeshire and Peterborough Co-production in Commissioning principles by introducing the 'Are you Coproducing?' toolkit to ensure inclusion, participation and collaboration in design and quality improvements of services.	2023-2025	Carol Anderson, Chief Nurse, ICB ICB Designated Clinical Officer DCS for PCC and CCC Director of Education from PCC and CCC	Children and Maternity ABU MH and LD ABU
Health reviews in special schools: CYP enrolled in a special school will be able to access routine health review appointments at school rather than in hospital if appropriate.	23/24	Steve Bush, Medical Director of the ABU Partnership	C&M Partnership

CYP physical health

Where we want to be by 2028 compared to where we are now and how we will measure success:

- CYP Continence: Pilot to reduce demand on hospital-based services for continence advice, guidance, and support by developing a community-based service.
- CYP Asthma: pilot to reduce reliance on reliever medications
- CYP Asthma: pilot to reduce avoidable asthma admissions (including establishing asthma friendly schools)
- CYP Respiratory: pilot to reduce avoidable hospital admissions due to respiratory exacerbations.
- CYP Epilepsy: pilot to increase access to epilepsy specialist nurses as recommended by NICE.
- CYP Mental Health Epilepsy: pilot to increase identification and support to CYP with epilepsy and mental health difficulties.
- CYP Obesity: on track to reduce childhood obesity to pre-pandemic levels by 2026.

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- CYP Obesity: increase the number of children in school meeting physical activity recommendations.
- CYP Obesity: complications from excessive weight (CEW) pilot to reduce inequalities correlated with childhood obesity.
- CYP Obesity: Increase the number of holistic individualised plans and person–centred care packages for CYP with obesity.
- CYP Diabetes: Increase access to real-time continuous glucose monitors and insulin pumps across the most deprived quintiles and from ethnic minority backgrounds.
- CYP Diabetes: Increase proportion of those with Type 2 diabetes receiving recommended NICE care processes.

Deliverable / Milestones	**Timelines**	**SRO**	**Oversight group/s**
CYP Asthma programmes Respiratory forum established. In line with the CORE20PLUS5 aims, reducing respiratory exacerbations and emergency hospital admissions due to those exacerbations. Joined up approach across primary care /schools /community and acutes. Asthma management in schools – training package Wider determinants of health addressed re environment / pollution.	2022-2025 2023-2025 2023-2025 2022-2025	Karlene Allen, Commissioning Manager Children and Maternity, ICB Jyoti Atri, Director of Public Health Director of Education at PCC and CCC	C&M Partnership Executive Group
CYP Diabetes programmes In line with Core20plus5 aims –reducing impact of diabetes in CYP. Diabetes management pathways in place Psychological support in place with long-term conditions management Transitions planning for CYP with diabetes robustly managed. Joined up approach across primary care /school s/community and acute care. Use of digital technology to support ongoing monitoring	2023-2025 2023-2025 2023-2025 2023-2025	Karlene Allen, Commissioning Manager Children and Maternity, ICB Jyoti Atri, Director of Public Health Director of Education at PCC and CCC Kirstie Lynn, Service Manager Children's Community Specialist Nursing Service CCS/CPFT	C&M Partnership Executive group Provider Trusts
CYP Epilepsy programme Reduction in health inequalities for CYP with long term conditions In line with Core20plus5 aims –reducing impact of epilepsy in CYP (ensuring epilepsy management pathways in place)	2023 - 2025 2023-2025 2023 - 2025	Karlene Allen, Commissioning Manager Children and Maternity, ICB	C&M Partnership Executive group

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Deliverable / Milestones	Timelines	SRO	Oversight group/s
Psychological support in place with long term conditions management Transitions planning for CYP with epilepsy robustly managed. Joined up approach across primary care /school s/community and acute care. Use of digital technology to support ongoing monitoring.	2023 - 2025 2023-2025 2023 - 2025	Jyoti Atri, Director of Public Health Director of Education at PCC and CCC Kirstie Lynn, Service Manager Children's Community Specialist Nursing Service CCS/CPFT	Provider Trusts

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Mental Health, Learning Disabilities and Autism

Overview

Within our system there is a strong history of partnership working across health, local authority, and voluntary and community sector to plan, deliver and improve services for people with mental health needs, people with learning disabilities and autistic people. This has led to collaborative models of delivery and service improvements to help improve access and outcomes, for example the YOUnited collaboration with the voluntary sector for Children and Young People's emotional and mental health and the implementation of a new community mental health model in Peterborough.

The Mental Health, Learning Disabilities and Autism (MHLDA) Partnership has been set up to drive the development and the delivery of improved care and outcomes for the Cambridgeshire and Peterborough population who receive mental health, learning disability and autism services.

Our vision is to embed collective responsibility for mental health, learning disabilities and autism across our ICS, and together with system partners improve the lives of our local population through driving the transformation of health and care services.

The aims of the collaborative are:

- To develop strong collaborative leadership where MH, LD & A features throughout the ICS to support holistic population health management by making mental health everyone's business.
- To drive the transformation of the design and delivery of care to improve service provision and population health.
- To support reductions in health inequalities which are caused by a complex mix of societal factors through advancing place-based approaches which address the wider determinants of health.
- To support improvements of service users' and carer's experience and recovery through outcome measures, promoting shared decision making and personalised care.

Our delivery programmes for 23-28 are focused on the improvement areas set out in the Long-Term Plan and the NHS Mental Health Improvement Plan, as well as local transformation priorities. The partnership will develop and deliver:

- Community-based models to enable support and care to be provided closer to home, which will help address the demand and capacity pressures on inpatient care.
- A focus on reducing health inequalities, improving outcomes and access to health and care services for people with LD & ASD
- Strong and strategic partnerships with the voluntary sector reducing the burden on secondary and primary services.
- A focus on partnership working and integration.

Delivery plans

Improving access to Mental Health Community Support

Objectives:

- Develop models of care to increase access and experience of mental health support across the spectrum of need.

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- Address the demand and capacity pressures in primary and secondary care through redesign and transformation.
- Reduce Health Inequalities through targeted interventions.

Measured by:

- Increase in the number of adults and older adults accessing community mental health services.
- Increase in Dementia Diagnosis rates.
- Reducing waiting times for community mental health services
- Service satisfaction rates
- Monitoring of access by hard-to-reach communities

Initiative:

Building integrated community mental health through roll out of stepped care model, which will increase access to mental health services by 5%, improve treatment options, and seek to address wider determinants of health.

Progress to Date:

- Exemplar Pilot delivered in Peterborough and evaluation complete
- Interventions for rollout identified.

Impact:

People with mental health issues will be able to access a wider range of treatment and support options to meet their needs.

Y1-2	Y3-5	SRO	Oversight Group
• Rollout of stepped care model in Cambridgeshire • Delivery of pilot community rehab model • Implementation of Move Away from CPA/Outcomes measurement	• Embed sustainable Community Rehab Model • Embedding Stepped Care model and ensuring interventions support access for younger adults and older adults	John Webster Managing Director, MHLDA Partnership	Community Strategic Partnership

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Initiative:

Collaborating with the voluntary sector to strengthen engagement and involvement in the MHLDA Partnership and system structures, ensuring the voice of the VCS supporting mental health and people with a learning disability and autism is represented across all programmes and projects to shape mental health support for our communities.

Progress to date:

- Model agreed
- Partner to support strategic development of the sector identified

Impact:

The MHLDA VCSE sector will have the capacity to meaningfully engage in system structures and are represented across all programmes and projects to shape mental health support for our communities.

Y1-2	Y3-5	SRO	Oversight Group
• Implement model • Launch event and embed sector engagement • Build influence of the sector to support Mental Health, Learning Disability and Autism delivery priorities	• Evaluate success of model • Development of sustainable model led by VCSE	John Webster Managing Director, MHLDA Partnership	MHLDA Partnership Board

Initiative:

Targeted mental health programme for rough sleepers to improve access to treatment and ongoing support.

Progress to date:

• Funding approved for Peterborough service to be implemented
• Provider identified and mobilisation underway

Impact:

People experiencing homelessness will receive specific mental health treatment to support better life outcomes.

Y1-2	Y3-5	SRO	Oversight Group
• Implement Peterborough model Embed in local homelessness pathways and align with Homelessness Hub for Peterborough • Contribute to wider system plan for healthcare for homelessness population	• Evaluate success of programme • Review expansion in line with homelessness access for the system	ICB SRO TBC	Community Strategic Partnership

Initiative:

- Improving pathways for older people with focus on ensuring the dementia diagnosis rate is increased to at least 67% of the estimated prevalence of dementia based on GP registered populations, ensuring individuals and families receive early treatment and support.

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Progress to date:

Project yet to be initiated.

Impact:

Older People's mental health will be a priority with more opportunities to access a wide range of support and treatment options for individuals and their families and carers.

Y1-2	Y3-5	SRO	Oversight group
• Map system projects with alignment to older people mental health (i.e. frail elderly, loneliness) and link activity to MHLDAP • Refresh Dementia Strategy with system partners • Define programme required to address current waiting times and future delivery options and workforce requirements	• Carry out pilots with VCS partners to support individuals and families/carers • Review and amend treatment pathways	John Webster Managing Director, MHLDA Partnership	Community Strategic Partnership

Initiative:

Lead the implementation of specific areas of the 2022-25 priorities of the C&P children and young people's mental health strategy; including improving transition pathways between Children and Young People's and Adult MH services and ensuring access to services for 18–24-year-olds is developmentally appropriate.

Progress to date:

• CYPMH Strategy developed
• NHSE Toolkit for transitions
• Transitions working group established with representation from Adult and CYP Stakeholders

Impact:

Services will be flexible and developmentally appropriate to meet needs and not determined by rigid age boundaries.

Y1-2	Y3-5	SRO	Oversight group
• Hold system event to identify workstreams and activities required to support transfer/transitions programme • Resource work streams • Carry out engagement activity	• Deliver work programmes • Review changes required to commissioning and contracting • Implement new models and pathways	Karlene Allen Deputy Director of Maternity and Childrens Commissioning / Deputy Chief Nurse - ICB John Webster Managing Director, MHLDA Partnership	Children and Young People Mental Health Delivery Board MHLDA Partnership Board

Developing crisis care and reducing inequalities.

Objectives:

- Build resilience through alternative crisis solutions.
- Improve in-patient discharge pathways building on sustainable interventions to deliver care and support closer to home.
- Ensure system effectiveness in the delivery of statutory responsibilities.

Measured by:

- Adherence to statutory responsibilities
- Reduction in out of area placements and length of stay in an inpatient setting.
- Usage of s136 suite and places of safety

Initiative:

Pathways are improved to ensure patients experience discharge from inpatient settings with treatment and support which meets their needs and reduces out of area placements.

Progress to date:

- System assessment against 10 key initiative supporting effective discharge for Adults and Older People
- NHSE Mental Health and Community Discharge Challenge undertaken to establish action plan
- NHSE national requirements defined under Mental Health, Learning Disability and Autism Quality Transformation Programme to deliver a reimagined model of care.

Impact:

Patients receive quality care when requiring an inpatient admission and when ready to be discharged experience a joined-up process ensuring they are supported in more appropriate settings with the range of specialist support and accommodation to meet their needs.

Yr 1-2	Yr 3 - 5	SRO	Oversight Group
• Implementation of short- and medium-term actions required for pathway improvements aligned to NHSE Roadmap for Quality Transformation • Review of resources and models to improve Adult inpatient discharge process for all service user groups • Accommodation needs assessment complete, and recommendations enacted	• Implementation of long-term actions to improve discharge pathways for Mental Health and Learning Disability • Delivery and assessment of improvements to availability of specialist accommodation and support	Holly Sutherland, Deputy Chief Operating Officer CPFT	Crisis Strategic Partnership

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Initiative:

Delivery of the system responsibilities under the Mental Health Act are reviewed to ensure resources are effectively deployed.

Progress to date:

- Scoping the range of interdependent system challenges through system events
- Planning for legislative changes

Impact:

When the Mental Health Act is required, there is a joined-up system response with the appropriate resources, training and awareness across all relevant system partners.

Yr 1-2	Yr 3 - 5	SRO	Oversight group
• Workstream established with system partners to define target operating model • Review of the AMPH service • Development of case for change • Ensure legislative changes are enacted in the system pathway	• Implementation of identified changes to deliver MHA responsibilities with identified system resources, appropriate escalation and adherence to legislation	John Webster Managing Director, MHLDA Partnership Donna Glover, Assistant Director Safeguarding Cambridgeshire County Council	Crisis Strategic Partnership

Developing learning disabilities and ASD care

Objectives:

- Improve access and experience of services for Autistic people.
- Reduce health inequalities for LD & ASD populations.
- Reduce premature mortality for LD & ASD populations.

Measured by:

- Service satisfaction rates for Autism services
- Reduction in waiting times for Autism services.
- Number of Annual Physical Health Checks carried out.
- Improvement in health interventions for people with a Learning Disability

Initiative:

Prioritising and enacting the recommendations from the All-Age Autism Strategy to transform adult autism services and improve access and treatment options.

Progress to date:

All Age Strategy 2021-26 in place following engagement with system stakeholders

Yr1-2	Yr 3-5	SRO	Oversight Group
• Review of 8 recommendations to determine priority areas and system partner responsibilities • Additional focus on specific recommendation to improve diagnostic pathways, improve waiting lists and pre and post diagnostic support	• Project delivery against key areas by system partners • Embed pathway and service solutions • Conduct review against strategic recommendations	Karlene Allen Deputy Director of Maternity and Childrens Commissioning / Deputy Chief Nurse - ICB Oliver Hayward Assistant Director – Adult Social Care Commissioning	LD&A Strategic Partnership

Initiative:

Reduce health inequalities for people with a Learning Disability through improved quality and delivery of health interventions such as vaccination programmes, and completion of annual physical health checks.

Progress to date:

- Focus on improving Annual Health Checks via LD register
- LD Needs Assessment commissioned

Impact:

People with a Learning Disability will receive proactive health interventions to improve their health outcomes.

Yr1-2	Yr 3-5	SRO	Oversight group
• Improve quality of Health Action Plan • Continue improvement plan for Annual Health Checks • Needs Assessment to inform scope of further Health Inequalities focus	• Health Inequality programme for LD established • Delivery and impact of health and interventions monitored	Karlene Allen Deputy Director of Maternity and Childrens Commissioning / Deputy Chief Nurse - ICB	LD&A Strategic Partnership

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Community Diagnostic Centres

Overview

Working to our shared vision of 'All Together for Healthier Futures', the 2023/24 operational planning guidance, the NHS Long term plan, the Richards report on diagnostics (Diagnostics: Recovery and Renewal. Oct 2020) and the NHSEI CDC National Guidance – June 2022, our Community Diagnostic Centre (CDC) plan aims to deliver flexible and resilient diagnostic capacity for our population.

In the first instance, the current acute capacity will be supplemented by establishing and operating three Community Diagnostic Centres at the North Cambridgeshire hospital (Wisbech), the Princess of Wales Hospital (Ely) and Unex House (Peterborough). This will provide community access to core diagnostic tests while working towards meeting the six primary aims of the CDC programme:

- Improved population health outcomes.
- Increased diagnostic capacity.
- Improved productivity and efficiency.
- Reduced health inequalities.
- Improved patient experience.
- Support for the integration of primary, community, and secondary care.

By ensuring that our population has timely access to diagnostic test we will be able to better identify and provide appropriate treatments at an earlier stage in any disease progression. This will be particularly important in improving outcomes for cancer patients.

Our key targets are to reduce waiting times for diagnostic tests, support faster cancer diagnosis and improve access to screening in the community, including for rural and remote communities.

Oversight for delivery is through the System Diagnostic Board, with clinical and operational representation from all providers.

Delivery plans:

Increase diagnostic capacity

In order to deliver faster diagnostics for cancer services and to meet the 6-week standard for other conditions, we recognise that we need to increase our diagnostic capacity. This will be achieved by improving efficiency and productivity of existing services, but by also increasing the capacity of the services we can offer. CDCs will offer these services closer to the persons home.

Delivery of additional diagnostic capacity through the CDC Programme will occur over several phases:

- **Early Adopter** Additional capacity funded by the NHSE/I CDC Programme (including CT and MRI mobiles on acute sites) in advance of new CDC facilities. CDC funding of mobiles on non-CDC locations will end 31 March 2023.
- **Phase I** Delivery of both CT and MRI mobile capacity in Wisbech (North Cambs Hospital) in April 2023
- **Phase II** Delivery of the new Wisbech CDC facility (providing other diagnostics including NOUS, Echocardiography, ECG, and spirometry) in September 2023

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- **Phase III** Delivery of the new Ely CDC facility (based on Princess of Wales Community Hospital) in October 2023
- **Phase IV** Delivery of the Peterborough CDC in 2024/25
- **Later Phases** Explore Southwest CDC

Deliverable/ milestone		Timeline	SRO/Lead Org.	Oversight group/s
Phase I				
CT and MRI Mobiles				
	Complete Estates works	Apr 2023	CCS	SDB
Begin:	CT	Apr 2023	CUH	SDB
	MRI	Apr 2023	CUH	SDB
Phase II				
Wisbech CDC Build				
	Complete Estates works	August 2023	CCS	SDB
Begin:	NOUS	Sept 2023	CUH	SDB
	Cardiology diagnostics	Sept 2023	CUH	SDB
	Respiratory diagnostics	Sept 2023	CUH	SDB
	Skin	Sept 2023	CUH	SDB
	Urology/Gynae diagnostics	TBC	CUH	SDB
	Other modalities TBC	TBC	CUH	SDB
Phase III				
Ely CDC Build				
	Complete Estates works	Aug 2023	CCS	SDB
Begin:	NOUS Service	Oct 2023	CUH	SDB
	Respiratory diagnostics	Oct 2023	CUH	SDB
	Cardiology diagnostics	Oct 2023	CUH	SDB
	CT	Oct 2023	CUH	SDB
	MRI	Oct 2023	CUH	SDB
	X-Ray	Oct 2023	CUH	SDB
	Phlebotomy	Oct 2023	CUH	SDB
	Fibroscan	Oct 2023	CUH	SDB

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Deliverable/ milestone	Timeline	SRO/Lead Org.	Oversight group/s
Skin	Oct 2023	CUH	SDB
Urology/Gynae Diagnostics	TBC	CUH	SDB
Mammography	TBC	CUH	SDB
Other modalities TBC	TBC	CUH	SDB
Phase IV			
Open Peterborough CDC	Mar 25	NWAFT	SDB
Later Phases			
Explore South West CDC	Mar 24	ICB	IRC

Improve productivity and efficiency through continuous improvement

Our System wide continuous improvement approach will support the work to increase productivity and efficiency. During 2023/24 the ICB will identify opportunities for increased productivity and new ways of working through a capacity and demand review of current diagnostic services across the system. Utilising the outcomes of the review, best practice guidance and engaging system wide clinical and operational stakeholders' improvement plans to maximise productivity and efficiency across diagnostic services will be developed. Utilising continuous improvement methodology and tools the plans will be delivered starting in early 2024. Ongoing review of opportunities, best practice and innovation will continue through maximising expertise within the system Diagnostic board and wider stakeholders.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Adopt a continuous improvement approach	Apr 24	DCI	SDB/QITG
Capacity and Demand Review	Sept 23	DPD	SDB
Development and roll out of productivity improvement plans	March 24	DPD	SDB

Reduce health inequalities and improve patient experience

The locations of the Cambridgeshire and Peterborough CDC were chosen as much as possible to provide easier access to the areas of the country where we see the greatest inequalities. By establishing facilities closer to these communities, we can help address inequality of access. Local efficient services that limit the need for our population to have to always the travel to an acute hospital site will improve their experience of being on a diagnostic pathway. Coupled with a reduced waiting time, this will deliver an overall improved population experience.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Improve access for rural/remote communities	Apr 24	DCI	ICB
Improve access for screening	Apr 24	DCI	SDB
Care closer to home	Apr 24	DCI	ICB
Fast access via GP	Apr 24	DCI	ICB

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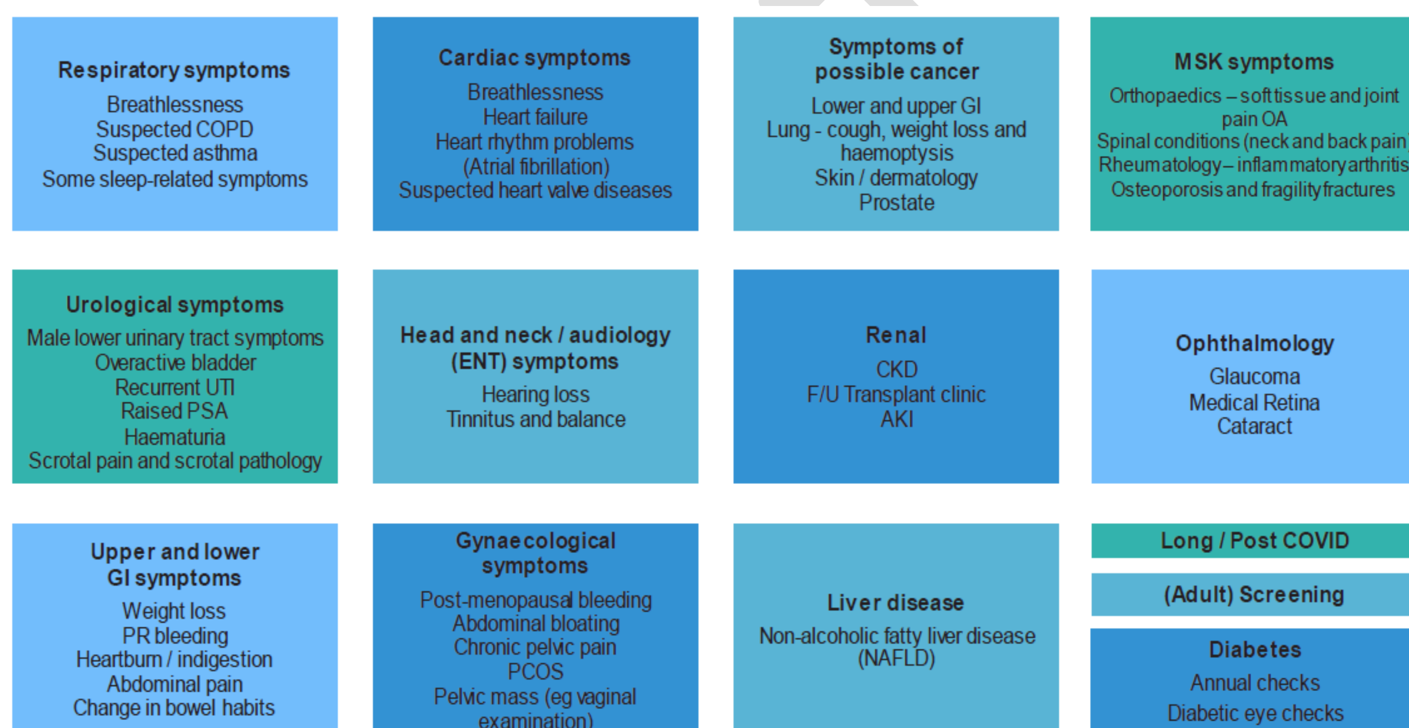
Support for the integration of primary, community, and secondary care

Key to the impact of CDCs will be the ability to design and implement new integrated pathways that will cut across traditional boundaries of primary, community and secondary care. Having a local CDC will encourage the development of shared care and shared pathways, improving our population's experience of health care.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Direct GP access to diagnostics	Apr 24	DCI	SDB
Single results sharing system	Apr 25	ICB CFO	DEG
Integrated diagnostic pathways (See fig. 1 below)	Apr 24	DCI	SDB

Figure 1



(Taken from: Community Diagnostic Centres Guidance for planning, design and implementation. NHSE June 2022, page 20)

Abbreviations

CDC – Community Diagnostic Centre
SDB – System Diagnostic Board
IRC – Improvement and Reform Committee
ICB – Integrated Carer Board
QITG – Quality Improvement and Transformation Group
DEG – Digital Enabling Group
CUH – Cambridge University Hospital – CDC Implementation lead for POW/NCH
CCS – Cambridgeshire Community Services – Estates lead organisation for CDCs at NCH and POW
DCI – ICB Director of Clinical Improvement
CFO – Chief Financial Officer – the CFO is the Exec lead for Digital.
DPD – ICB Director of Performance and Delivery

Primary Care Transformation

Overview

Through embracing the opportunities and delivering the recommendations outlined within the 'Next Steps for integrating primary care: Fuller Stocktake report' (commissioned by NHSE, published May 2022), our aim is to improve primary care services for our population by facilitating the collaborative working required at neighbourhood level to ensure services are as accessible and easy to navigate as possible. Our Primary Care Transformation strategy has three key objectives:

- Support the evolution of more sustainable General Practice clinical and business models.
- Co-design, develop and support delivery of scalable primary care transformation solutions.
- Embed change through service collaboration and integration at neighbourhood level.

We aim to improve access to services for our population whilst driving down health inequalities, supporting General Practice and wider primary care teams to better manage demands on their services and ensuring better patient, carer and clinician experience and outcomes. Integrated working involving health, care, local council, voluntary sector, and community assets at neighbourhood level is key to these changes.

What needs to happen to drive this change?

The Fuller Stocktake Report, and the associated Kings Fund paper 'Levers for Change in Primary care; a review of the literature' (April 2022) highlighted several areas of focus for 2023-25 to support systems in achieving their key objectives. This action framework is detailed below:

Action	Timeline	Oversight Group/s	SRO
Develop a single system-wide approach to managing integrated urgent care to guarantee same-day care for patients and a more sustainable model for practices	March 2025	PCCC, PCOG, ABUs & North/South Place	Gary Howsam
Assist systems with integration of primary and urgent care access	March 2025	Regional PC Strategy & Recovery Groups	N/A
Enable all PCNs to evolve into integrated neighbourhood teams	March 2025	PCCC, PCOG, ABUs & North/South Place	Gary Howsam
Co-design and put in place the appropriate infrastructure and support for all neighbourhood teams	March 2025	PCCC, PCOG, ABUs & North/South Place	Gary Howsam
Develop a primary care forum or network at system level	March 2025	PCCC, PCOG, ABUs & North/South Place	Gary Howsam
Embed primary care workforce as an integral part of system thinking, planning and delivery	March 2025	PCCC, PCOG, ABUs & North/South Place	Gary Howsam
Include primary care as a focus in the forthcoming national workforce strategy to support ICSs to deliver	March 2025	Regional PC Strategy & Recovery Groups	N/A
Pivot to system leadership as the primary driver of primary care improvement and development of neighbourhood teams in the years ahead	March 2025	Regional PC Strategy & Recovery Groups	N/A
Improve data flows	March 2025	Regional PC Strategy & Recovery Groups	N/A

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Action	Timeline	Oversight Group/s	SRO
Develop a system-wide estates plan to support fit-for-purpose buildings for neighbourhood and place teams delivering integrated primary care	March 2025	PCCC, PCOG, ABUs & North/South Place	Gary Howsam
DHSC and NHSE should provide additional, expert capacity and capability to help offer solutions to the most intractable estates issues	March 2025	Regional PC Strategy & Recovery Groups	N/A
Create a clear development plan to support the sustainability of primary care and translate the framework provided by Next steps for integrated primary care into reality, across all neighbourhoods	March 2025	PCCC, PCOG, ABUs & North/South Place	Gary Howsam
Work alongside local people and communities	March 2025	PCCC, PCOG, ABUs & North/South Place	Gary Howsam
Embed primary care workforce as an integral part of system thinking, planning and delivery	March 2025	PCCC, PCOG, ABUs & North/South Place	Gary Howsam
Include primary care as a focus in the forthcoming national workforce strategy to support ICSs to deliver	March 2025	Regional PC Strategy & Recovery Groups	N/A
Pivot to system leadership as the primary driver of primary care improvement and development of neighbourhood teams in the years ahead	March 2025	Regional PC Strategy & Recovery Groups	N/A

Where actions are aligned to the ICS, the ICB will convene, engage, facilitate, and assure transformational change acknowledging system partners are critical to delivery. System providers (including all Primary Care providers; General Practice, Dentistry, Optometry and Community Pharmacy teams) will develop and own the plans to drive system change. The ICB will also work very closely with North and South Place, Accountable Business Units and Integrated Neighbourhood Teams to support ownership and delivery where required.

Key to abbreviations:

ICS – Integrated Care System

ICB – NHS Cambridgeshire and Peterborough Integrated Care Board

PCCC – ICB Primary Care Commissioning committee

PCOG – ICB Primary care Operational Group

North/South Boards – Boards of the North/South Integrated Care Partnerships

DHSC – Department of Health and Social Care

HEE – Health Education England

Estates

Overview

Our joint health and wellbeing and integrated care strategy recognises that our estate is a key enabler for the delivery of our vision and for the provision of accessible, safe, integrated and cost-effective health and care services.

NHSPS have worked closely with system partners on a strategic review of estates which has identified priority areas to focus on. Our 3 key objectives were agreed by the ICB Board on 10th March 2023 as part of the ICS Estates strategy 2023 – 2033:

- Transform Places and Spaces
- Create a smarter and greener estate
- Achieve excellence in data and insights

. These three key objectives do not sit as isolated headings but are intrinsically woven together and need to reflect wider socio, economic and environmental health factors to enable successful delivery of the system priorities.

As a mechanism to support transformation, the estates element of the JFP is cognisant of the multi-strands required to support living well and reduce health inequalities which includes travel and transport, digital and technology, access to green spaces to name a few. This wider holistic approach which will flow through each priority area and support the wider System Estate Strategy

The success of this workstream is dependent on collaboration with operational, clinical and professional colleagues, with direction on how and where services should be delivered. We have set out the deliverables with ambitious timescales that we will achieve by working across all partners within the ICS. There is further work required on some of the longer-term detailed deliverables.

Delivery plans:

Transform Places and Spaces

Objectives:

- Development of integrated hubs
- Integrated solutions for areas of highest population growth
- Increased access to community diagnostics
- Utilise wider public sector estate

The North and South Partnership delivery plans have identified priorities that support the delivery of care much closer to home. To support this, they each aspire to align the clinical and operational workforce from community health providers to neighbourhood footprints. Additionally, they aim to bring more local people into the workforce so that it reflects the diversity of local communities and proactively helps marginalised people access healthcare closer to home. This ambition will see focus on, but not limited to:

- Discharge to assess
- Virtual wards
- Mental health crises response
- Enhanced health in care homes and
- Urgent community response to support people who are unwell to be cared for safely at home.

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- Access to diagnostics from phlebotomy, electrocardiogram and spirometry to more complex diagnostics like MRI and endoscopy without having to bring patients into hospitals.

To enable this both North and South Partnerships seek to develop a shared neighbourhood approach to estate bringing NHS trusts, local authorities and third sector partners together to facilitate the optimum colocation of local services. An overarching aim of this strategic approach is to reduce the need for continual growth of beds in the acute sector. Notwithstanding this objective both North and South Partnerships acknowledge the need for investment in new infrastructure at both Hinchingbrooke and Addenbrookes Hospital sites given the ageing condition of much of the estate at those locations.

Development of the estate is dependant on understanding of the local population needs and how the Partnerships intend to provide care to that population. It is important that the development of the estate is led by these ambitions.

Deliverable/ milestone	**Timeline**	**SRO**	**Oversight group/s**
Develop integrated hub policy and assess site options	March 2025	North & South Place Partnerships Managing Directors (John Rooke North) and Heather Noble South), supported by David Parke (S) and Lucy MacLeod (N) & System Estates colleagues	System Estates Group
Agree physical estate required in areas of highest population growth	March 2024	North & South Place Partnerships Managing Directors (John Rooke North) and Heather Noble South supported by David Parke (S) and Lucy MacLeod (N) & System Estates colleagues	System Estates Group
Community diagnostic centres established in Ely, Peterborough and Wisbech	March 2024	Robert Freake & Gary Howsam, CCIO	System Estates Group
Work with partner organisations to assess options for optimising public sector estate and creating collaborative solutions	March 2025	Kit Connick/Alison Manton	System Estate Group
All RAAC constructed health buildings have been identified and have remediation plans in place	March 2024	Kit Connick & David Parke	System Estates Group
Strategic growth sites have System approved business cases in place for delivery of healthcare	March 2025	North & South Place Partnerships Managing Directors (John Rooke North) and Heather Noble South), supported by David Parke (S) and Lucy MacLeod (N) & System Estates colleagues	System Estates Group
Full Business Case Approval for new Cancer Hospital and Children's Hospital and Hinchingbrooke Hospital	March 2025	Trust Project Directors	System Estates Group
Long term plans for CUH, Fulbourn, Princess of Wales and Brookfields supported by System	March 2025	Trust Project Directors	System Estates Group

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A smarter and greener NHS estate

Objectives:

- Improve estate flexibility and utilisation
- Reduce office accommodation
- Optimise assets and remove unwarranted variation
- Achieve net zero by 2040 for the emissions we control directly (and by 2045 for our entire emissions profile)

As a costly asset, it is critical that the full capacity of our estate is utilised. In many cases our estate is only utilised during peak day times with significant capacity out of hours. There are various reasons for this but in the main is because of traditional working patterns rather than patient preference. We need to understand whether changes can be made that would result in our space being used for longer periods of time before we make decisions to invest in additional space, that also brings additional costs. We must also ensure that we consider carefully whether investment in more space and in particular new build is the most sustainable option available.

The recently published NHS Net Zero Building Standards provides tools to consider the whole life environmental cost of new build versus refurbishment. We should also be considering whether investment in more digital infrastructure can provide more sustainable solutions to delivering healthcare before increasing our estate footprint. These key questions should be resolved in all business cases for new estate.

The pandemic has change how many of us work and we recognise that there may be an opportunity to reduce the amount of office space that we have across the system. This may be made more possible by our partner organisations sharing access to locality office hubs that could offer opportunities for improved collaboration spaces.

Deliverable/ milestone	Timeline	SRO	Oversight group/s
Achieve an overall reduction in office accommodation across the System through use of digital transformation, sharing of work hubs across organisations and creation of the most suitable spaces.	March 2026	Lucy MacLeod (North) & David Parke (South).	System Estates Strategy
Ensure care is being delivered in the right place and our estate in turn is being utilised as efficiently as possible	March 2025	Lucy MacLeod (North) & David Parke (South).	System Estates Strategy
Apply the NHS Net Zero Building Standards to all proposals for refurbishment and new build	March 2024	Fiona O'Mahony, David Parke (South) & Lucy MacLeod (North).	System Estates Strategy
Develop decarbonisation plans for all our buildings that will support a road map to the net carbon zero target for the NHS	March 2024	Fiona O'Mahony, David Parke (South) & Lucy MacLeod (North).	System Estates Strategy
Deliver care as close as possible to home with the support of digital technology where possible to reduce unnecessary journeys	March 2026	Nicci Briggs & John Clayton	System Estates Strategy

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Excellence in delivery and insights

Objectives:

- Improve estate data and insights
- Develop a long term System owned capital plan
- Resource and PMO to drive delivery

Our health and care estate must be safe and compliant with regulations and provide welcoming and accessible spaces for both our patients and staff. Adequate and sustained levels of investment will be continually required to achieve this. Given the challenging capacity and financial pressures of the system this will continue to be difficult, but it must be a core part of the Estate Strategy.

The partners across the System should have a shared understanding of priorities to support informed decisions on investment and a longer-term capital investment plan is required to support a roadmap to improving our estate. Access to a comprehensive data providing insight into how our estate performs is vital to enable the right investment decisions to be made. This data has not been available in one place and so we have ambition to facilitate access to this data from a shared planning tool.

Deliverable/ milestone	**Timeline**	**SRO**	**Oversight group/s**
Estate financial and condition data from System partners to be accessed from a shared planning tool	March 2025	All respective System CFOs	System Estates Group
Develop ICS capital investment prioritisation framework	March 2024	Nicci Briggs, Chief Finance Officer, ICB	Capital and Investment Committee
Long term System capital prioritisation to be agreed and understood by all partners	March 2025	Nicci Briggs, Chief Finance Officer, ICB	Capital and Investment Committee
Update governance for managing the System estate and provide dedicated PMO support	September 2023	Kit Connick, Chief Officer Partnerships & Strategy, ICB	System Estates Group

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Digital

Overview

Our digital vision is to use technology to improve outcomes for residents by empowering them to control their own health, providing them with efficient, joined up services and giving staff the technology to do their jobs to the best of their ability.

Our Digital Strategy has been widely consulted and developed collaboratively over a 12-month period with our health and care partners across the region. It has had input from our public representatives and highlights our intention to collaboratively deploy digital technologies to improve services and health and care outcomes for our residents.

Our digital vision enables delivery of our ICS system-wide vision and goals and allows us to achieve the digital aspirations of NHS England.

All the programmes support us to achieve this vision and to develop a world-class digital infrastructure and information systems. Our strategy builds on what already is working well across our system. For some of our partners convergence of systems may be possible. For other partners and for our Places we will strive for integration or interoperability.

Our digital programmes are:

- Shared care record
- Electronic patient record
- Digital social care records
- Secure data environment
- Transforming primary care
- Digital innovation and transformation
- Robotic process automation
- Virtual wards
- Diagnostics and digital image sharing

To get the best value for our residents, the above programmes include nationally sponsored and funded digital products, innovations, and services. These products form part of our transformation and innovation programme and others are part of our digital business-as-usual programme, providing vital technological infrastructure to run our health and care services effectively.

Delivery plans:

Shared Care Record - connect

The SCR gives visibility of GP, community, social care, mental health and acute patient records. This supports safer and better joined-up care as residents move between different parts of the health and social care system.

What we want to achieve by when:

- Appropriate access to a complete view of a person’s health and social care record for all clinical teams by March 2025.
- Non-clinical staff in social care settings able to access appropriate information and input data into digital records in real time.

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Milestone	Timeline	SRO	Oversight group/s
Phase 1 Go Live (Primary Care, Community and Mental Health Data)	Q1 FY23/24	Scott Haldane, Director of Finance, CPFT	DEG
Phase 2 Go Live (Acute and social care data)	Q4 FY23/24	Scott Haldane, Director of Finance, CPFT	DEG
Onboarding of other care settings (Care homes, hospices etc)	Q4 FY24/25	Scott Haldane, Director of Finance, CPFT	DEG

Electronic patient record (EPR) - connect

Our EPRs/ EPR will provide clinicians with more information at their fingertips to make better, more effective decisions, where we don't already have this. They give automatic access to decision support tools to ensure that clinical decisions are based on the best available information.

What we want to achieve by when:

- Interoperable systems across hospital settings, giving one view of a residents' care, rather than having to access several systems.

Milestone	Timeline	SRO	Oversight group/s
Options assessed and system approach agreed	Q1 FY23/24	Nicci Briggs, Chief Finance Officer, ICB	Management Exec / ICB
Board approvals	Q2/Q3 23/24	Nicci Briggs, Chief Finance Officer, ICB	Management Exec / ICB
Joint Contract Procurement (RPH/NWAFT)	Q1 24/25	Nicci Briggs, Chief Finance Officer, ICB	Management Exec / ICB
RPH EPR Go Live	Q3 26/27	Nicci Briggs, Chief Finance Officer, ICB	Management Exec / ICB
NWAFT EPR Go Live	Q1 28/29	Nicci Briggs, Chief Finance Officer, ICB	Management Exec / ICB

Secure Data Environment (SDE) - transform

SDEs will provide approved users with timely and secure access to health and care data. These users can be researchers, analysts and planners across the health and care ecosystem. The SDE was previously called a Trusted Research Environment and it is used for research across care settings.

SDE service Users are given access to the data approved under data sharing agreements. The secure platform puts virtual walls around data under each agreement to ensure that users can only access data for which they have been approved. All data is de-identified so does not contain personal information such as names, addresses or NHS numbers.

SDEs will become key platforms to access NHS health and social care data for research into diseases and conditions affecting the population. They will support the development of new treatments and the analysis of how health and care is delivered to continually improve it.

What we want to achieve by when:

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- Support of the OBC by agreeing the statement of support [attached] for inclusion in our updated OBC to be submitted to NHS England.
- Subject to confirmation of funding, engage with the development of pilot use-cases in 2023-24.
- Mobilise and deliver momentum around this vision, and ensure we have access to a range of stakeholders to provide support, feedback, and challenge.

Milestone	Timeline	SRO	Oversight group/s
OBC agreement and letters of support	Q1 23/24	Mark Avery, Director of Informatics, CUP and EAHSN	DEG
Engage with the development of pilot use-cases (subject to confirmation of funding	Q4 23/24	Mark Avery, Director of Informatics, CUP and EAHSN	DEG

Transforming primary care – digitise and transform

The programme will delivery digital improvements to support primary care transformation.

What we want to achieve by when:

- Development of PCN and Practice staff, to ensure collaboration and consistency of digital offering, through an ICS-wide training approach.
- Employment of Training Team Coordinators to support and spread the learning to all PCNs and ensure consistency of services.
- Continuation of existing PCN Digital Champions roles and delivery of a coordinated digital development programme

Milestone	Timeline	SRO	Oversight group/s
Development of PCN and Practice staff	Q3 23/24	Greg Lane, Director of Clinical Improvement, ICB	Management Exec / ICB
Employment of Training Team Coordinators	Q3 23/24	Greg Lane, Director of Clinical Improvement, ICB	Management Exec / ICB

Digital innovation and transformation – digitise and transform

Digital Innovation and transformation support implementation of innovative technologies and new processes to improve health and care interventions.

What we want to achieve by when:

- Plan and hold an engagement event in C&P to address the innovation strategic priority and to ensure that we adapt the right technologies and also support our own innovations to scale.
- Plan and monitor benefits that will be gained from applying new innovations.
- Amend rollout plans if needed to ensure innovation is adopted and spread.
- Evaluate the short, medium, and long-term impact of innovation.

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Milestone	Timeline	SRO	Oversight group/s
C&P Supplier Innovation Engagement event	Q3 23/24	Nicci Briggs, Chief Finance Officer, ICB	Management Exec / ICB
Agree and adopt digital innovation strategy and plan	Q4 23/34	Nicci Briggs, Chief Finance Officer, ICB	Management Exec / ICB

Digitising social care records (DSCR) – digitise and connect

The DSCR allows the digital recording of care information and care retrieved by an individual in a social care setting, replacing traditional paper records. The outcomes are person centred records, which enable information to be shared securely and in real time, with authorised individuals across the health and care sector. These records will play an important part in joining up care across social care and the NHS, freeing up time spent by care workers and managers and administrative tasks, whilst equipping them with the information they need to deliver care.

What we want to achieve by when:

- 80% of CQC registered Adult Social Care Providers have a digital social care record solution in place that can interoperate with a local Shared Care Record by March 2024

Milestone	Timeline	SRO	Oversight group/s
Year 1 Target Completion (30 Care home settings)	Q1 23/24	Rob Nimmo, ICS Head of Digital Transformation	DEG
Year 2 Plan Sign off	Q1 23/24	Rob Nimmo, ICS Head of Digital Transformation	DEG
Completion of Year 2 Target (80% of CQC registered Adult Social Care Providers)	Q4 23/24	Rob Nimmo, ICS Head of Digital Transformation	DEG
Year 3 Plan Sign off	Q1 24/25	Rob Nimmo, ICS Head of Digital Transformation	DEG

Virtual wards - transform

Digital support for implementation of virtual wards.

What we want to achieve by when:

- Continue the roll out and safe expansion of the programme. This should include a strategy for wider integration with UCR and other 'front door' services.
- Consistent clinical pathway design
- Safe and cost-effective utilisation of digital monitoring across C&P.

Milestone	Timeline	SRO	Oversight group/s
Agree programme funding for FY23/24	Q2 23/24	Kim Ashall, Head of Virtual Wards Programme, NWAFT and system	DEG

Milestone	Timeline	SRO	Oversight group/s
Develop digital workstream including agreement on resourcing and governance	Q2 23/24	Kim Ashall, Head of Virtual Wards Programme, NWAFT and system	DEG
Agree workforce and digital delivery plans (subject to funding confirmation)	Q3 23/24	Kim Ashall, Head of Virtual Wards Programme, NWAFT and system	DEG

Robot process automation (RPA) – digitise and transform

RPA can support our staff in patient administration, appointment scheduling, report generation and distribution, and in back-office processes in corporate functions like HR, finance, claims and administration.

What we want to achieve by when:

- Review and consolidate a Robotic Process Automations across the system.
- Build on existing capabilities within the system and share best practice for automations.

Milestone	Timeline	SRO	Oversight group/s
System wide review and strategy and benefits case for board approval	Q1 23/24	Keith Donovan PMO - Cambridgeshire & Peterborough ICS – Regional Productivity Group	DEG
Implement existing automations in 4 providers that currently have no RPA	Q3 23/24	Keith Donovan PMO - Cambridgeshire & Peterborough ICS – Regional Productivity Group	DEG
Establish regional RPA community of practice group	Q3 23/24	Keith Donovan PMO - Cambridgeshire & Peterborough ICS – Regional Productivity Group	DEG

Digital diagnostics capability - digitise

Development of new diagnostics capacity to enable image sharing and clinical decision support, linked to the development of Community Diagnostic Hubs and imaging and pathology network improvements.

What we want to achieve by when:

- Improved diagnostic waiting times, with more accurate image interpretation, leading to earlier treatment, improved outcomes, and reduction in care needs.

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Milestone	Timeline	SRO	Oversight group/s
Scope diagnostic & imaging clinical requirements across C&P ICS	Q1 23/24	Savi Cartwright, Strategic Clinical Services IM&T Consultant	DEG / System Diagnostics Board
Gather & document business requirements from multiple stakeholders and translating the requirements into diagnostic digital programme requirements.	Q2 23/24	Savi Cartwright, Strategic Clinical Services IM&T Consultant	DEG / System Diagnostics Board
Production of C&P Diagnostic & Imaging Plan/OBC for Year 1/2/3 of the diagnostic's digital capability programme, with implementation plans in short and long-term savings	Q2 23/24	Savi Cartwright, Strategic Clinical Services IM&T Consultant	DEG / System Diagnostics Board

Enabling themes

We have agreed six enabling themes of work:

Infrastructure and levelling up:

- Make optimal use of our existing digital infrastructure and update this when appropriate.
- Providing the best security for our IT systems and data.
- Optimizing our Electronic Patient Record Systems, creating a safe, robust, and fast network.
- Enhancing our Electronic Prescriptions and Medicines Administration systems (EPMA).
- Continuing to improve our digital maturity as a system.

Improved models of care:

- Co-designing services and innovation with our residents to provide the best possible health and care.
- Embedding robotic processes where they bring benefits.

Bringing our people with us (digital upskilling):

- Providing the best possible digital training for our clinicians and staff. Using our network of Digital Champions to upskill our primary care workforce and their customers.
- Digitally upskilling our future workforce by building digital solutions into their training and pathways.
- Supporting people to use digital innovations that will enhance their care and roles.

Supporting our residents:

- Personalisation of services so that our residents are in control of their health and care.
- Implementing our shared care record, patient portal, population health management system and digitising social care record programmes.

Population health management and research:

- Providing digital services that support and improve our delivery of care and reduce health inequalities.

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- Developing information sharing agreements to help data flows and ensure they are secure.

Developing and securing our digital infrastructure:

- We will exploit the potential of digital technologies to transform the delivery of care and resident outcomes, working within the national What Good Looks Like Framework.
    - Well led – We will continue to build digital and data expertise and accountability into our leadership and governance arrangements and ensure delivery of the system-wide digital and data strategy. We will identify and recruit to digital leadership roles within the ICS to ensure that we are delivering the best possible digital outcomes.
    - Ensure smart foundations – We will continue to work across the system to ensure all digital and data infrastructure deliver reliable, modern, secure, sustainable, and resilient services. We will work to ensure all organisations have highly skilled and well-resourced teams, sharing expertise and capacity at system level where most appropriate.
    - Safe practice – We will continue to work will all organisations to ensure that our digital services meet the standards required for safe care.
    - Support people – We will work across the system to develop a workforce that is able to make the very best of world class digital solutions. Our health and care professionals must have access to the most effective technology to enable them to provide the best care possible for their patients. Enabling health and care professionals within our system to access and share information across care settings is recognised as a key enabler for truly transformational change.
    - Empower residents - We will provide access to our digital services to allow residents to collaborate with health and care professionals. We will enable citizen access to their integrated care record and care plans to empower then to manage their own health and care needs and will provide digital services to support residents to stay healthy or to manage monitoring and treatment at home. We want to enable our residents to fully participate in the management, monitoring and decision making regarding their health and care needs, providing access to these services through national initiatives such as the NHS App.
    - Improve care – We will develop new ways of working and models of care through the introduction of innovative digital tools and services, continually evaluate new advances in technologies and explore the opportunities for adoption. We will support and encourage collaboration between providers, academic networks, and commercial partners.
    - Healthy populations - We will build on existing platforms to improve our ability to identify groups of patients and identify specific interventions to further improve health and wellbeing in our system. We will scale up our operational analytics capability allowing us to improve system wide resource utilisation, flow, and the identification of system pressures.

Cambridgeshire South Care Partnership

Overview

Locally, the organisations that provide support, care and healthcare are working together as the Cambridgeshire South Care Partnership (CSCP) to better understand and address the needs and ambitions of people in our communities. We are developing new ways of collaborating and using our combined resources (staff, estates and funding) to deliver more joined up care, so that people living and working in our neighbourhoods experience the health and wellbeing outcomes that matter to them.

Our partnership is committed to transforming the ways we organise and deliver care so that our local people can enjoy healthy lives in strong, connected communities. We will do this by co-developing person-centred care models, informed by our people, data, and best practice evidence. We will collaborate with the Integrated Care Board teams, and our colleagues in the other partnerships and collaboratives to ensure alignment, avoid duplication of focus or effort, and minimise unwarranted variation.

The Cambridgeshire South Joint Strategic Board was established in August 2022 and is co-chaired by representatives from the local authorities, primary care and the hospitals.

Our Programme Boards will support the Cambridgeshire South Joint Strategic Board to lead the strategic co-development and delivery of new models.

We have agreed hosting arrangements for Cambridgeshire South Care Partnership with Cambridge University Hospitals NHS Foundation Trust and continue to build the team and structures to support future delivery.

South Place Partnership delivery priorities for the next two to five years:

- Build community-based infrastructure to enable support and care to be provided at home or in a neighbourhood setting, including Integrated Neighbourhood partnerships and care teams, care coordination hub, capacity and resilience, community diagnostics infrastructure
- Embed an integrated proactive and personalised care approach to reduce inequalities and increase years people enjoy good health
- Enable ‘home first’ through optimising and integrating urgent community/intermediate care to maximise care at/close to home and reduce attendance or admission to acute services
- Enable ‘home first’ through improved discharge coordination, pathway optimisation and new virtual care models to ensure right care in the right setting
- Collaboratively develop partnership working and integration enablers

Through these delivery priorities we will focus on individual schemes which contribute to the achievement of the ICS priorities. In year one we will focus on cardiovascular disease, high intensity users, the urgent community response, hospital discharge and virtual wards.

In addition, we will work to support the delivery priorities led by other parts of the system including primary care resilience, community diagnostics and digital transformation.

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Delivery plans

PRIORITY 1: Building community-based infrastructure to enable support and care to be provided at home or in a neighbourhood setting

OBJECTIVE 1.1

Build integrated neighbourhoods (INs) - In collaboration with local partners, lead the development of resilient Integrated Neighbourhood partnerships that can hold responsibility for design and delivery of support and care to meet the needs and ambitions of their population.

Progress to date:

- Neighbourhood Programme team in place, and linking with partner teams to support development of neighbourhood partnerships
- Co-developed and agreed 'working draft' Operating Framework for Integrated Neighbourhoods
- Hosted workshop for key partners across Cambridgeshire South to co-develop implementation plans for next 1-2 years
- Four Integrated Neighbourhood Boards established, building on existing governance and partnership working
- All Neighbourhood teams worked with new partners to deliver support and care through team-based arrangements

Milestones Y1	Milestones Y2	Milestones Y3-5	SRO	Oversight Group
• Each Neighbourhood has agreed its priorities based on PHM approach, staff insight and lived experience, and develop Annual Plans for delivery • All Neighbourhoods will engage with their communities about the experience and outcomes that matter to them • Neighbourhood budgets agreed for Integrated Neighbourhood Teams (INTs) with health, social care and VCS staff co-locating by the end of 23/24 (as physical estate permits) • Co-develop a plan for 'hubs' for	• Integrated Neighbourhood Operating Framework finalised, building in learning from 23/24, which ensures each neighbourhood has an agreed delivery plan, including shadow responsibility for relevant population outcomes. • Agree/delegate Neighbourhood budgets to fund transformation and service delivery • Co-design Neighbourhood workforce and organisational development, estates and digital infrastructure plans to deliver new way of working in neighbourhoods • Lead the development of, and embed core training and induction for Neighbourhoods, working for all partners	• Visible shift to all partners (patients, staff, providers) in how we plan and deliver care locally • Evaluate impact of Neighbourhood partnership based model – experience and outcomes that matter to citizens, e.g. increased years of healthy life expectancy	Erin Lilley, Director, Partnership Development & Transformation, CSCP	Proactive and Personalised Care Programme Board

communities to access services in their Neighbourhood				

OBJECTIVE 1.2:

Build integrated neighbourhood teams - In collaboration with system partners, lead the development and testing of a Neighbourhood-based personalised team care model to deliver proactive care, improve continuity of care and reduce health inequalities.

Progress to date:

- Improved recruitment of Additional Roles Reimbursement Scheme (ARRS) roles in PCNs.
- Implemented Winter Personalised Care initiatives across all PCNs and their partners.
- Tested patient experience and outcomes measurement tool.
- Developed and recruited to Personalised Care lead role, hosted within a VCS partner.
- Worked with partners to start planning for alignment of community staff within Integrated Neighbourhood Teams

Milestones Y1	**Milestones Y2**	**Y3-5**	**SRO**	**Oversight group**
• Clinical and professional staff aligned to IN teams based on priority needs of local population, to build Neighbourhood Personalised Care Teams, supported by appropriate governance arrangements. • Embed Personalised Care lead role, provide training and support to workforce undertaking these roles within INs, and develop plan to optimise personalised care models. • Optimise planning for and recruitment of Additional Roles Reimbursement Scheme (ARRS) roles in PCNs. • Co-design and test primary care mental health model	• Further scale models to support larger populations and delivering more complex care • Review other workforce groups identify opportunities for support and alignment e.g. teams delivering health and social care to people at home • Co-design plan for scaling, transferring and embedding outpatient / specialty services within neighbourhood models and settings • Individuals identified with long term conditions who are likely to experience worse outcomes, and personalised shared care plans put in place	• Accessing care feels seamless across services and people receive early support to prevent crisis, with care delivered close to home • Fully integrated Neighbourhood Personalised Care Teams working as one with single leadership • Full time jointly funded and appointed operational managers and support to deliver this model • Single care record for each patient/citizen, and digitally enabled shared care plans (in real time)	Erin Lilley, Director, Partnership Development & Transformation, CSCP	Proactive and Personalised Care Programme Board

PRIORITY 2: Embedding integrated proactive and personalised care to reduce inequalities and increase years people enjoy good health

OBJECTIVE 2.1:

Addressing wider determinants of health - Coordinate partner activities to deliver prevention and community engagement initiatives that tackle inequalities.

Progress to date:

- Collaborated across partners and communities to co-design and deliver Heat for Health programme, including warm hubs and increased options to access support funds.
- Worked with partners to deliver electric blankets to vulnerable individuals
- Pilot approach to addressing digital inequalities within IN initiatives

Milestones Y1	Milestones Y2	Y3-5	SRO	Oversight group
• Multiagency coordination of Cost of Living Support by joining up governance/ projects • Establish/embed sustainable Community Hubs, building on Warm Hubs, vaccination hubs and other existing/planned Hubs • Align and agree how available inequalities and prevention funding will be used at Neighbourhood and District Level	• Support focused approach using access to local and hyper-local knowledge	• Evaluate impact of proactive support and use learnings to inform co-development of future plans	Erin Lilley, Director, Partnership Development & Transformation, CSCP	Proactive and Personalised Care Programme Board

OBJECTIVE 2.2:

Addressing wider determinants of health – in collaboration with partners, codesign and deliver personalised care approaches to meet the reduce high impact service use reduce health inequalities

Progress to date:

- Jointly-funded and piloted new models of care including: a Drug and Alcohol Recovery Worker, the Moon Project for children affected by Domestic Violence and a Carers Care Coordinator in East Cambs
- Winter Wellbeing projects identifying cohorts at risk of worse outcomes and providing proactive and personalised care and support

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Milestones Y1	Milestones Y2	Y3-5	SRO	Oversight Group
• Co-design approaches to identify and address needs of people with high intensity service use within Neighbourhoods • Appreciative Inquiry and co-design/co-production approach in place to understand root causes of high impact service use and co design changes • Pilot AI-based tool to predict people likely to be admitted to hospital in 6-18 months and offer tele-coaching and personalised care plans to reduce acute attendances	• Scale use of personalised care planning and measurement of patient/citizen reported experience and outcome measures • Routine use of population health management and appreciative inquiry approaches to identify service users, understand their needs and personalise their care • Use of iterative learning to improve pathway and service redesign (including future resource alignment)	• Evaluation of predictive hospital avoidance and use this to co-develop future plans	Erin Lilley, Director, Partnership Development & Transformation, CSCP	Proactive and Personalised Care Programme Board, CSCP

OBJECTIVE 2.3

Preventing and managing long term conditions – in collaboration with partners, co-develop and implement integrated and proactive models of the care to prevent and manage long term conditions with a particular focus on cardiovascular disease (hypertension & heart failure), diabetes, frailty, respiratory conditions and mental health.

Progress to date:

- Commenced the co-development & piloting of potential elements of an integrated population health model for hypertension
- Commenced the co-development and piloting of potential elements of an integrated population health model for diabetes
- Monthly Health Hub offering health checks and advice in Cambridge City
- Healthier Weight Project including Menopause Event, awareness raising tools, health checks, healthy walks, housebound insulin dependency reviews, group consultations and peer support in East Cambs
- Agreement to collaborate with the Children's & Maternity Partnership to improve management of asthma in children
- Piloted single-sessions of support with a therapist, by phone/video call within two weeks for CYP and families with mild to moderate mental health challenges
- Winter project supported men struggling with poor mental health or cost of living that are unlikely to engage with early support

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- Cambridge Central Mosque hosted day of wellness related workshops, information stalls & activities for local community
- Collaborated on system Falls Prevention Strategy, completing a comprehensive service mapping for falls prevention and management services
- Collaborated on expansion of Care Together programme across Cambridgeshire South, including pathway redesign for care closer to home

Milestones Y1	Milestones Y2	Y3-5	SRO	Oversight Group
• Continue to co-develop & pilot an integrated population health model for hypertension prevention, detection and management across primary and community care at Neighbourhood level • Innovation funding to Neighbourhoods to support identification and management of local patients • Work with partners to review and understand existing diabetes support, services, and pathways • Continue to co-develop and pilot an integrated population health model for diabetes prevention, detection and management across primary and community care at IN level • Support PCNs through Neighbourhood working to improve Diabetes related outcomes against 3 Treatment Targets (3TT) and 8 Care Processes (8CP) • Co-design and pilot intervention for PHM Target cohort 1 in Cambridge City IN • Working with the MH ABU to co-develop MH Community Connector posts and how they are embedded in Neighbourhood Teams	• Evaluate pilots and co-develop integrated hypertension mod el for scaling, linked with Neighbourhoods (i ncluding resource alignment) • Co-develop and pilot an integrated Heart Failure model, linked with Neighbourhoods (i ncluding resource alignment) • Diabetes pathway and service redesign based on learning (Funding required) • Collaborate with Mental Health team and citizens to iteratively improve service integration and embed within Neighbourhoods • Evaluate and iteratively improve mode/s for supporting people at risk of developing moderate to severe frailty • Alignment of mild-moderate falls approach with the Urgent Community Response and Step Up/ Intermediate Care models	• Evaluate the impact on population health outcomes from earlier identification and management of cardiovascular disease, and iteratively improve care models. • Demonstrable improvement in management of Diabetes 3 Treatment Targets (3TT) and 8 Care Processes (8CP) • Reduction in unplanned care attendances and days of school missed for children with asthma • In collaboration with the MH Team, evaluate impact on population health outcomes, with a focus on reducing health inequalities • Ongoing cycle of valuation of population	Erin Lilley, Director, Partnership Development & Transformation, CSCP	Proactive and Personalised Care Programme Board, CSCP

Milestones Y1	Milestones Y2	Y3-5	SRO	Oversight Group
• Collaborate on expansion of CPFT led MH Community Transformation across Cambridgeshire South, including pathway redesign for care closer to home • Lead the co-design and pilot for an integrated multi-disciplinary team model for assessment and secondary prevention of falls, with IN component • Lead the co-design and implement the interventions for PHM Target cohort 2, starting in Ely North & Ely South IN: People at risk of developing moderate to severe frailty (aged 45+, with Heart Failure, pre-diabetes, no falls history) • Collaborate on expansion of Care Together across South Place, including pathway redesign for care closer to home		outcomes related to mild-moderate frailty, with a focus on prevention and early intervention		

PRIORITY 3: Enable 'home first' through optimising and integrating urgent community/intermediate care to maximise care at/close to home and reduce attendance or admission to acute services

OBJECTIVE 3.1:

Optimising and integrating step up/ intermediate care services – in collaboration with partners, develop, implement and integrate 'Call Before You Convey' model

Progress to date:

- Developed model for access to Call Before You Convey (CB4UC), a clinician led service with option for paramedics to refer direct to step up/intermediate care services.
- Implemented CB4UC clinician cover Mon - Fri 10-18hrs (Sat/ Sun from end Feb)
- Ambulance service contact CB4UC to discuss options to admission avoidance, including being routed directly to assessment units/ ambulatory care or ED as appropriate

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Milestones Y1	Milestones Y2	Y3-5	SRO	Oversight Group
• Embed 7-day service provision, extending service provision until 10pm • Triangulate data with EEAST and Acute providers to enable evaluation of data/ service demand profiles; to inform UCR capacity planning and commissioning requirements to meet population needs • Start to co-design proactive urgent care pathways with Neighbourhood teams	• Iteratively improve the CB4UC IVR model based on evidence and partner feedback	• Evaluate the impact of UCR admission avoidance delivery models, based on experience and outcomes that matter to service users, the wider population and the providers, aligned with best practice models and national requirements, utilising peer reviews and clinical audit.	Yvonne Beaumont-Hill and Sabina Fitton, Director, Operations & Delivery, CSCP	Home First Programme Board, CSCP Unplanned Care Board, ICS

OBJECTIVE 3.2:

Optimising and integrating step up/ intermediate care services - in collaboration with partners, develop, implement and integrate step-up/ step down care (ICT & RBT)

Progress to date:

- Not in scope for current year.

Milestones Y1	Milestones Y2	Y3-5	SRO	Oversight group
• Systemwide evaluation of Pathway 1 provision, building on outputs from ICB commissioned review • Evaluate utilisation of commissioned resource to ensure capacity optimisation and inform C&D modelling • Scope current VCSE service provision in admission avoidance and evaluate opportunity to utilise VCSE resource to enhance step up provision within CSCP system	• With partners, co-design system wide integrated delivery model to meet the needs of the population based on C&D modelling undertaken by ICB	• Evaluate the impact of UCR admission avoidance delivery models, based on experience and outcomes that matter to service users, the wider population and the providers, aligned with best practice models and national requirements, utilising peer reviews and clinical audit.	Director, Operations & Delivery, CSCP	Home First Programme Board, CSCP Unplanned Care Board, ICS

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OBJECTIVE 3.3:

Optimising and integrating step up/ intermediate care services - in collaboration with partners, review and integrate Urgent Community Response model (JET, ERS, Granta, etc)

Progress to date:

- Granta provision of UCR model went live in January 23, with ongoing collaboration with EEAST to identify patients who could potentially be managed without conveyance to hospital.
- React Cars – rapid response with Advanced Nurse Practitioners to assess and identify people who could remain at home with support.

Milestones Y1	Milestones Y2	Y3-5	SRO	Oversight group
• Undertake a service benefits realisation evaluation of the Granta UCR service to inform impact of extending the service to support delivery of a 7-day service 8am – 10pm • Develop UCR pathways to support virtual ward, early facilitated discharge and admission avoidance • Utilise ICB C&D data to inform the rightsizing the UCR services, ensuring maximum utilisation of current resources, developing business cases if increased provision is required. • • Review current delivery model and co-design/ implement system response to meet demand, incorporating VCSE	• Iteratively improve integrated UCR evidence-based models of care/ service delivery	• Visible shift to all partners (patients, staff, providers) in how care and services are planned and care delivered • Ongoing evaluation of the impact of place-based model for delivery of UCR provision, based on the experience and outcomes that matter to the population e.g. feedback from care receivers/ carers and service providers	Director, Operations & Delivery, CSCP	Home First Programme Board, CSCP Unplanned Care Board, ICS

OBJECTIVE 3.4:

Optimising and integrating step up/ intermediate care services - in collaboration with partners, review and integrate rapid stabilisation services/G&A for ‘planned’ step up care.

Progress to date:

- Not in scope for current year.

Milestones Y1	Milestones Y2	Y3-5	SRO	Oversight Group
• Scope opportunity for delivering urgent outpatient activity at place, i.e. frailty, osteoporosis, falls clinics, working closely with system partners to identify an integrated model of care • Pilot principles and evaluate outcomes	• Co-develop the service model for specialist support based on the 23/24 scoping work	• Ongoing evaluation of relevant population health outcomes, user experience, and impact on acute care capacity	Director, Operations & Delivery, CSCP	Home First Programme Board, CSCP Unplanned Care Board, ICS

OBJECTIVE 3.5:

Optimising and integrating pathways for specialist support - in collaboration with partners, review and integrate alternative pathways to unplanned emergency department care (Same Day Emergency Care / Minor Injury Units / Urgent Treatment Centres)

Progress to date:

- Not in scope for current year.

Milestones Y1	Milestones Y2	Y3-5	SRO	Oversight Group
• Identify current SDEC/ MIU/ UTC provision support interfaces • Partnership working to inform gaps in support and identify pathway requirements	• Work collaboratively with all partners to bolster current established access routes	• Ongoing evaluation of relevant population health outcomes, user experience, and impact on acute care capacity	Director, Operations & Delivery, CSCP	Home First Programme Board, CSCP Unplanned Care Board, ICS

OBJECTIVE 3.6:

Develop support model for care/nursing homes - in collaboration with partners, co-develop support and care model to reduce use of unplanned care services by people living in care or nursing homes

Progress to date:

- Not in scope for current year.

Milestones Y1	Milestones Y2	Y3-5	SRO	Oversight Group
• Review the current support provision for Care/Nursing homes	• Continue to iteratively improve service model	• Ongoing evaluation of relevant population health outcomes, user	Director, Operations & Delivery, CSCP	Home First Programme Board, CSCP Unplanned Care Board, ICS

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• Triangulate CUH ED attendance and admission data with care home provision to identify high service users, identifying top 5 users for focussed support • Using PDSA approach, identify and implement a support model, to reduce demand and enable place-based care delivery, based on top five care home high users of ED data		experience, and impact on acute care capacity		

PRIORITY 4: Enable 'home first' through improved discharge coordination, pathway optimisation and virtual care to ensure right care in the right setting

OBJECTIVE 4.1:

Optimising coordination of discharge planning and transfers of care - in collaboration with partners, review and integrate discharge planning and transfer of care pathways to ensure the right care is delivered in the right setting

Progress to date:

- Co-developed a virtual Transfer of Care Hub (TOCH) to facilitate timely decision making on pathways 1-3 discharge with system-wide partnership working
- Additional funding secured to enable resourcing of the TOCH –backfilling current commitments and commissioning additional resource to enable pathway review and development
- Additional funding secured to enable a system- wide digital solution to support the visibility of system capacity and pressure points.

Milestones Y1	Milestones Y2	Y3-5	SRO	Oversight Group
• Utilise the system-wide workforce backfill resource from the additional funding to support the	• Continue to refine processes to improve patient	• Ongoing review and evaluation of the effectiveness of the TOCH	Director, Operations & Delivery, CSCP	Home First Programme Board, CSCP

development of TOCH pathways and procedures • Develop operational processes to support effective management of TOCH caseload • Further development of the digital solutions to support co-ordination of system capacity and enable data visibility. • Utilise ICB C&D analysis outcomes to inform capacity requirements for winter resilience. • Embed the Harm review processes for TOCH patients, engaging with Healthwatch • Agree workforce and funding requirements to continue TOCH processes into 24/25 • Review the TOCH functionality in line with updated national guidance in Q4 23/24	outcomes and experience for complex discharges, through improved pathway reviews and co-design. • Agree long term workforce model to sustain and grow the TOCH functionality based on 23/34 learnings and outcomes	functionality in line with best practice models and national requirements utilising peer reviews and clinical audit		Unplanned Care Board, ICS

OBJECTIVE 4.2:

Implement virtual ward model - in collaboration with partners, further develop Virtual Ward (VW) capacity to 80% utilisation of 70 bed equivalent.

Progress to date:

- South Cambridgeshire delivering VW capacity equivalent to 30 beds (acute), with occupancy rates currently 55-65%

Milestones Y1	**Milestones Y2**	**Y3-5**	**SRO**	**Oversight Group**
• Collaborate with partners to support the expansion of the current VW model to increase care at home • Develop pre-hospital VW approach in conjunction with Primary Care UCR for the South to increase VW utilisation and	• Continue to refine VW processes to improve patient outcomes and experience to improve care models	• Evaluate relevant population health outcomes, user experience, and impact on acute and social care capacity	Director, Operations & Delivery, CSCP	Home First Programme Board, CSCP Unplanned Care Board, ICS

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reduce acute hospital occupancy, to include direct referrals from GP services • Achieve the occupancy target 80% - 85% • Evaluate patient outcomes and experience of VW care provision.	• Evaluate VW model and expand to other specialties / service providers aligned to demand and needs assessments			

OBJECTIVE 4.3:

Optimise discharge pathways 1 to 3 - in collaboration with partners, embed John Bolton model across pathways 1 to 3 to ensure the right care is delivered in the right setting

Progress to date:

- Pathway 1 Trusted Assessor (TA) model introduced in Cambridgeshire South, with the continuation of principles to include admission avoidance/ early facilitated discharge TA model by EIT
- Trial commenced for Pilot P2 D2A model for patients with ongoing assessment of care needs
- Evaluation of compliance with John Bolton model of care and identification of scope for improvement.
- Identification of gaps in pathway models and specifications and associated governance processes including reporting

Milestones Y1	Milestones Y2	Y3-5	SRO	Oversight Group
• Embed TA principles across Pathway 2 health beds • Embed John Bolton principles across the system, and align the related coding and reporting requirements • Co-review and co-design the discharge pathways identified as not meeting the population needs. • Develop robust collaborative processes to support co-designed pathway delivery and evaluation • Evaluate user experience, and the impact on health and social care capacity	• Working in collaboration with partners to deliver continuous improvement and integrate service models • Ongoing review and evaluation of the relevant population health outcomes, user experience, and the impact on health and social care capacity	• Evaluate relevant population health outcomes and the impact on health and social care capacity	Director, Operations & Delivery, CSCP	Home First Programme Board, CSCP Unplanned Care Board, ICS

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North Cambridgeshire and Peterborough Partnership

Overview

We have established a key vision for North Care Partnership: To support people to stay well, be independent and live happier and healthier lives, ensuring every person matters and every contact counts.

Across North Cambridgeshire and Peterborough, we aim to work in partnership with our population and local partner stakeholder organisations to provide an integrated health and care system fit for the future.

This means people receiving and having access to seamless holistic services that meet their physical, social and mental health needs at the earliest possible opportunity.

Through a focus on the individual, and communities, as opposed to structure, we place an increased priority on prevention and pro-active care rather than reactive treatment. We expect to increasingly deliver most of an individual's care needs in their local community and to reduce the need for hospital-based care.

Improving equity, through an integrated approach to:

- Prevention of ill health, early intervention, health improvement and creating environments that support and enable people to live healthily.
- Ensuring our actions are centred on the individual, their goals, and the communities in which they live and supporting people to help themselves.
- Having shared planning and decision making with our residents.

Our strategic priorities:

- Striving to achieve better health outcomes for everyone in the North Care Partnership
    - Care closer to home.
    - Prevention and early intervention – wrapping our Neighbourhood Teams working alongside our communities to keep them well for longer.
    - Standardise and improve outcomes for everyone, prioritising those of greatest need.
    - Utilising data insights and evaluation to enable better outcomes
- To develop and deliver a sustainable, integrated health and care system across the North Care Partnership
    - Integrating through delivery, wrapping services around our communities, developing shared protocols/policies enabled by shared data and technology.
    - New models of care, building steppingstones within the community reversing the reliance on secondary care and bed based social care.
    - Coproduction with our communities – listening to our communities and modifying our delivery dependent on age/race/disability/needs.
- To create a sustainable workforce
    - Getting the best from our collective workforce.
    - Seizing opportunities from shared health and care workforce.
    - Creation of new integrated provider roles, providing joint continuous professional development across Health and Social care.
- To create a financially balanced system

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- ‘One and done’ ethos - driving efficiencies for the Place and value to our communities to create a financially balanced system.
- Improve sharing of best practice regarding pooled or aligned budgets, aligned to resources and shared outcomes.

Based upon our ICS Health and Wellbeing strategy, our North Partnership has developed its plans and priorities, ready for delivery in 2023/24 and beyond.

These balances delivering on population health and care outcomes, performance improvement and improving equity of access and outcomes.

It also requires us to building more integrated models of delivery to meet future demand and longer-term resilience for our care staff, residents, and carers.

Delivery plans

Growing Well

Initiative:

Optimise and improve equity of uptake of childhood immunisations.

Progress to date:

Childhood immunisation programme led by public health team.

Impact:

Improve uptake and equity of uptake of childhood immunisations.

Year 1-2	Year 3-5	SRO	Oversight Group
Pilot a service in each locality combining health and local authority data to support case finding. Provide call and recall, targeted conversations and to provide specific outreach sites to provide local access to services Evaluate impact and uptake and adapt delivery model	Establish and expand to multiple public health programmes. Develop case finding analytical capabilities. Develop a multi-channel public information campaign with tailoring to specific communities/languages.	Emmeline Watkins, Deputy Director of Public Health	North Care Partnership Board

Initiative:

Support the development of family hubs with accessible services for communities.

Progress to date:

- Published Start for Life Offer
- Parent Care Panel in place
- Initial Family Hub Buildings identified
- Digital platform in place

Impact:

- Improved physical health and mental health and emotional wellbeing.
- Families able to make positive choices/ improved family awareness of where to get help and confidence to ask for help.
- Improved readiness for next stage of life/school.
- Improved social networks / reduced isolation.

Year 1-2	Year 3-5	SRO	Oversight Group
Family hubs open their doors. Define a parenting programme plan, including an online offer. Define Home Learning Offer. Workforce planning commences	Expansion of the programme through available services including perinatal and infant/parent relationship support, speech and language support for home learning Longer term workforce planning	Kat Band, Assistant Director Children's Services, Barnados	North Care Partnership Board

Initiative:

Develop a model of virtual wards/hospital at home for children and young people

Progress to date:

- Project initiation
- Analysis of best practice models

Impact:

- Provide safe and effective alternatives to hospital-based care which has the potential to improve recovery and outcomes for children and young people
- Reduce pressure on hospital paediatric inpatient facilities

Year 1-2	Year 3-5	SRO	Oversight group
Scope and develop the model based upon best practice Workforce and financial planning Pilot and test the model through our acute hospital and community services for children and young people	Establish and baseline the model of care Scale the model to meet the demand in North Cambridgeshire and Peterborough	Arshiya Khan, Deputy Chief Executive at North West Anglia NHS Foundation Trust and Director of Strategy & Planning	Virtual Ward Programme Board

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Living Well

Initiative:

Optimise and improve equity of uptake of screening, health checks and immunisations (all ages) providing support to stay active and healthy

Progress to date:

- Service planning and cohort identification (Core 20+5 and those with inequity of access and outcomes).
- Request for health inequalities funding.
- Assessment of data requirements

Impact:

Improve outcomes and effectively address and reduce unequal health outcomes for residents and variation in uptake. Focusing on: heating and eating; safe housing; immunisations; high blood pressure; early cancer diagnosis; and long-term condition optimisation.

Year 1-2	Year 3-5	SRO	Oversight Group
Pilot a service in each locality combining health and local authority data to support case finding Provide call and recall, targeted conversations and to provide specific outreach sites to provide local access to services Evaluate impact and uptake and adapt delivery model	Establish and expand to multiple public health programmes Develop case finding analytical capabilities Develop a multi-channel public information campaign with tailoring to specific communities/languages	Emmeline Watkins, Deputy Director of Public Health	North Care Partnership Board

Initiative:

Support the design and roll-out of community mental health teams aligned to our integrated neighbourhoods.

Progress to date:

- Exemplar Pilot delivered in Peterborough and evaluation complete.
- Interventions for rollout identified.

Impact:

People with mental health issues will be able to access a wider range of treatment and support options to meet their needs.

Year 1-2	Year 3-5	SRO	Oversight Group
Rollout of stepped care model in Cambridgeshire	Delivery of Community Rehabilitation Model	Debbie Smith, Chief Operating Offier, CPFT	Community Strategic Partnership (led by MHLDA ABU)

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Year 1-2	Year 3-5	SRO	Oversight Group
Scoping of community rehabilitation model Implementation of Move Away from CPA/Outcomes measurement	Embedding Stepped Care model and ensuring interventions support access for younger adults and older adults		

Initiative:

Develop and support multi-partner initiatives (in each locality) to support those challenged by cost of living (all ages) including through community hubs.

Progress to date:

- Cost of living programme with and through Peterborough, Fenland and Hunts Councils.
- Warm spaces implemented.

Impact:

Improving outcomes for people most impacted by cost-of-living challenges and in deprived communities.

Year 1-2	Year 3-5	SRO	Oversight group
Baseline mapping of existing hubs and access points Targeting specific individuals and households at greater risk through cost-of-living challenges. Pilot an 'access and information' community hub in at least each locality	Consider developing access and information hubs in each neighbourhood Develop analytical systems with precision for identifying those at risk of poorer outcomes due to life circumstances	Paul Medd, CEO Fenland District Council	North Care Partnership Board

Initiative:

Identify and support high intensity users (HIU) and those at risk of cardiovascular disease (CVD) through population health analysis and targeted interventions.

Progress to date:

- Winter initiative.
- Service model development
- Business case development
- Cohort identification
- Development of CVD local

Impact:

- CVD: 5% reduction in deaths; 5% reduction in acute admissions with heart failure; 10% reduction in death within the poorest quintile
- HIU: reduction in A&E attendances, admissions, and ambulance conveyance

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Year 1-2	Year 3-5	SRO	Oversight Group
Implement a targeted multidisciplinary model for those who make most high intensity use of urgent care services. Implement a model for supporting those people in each neighbourhood at risk of hospitalisation. Evaluation and quality improvement.	Adaption and scaling to cover a greater number of residents who are high-impact users and are at risk from cardiovascular disease.	Abby Richardson, Clinical Lead for Integrated Neighbourhoods	North Care Partnership Board.

Ageing Well

Initiative:

Deliver improvements in our urgent care system and hospital flow including the implementation of our transfer of care hub and virtual wards.

Progress to date:

- Co-development of a virtual Transfer of Care Hub (TOCH)
- Secured £530k to enable resourcing of the TOCH and £650k to enable a system- wide digital solution
- Implementation of virtual wards
- Identification of priority initiatives

Impact:

- Reduction in length of stay (acute and community) and improved waiting times in A&E
- Increase in home-based care solutions (versus bed-based care)
- Occupancy of greater than 80% in virtual wards
- Reduction in emergency admissions and ambulance conveyance
- Improved experience and outcomes for residents

Year 1-2	Year 3-5	SRO	Oversight group
Implement models and improvement in: • Same day emergency care • High-intensity users • Transfer of care hub • Integrated discharge • Virtual wards	Embed and develop scope and scale of models	Arshiya Khan, Deputy Chief Executive at North West Anglia NHS Foundation Trust and Director of Strategy & Planning	North System Resilience Group

Initiative:

Develop a model of multidisciplinary support for prevention and support for those who at risk of becoming frail and who are frail.

Progress to date:

- Initial project scoping

- Determination of Huntingdonshire as the pilot site
- Identification of SRO and key stakeholders

Impact:

- Number and rate of unplanned (or avoidable) in people age 65 years or more
- Proportion of people who were still at home 91 days after discharge
- Permanent admissions to residential and nursing care homes, per 100,000 population

Year 1-2	Year 3-5	SRO	Oversight Group
Design and implement a model of multidisciplinary support for frail residents in Huntingdonshire. Develop case finding techniques with council, VCFS for those who are at risk of isolation/frailty. Evaluate the model.	Embed and develop scope and scale of model with roll-out across localities in Fenland and Peterborough.	Oliver Morley, Interim CEO, Huntingdon District Council	North Care Partnership Board.

Initiative:

Develop (in partnership with our South Care Partnership) and deliver upon a long-term strategy for integrated and resilient intermediate care.

Progress to date:

- Analysis of best practice models
- Analysis of demand and capacity requirements

Impact:

Ensuring individuals receive care at the right time in the right place, reducing acute hospital admission.

Year 1-2	Year 3-5	SRO	Oversight group
Scope and develop the model based upon best practice Service mapping across health, care and voluntary services Population analysis (including demographic change), capacity, workforce and financial planning To implement a proactive multidisciplinary and integrated discharge function in our hospitals to improve the discharge support to our residents and to improve our a ‘home first’ approach	Implement a future-proofed and integrated model of intermediate care, with a focus on: Home-based intermediate care Reablement Bed-based intermediate care Crisis response	Debbie McQuade, Service director, Adults & safeguarding, CCC and PCC	Cambridgeshire and Peterborough Unplanned Care Board

Neighbourhoods

Initiative:

Implement and develop our integrated neighbourhood teams as our model of improving equity, prevention and integrated care.

Progress to date:

- Built Neighbourhood Programme team, linking with partner teams to support development of neighbourhood partnerships
- Developed Maturity Framework for Integrated Neighbourhoods
- Eight Neighbourhood Boards established building on existing governance and partnership working
- All Neighbourhoods worked with new partners to deliver through team-based arrangements.

Impact:

- Visible shift to all partners (residents, staff, providers) in how we plan and deliver care
- Evaluate impact of Neighbourhood partnership-based model – experience and outcomes that matter to citizens, e.g., increased years of healthy life expectancy.

Year 1	Year 2	Year 3-5	SRO	Oversight Group
Each Neighbourhood agrees priorities based upon staff insight and lived experience, and develop annual plans for delivery. All Neighbourhoods engage with their communities about the experience and outcomes that matter to them Agree Neighbourhood budgets to fund project and transformation work Integrated Neighbourhood Teams (INTs) with health, social care and VCS staff co-locating (as physical estate permits) Each neighbourhood has identified workforce and organisational development	Finalise Integrated Neighbourhood Operating Framework, building in learning from 23/24 Each neighbourhood has an agreed delivery plan, including shadow responsibility for relevant population outcomes. Agree/delegate Neighbourhood budgets to fund transformation and service delivery Co-design Neighbourhood workforce and organisational development plans Co-design plan for meeting estates and digital infrastructure needs to deliver new way of working in neighbourhoods Develop and embed core training and	Visible shift to all partners (residents, staff, providers) in how we plan and deliver care Evaluate impact of Neighbourhood partnership-based model – experience and outcomes that matter to citizens, e.g., increased years of healthy life expectancy	Abby Richardson, Clinical Lead for Integrated Neighbourhoods	Integrated neighbourhood programme board

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Year 1	Year 2	Year 3-5	SRO	Oversight Group
support requirements Events to share learning about neighbourhood based care from others in our system, and in other systems. Co-ordinate/establish 'hubs' for communities to access services in their Neighbourhood Test models for proactive identification of individuals with long term conditions who are likely to experience worse outcomes	induction on Neighbourhood working for all partners Scale successful models for proactive identification of individuals with long term conditions who are likely to experience worse outcomes, and ensure personalised shared care plan in place			

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Health and Wellbeing

Overview

Across Cambridgeshire and Peterborough, we face many challenges in improving the health and wellbeing of our local people and communities. The impact of COVID-19, combined with rising living costs, is continuing to impact on people's lives. More than ever, we need to find new, effective, and sustainable ways to work together to improve health and wellbeing and to prevent ill health. The pandemic also highlighted and exacerbated health inequalities, this strategy aims to tackle some of these inequalities.

Our strategy is a truly integrated piece of work, developed by working closely with local partners from health, social care, local authorities and the voluntary, community sector along with feedback from local people across Cambridgeshire and Peterborough.

Our Vision: All Together for Healthier Futures

The Overarching Ambitions:

- Have better outcomes for our children
- Reduce inequalities in deaths under 75 years
- Increase the number of years that people live in good health

The four priorities which we believe, through working in partnership, will make a difference to people's lives:

- Priority 1: Ensure our children are ready to enter and exit education, prepared for the next phase of their lives
- Priority 2: Create an environment which gives people the opportunities to be as healthy as they can be.
- Priority 3: Reduce poverty through better employment, skills, and better housing.
- Priority 4: Promote early intervention and prevention measures to improve mental health and wellbeing.

Our collective aim is simple – to work together to enable local people across Cambridgeshire and Peterborough to live happier and healthier lives."

Delivery plans (in development):

PRIORITY 1: Our children are ready to enter and exit education prepared for the next phases of their lives

Overview

Education, employment, socioeconomic background, and health are all complexly interlinked. Whilst our socioeconomic background and many other factors influence our readiness to enter formal education, our attainment once we are at school is affected by our background also.

'School readiness' is the preparedness of children to enter the formal education system at 4-5 years old. Influences on school readiness start before birth, with the socio-economic circumstances, mental and physical health of mothers affecting the outcomes of their children.

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High-quality early years education also improves readiness to enter formal education. It is associated with improved cognition, sociability and concentration when starting school, and the investment is recouped by better attainment, future productivity, and employment, (as well as a reduced attainment gap for children in low income families). Good parenting can have an impact on life chances, just as much as income, education and socioeconomic class which are all interlinked, and parenting support groups therefore can improve language, emotional and social development before school education begins.

The Education system teaches and promotes healthy choices, the ability to advocate for better environment and neighbourhoods for our communities, and to avoid risk behaviours. It further provides a structured social environment for development of interpersonal skills for the future, and to allow both broad and targeted interventions from public health to be delivered to young people. These measures can solidify habits and practices to create healthy and resilient adults.

School attendance has many positive impacts on health and wellbeing and once we leave school, our level of education is closely associated with our long-term health. Adults with a tertiary education were found to have lower rates of smoking and obesity after accounting for differences in age, gender, and income and were more likely to take up healthcare such as vaccines, and screening programmes. These factors directly contribute to improved health in those with higher levels of education.

Long-term outcomes

- Increase the number of children who show a good level of development (GLD/school readiness) when they enter education
- Reduce the number of young people aged 16-17 who are Not in Education Employment or Training (NEET)
- Reduce inequalities in both these outcomes

Delivery plans: Our children already to enter and exit education prepared for the next phase of their lives			
Deliverable	Timeline	SRO	Oversight
Increase uptake up of the Healthy Start Scheme	2023/25		CPH Team
Promote the Start for Life offer through health and community settings	2023/25		CPH Team
Ensure local service providers including midwifery, health visiting, and community partners have an aligned approach to support new families with their mental health during the perinatal period and to develop good parent/infant relationships	2023/25		CPH Team ABU – The Children’s Collaborative
Deliverable 4: Ensure all new parents & parents-to-be receive good infant feeding support	2023/25		CPH Team ABU – The Children’s Collaborative
Deliverable 5: Provide families with the support and advice they need to access Early Years and Childcare opportunities	2023/25		Heads of Early Years CCC & PCC ABU – The Children’s Collaborative

Deliverable 6: Ensure damp free accommodation for children with a respiratory condition	2023/25		Lead P3
Deliverable 7: Increase apprenticeships through Anchor institutions (Councils, Combined Authority, NHS, commissioned services)	2023/25		Lead P3
Deliverable 8: Improve Mental Health, Emotional Wellbeing and Resilience among the school aged population	2023/25		CPH Team
Deliverable 9: Improve immunisation rates at entry into school and exit from school	2023/25		Imms Board
Deliverable 10: Establish a mechanism to improve health outcomes for our school-aged population	2023/25		CPH Team
2.1 NEET Engagement programmes - multicomponent (classroom and work-based)			
2.2 Interventions with commissioned services contracted to offer a number of apprenticeship opportunities.			
2.3 Activity Agreements - between NEET and advisor, Career awareness leading to apprenticeships and other career-based learning opportunities supported by local employers			
Improve outcomes for vulnerable groups- Children in Care, Care leavers, Young carers, Young offenders, Young parents, Children with SEND, Children in alternative education provision, LGBTQ+, certain Ethnicities, Socio-economic deprivation, Traveller communities			

PRIORITY 2: Create an environment to give people the opportunity to be as healthy as can be. Reduce childhood and adult obesity.

Overview

Obesity is the most pressing public health challenge with national and global increases for several decades. There is evidence that there have been further increases in both childhood and adult obesity, post pandemic. Obesity is a complex issue and requires the whole system to work together if we are to be successful in halting and reversing the rise.

Policymakers however still tend to focus on single initiatives, but our ambition is to use the opportunity afforded by the Joint Health and Well Being/Integrated Care System Strategy of incorporating ‘systems thinking’ into our effort to tackling obesity. This approach requires transformational evidence-based change that requires interventions to promote change across areas that we know have the greatest impact upon obesity.

Nationally we have around two thirds of the adult population either overweight or obese. This requires a broad response, although we know there are higher rates amongst children and adults amongst certain groups and in deprived areas. Our interventions will be at a population level, they must affect everyone. Consequently, there is a focus upon creating environmental changes which affect everyone and address multiple settings, family, school, workplace, community, and the media.

However, we know people and communities respond differently to environmental and service level interventions which can exacerbate any inequalities. Our efforts therefore will reflect a “proportionate universalism” approach which will seek to understand the different needs and

motivations that drive people and communities. This understanding will need to be embedded into how we plan and implement policy and other interventions.

Historically, locally and nationally there has been a plethora of interventions reflecting the complexity of obesity, but they have had varying levels of impact. It is important as we move forwards that we have a clear evidence-based approach that will lower rates and decease any inequalities.

This clearly identifies synergies and areas of mutual benefit with the other three priorities being pursued in the Joint Health and Well Being Strategy Integrated Care Strategy. For example, the school environment can influence the diet and physical activity levels of children or the negative effects of easy access to fast food.

Although it is complex and challenging, we have set ourselves stretching ambitions for improving outcomes that will require ongoing development of interventions that will move us consistently along the path to achieving them.

Long term outcomes

- Reduce childhood and adult obesity
- Reduce inequalities in overweight / obesity

Delivery plans:

Create an environment to give people the opportunity to be as healthy as can be.

Reduce childhood and adult obesity.

Deliverable	Timeline	SRO	Oversight
Deliverable 1: Establish a delivery vehicle/group for years 2023/25	2023/24		Public Health
Deliverable 2: Develop and implement Behavioural Insights research-based interventions that have impact and traction on health behaviours	2024/25		Public Health
Deliverable 3: Identify and develop improvements in the internal and external food environment-based school food survey and behavioural insights research	2023/24		Education/Schools/Public Health/Environmental Health/LA Planning
Deliverable 4: Increase physical activity in schools e.g. active travel programmes, daily mile	2023/24		Education/Public Health/Place & Sustainability (Active Travel)
Deliverable 5: Develop integrated evidence based interventions for the behavioural and clinical treatment / management of obesity and associate clinical risk factors	2023/24		ICS

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PRIORITY 3: Reduce poverty through better housing, employment, and skills.

Overview

Poverty limits life chances, health and wellbeing, and has a much wider societal impact beyond the individuals who are personally affected. This priority focuses on reducing poverty through improving skills, better employment and better housing, though reducing poverty is much broader than just these aspects.

Paid work is the main route out of poverty for working-age adults. Sometimes paid work is not feasible for some people due to disabilities, caring responsibilities, or other life circumstances, though there is still a large opportunity for employers to show greater creativity and flexibility in their approach.

Employment is not a guarantee of escaping poverty; there are growing issues of in-work poverty and insecure employment which affect many of our residents and we also need to consider how to improve the opportunities for our residents to secure 'good' employment (stable, well-paid, and safe). A good job should also be one that does not pose a threat to physical or mental health.

The interaction between housing and poverty is two-way; poverty limits people's housing choices, often resulting in living in poor quality housing as that is all that is affordable or available. However, housing also affects the risk or severity of poverty; expensive housing reduces the financial resource for other life essentials, poor quality housing is likely to require considerably greater spend of limited incomes on heating, and poor quality or insecure housing also affects wellbeing and physical health which in turn can limit educational or employment outcomes. Stable, secure, and good housing can have huge benefits not just to health but to the wider life chances. For example, housing with adequate space not only improves personal privacy, reducing depression, anxiety and stress but also gives children room to play, a good night's sleep and provides sufficient study space, enabling better achievement.

The issue of poverty is being exacerbated by the cost-of-living crisis. The 'Let's Talk - your health and care' campaign that ran to inform the Health and Wellbeing Integrated Care Strategy has identified that 45.8% of the respondents (1051/2292) felt that the cost-of-living crisis was impacting their health and wellbeing; key themes were the cost of heating and not having the heating on, having to cut down or purchase cheaper versions of food, the costs of transport to key services such as hospital appointments, reducing activities and increasing feelings of isolation.

Long term poverty outcomes

- Reduce the proportion of children living in relative poverty
- Reduce the proportion of working age population claiming out of work benefits
- Reduce the proportion of working age population claiming in-work Universal Credit
- Deliver improved quality and availability of housing that meets health and wellbeing needs

Delivery plans: HOUSING Reduce poverty through better housing, employment, and skills			
Deliverable	Timeline	SRO	Oversight

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Establish a delivery vehicle/group for years 2023/25	2023/24		Public Health Emmeline Watkins
DELIVER NEW HOMES TO MEET HEALTH& WELLBEING NEED			
• Increase the supply of more affordable housing including addressing needs of key workers across Cambridgeshire and Peterborough.			
• Ensure the design and layout of new homes enable people, especially children, to live with personal privacy and be able to play, learn and rest.			
• Increase the number of homes which provide for specialist housing need.			
• Increase the availability of assistive technology in new homes & communities.			
IMPROVING QUALITY OF HOUSING TO ENABLE HEALTH & WELLBEING RESILIENCE.			
• Increase the identification and improvement of homes in poor condition across all tenures, especially for vulnerable groups such as children with asthma			
• Reduce housing related delayed transfers of care			
• Increase thermal comfort in homes, reducing excess winter and summer deaths			
• Improve quality of houses of multiple occupation			
INCREASING THE PROPORTION OF RESIDENTS IN SAFE AND SECURE HOUSING.			
• Increase prevention of homelessness by increasing early referrals by all partners into homelessness prevention teams			
• Improve access to health and wider services for those that are homeless, especially rough sleepers			
SUPPORTING MENTAL HEALTH AT HOME (FOR NEW AND EXISTING HOMES).			
• Increase the supply of homes suitable for the ageing population including dementia-friendly homes			
• Support people out of hoarding, improving their life chances and reducing risk of death due to fire and other risks for them, their neighbours and their visitors			

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Delivery plans: EMPLOYMENT and SKILLS Reduce poverty through better housing, employment, and skills			
Deliverable	Timeline	SRO	Oversight
Deliverable 1: Secure information to re-design the pathway to employment through health and social care services care. (Information to include the barriers to using the fit note to support patients to consider their ability to work? How the recording of the functional effects of the patient's	2023/24		ICB, Public Health

condition and fitness for work currently look, how the ideal referral pathway/health journey would look, how to challenge the patient perceptions about their ability to work			
Deliverable 2: Secure information to identify how the system can work collaboratively to support people into employment. To include following how Primary Care/Health/Social Care Professionals can be supported, how the new Integrated Neighbourhood structure can support, existing resources within the system	2023/24		ICB, Public Health
Deliverable 3: Identification of contact points/service provision/locations with which the work and health agenda could be integrated	2023/24		South Cambs District Council and other C&P Las Public Health Cambridgeshire Insights
Deliverable 4: Establish a collaborative system wide approach to employment services delivery that is integrated into skills/health/social care services and improves access.	2023/24		Cambridgeshire and Peterborough Combined Authority (CPCA) DWP, Public Health Cambridgeshire Insights, Work, HWB Oversight Group
Deliverable 5: Employer and employee hub to provide information and advice.	2023/24		System wide Health Safety and Wellbeing Group (CUH)
Deliverable 6: Public sector / Anchor institution role modelling in relation to access to skills and employment.	2023/24		ICS/LAs/Combined Authority
Deliverable 7: Improved training / support for leaders / managers to support employees in poor health.	2023/24		ICB & Combined Authority

PRIORITY 4: Promoting early intervention and prevention measures to improve mental health and well-being.

Overview

Good mental health and well-being are essential factors in a thriving community. The impacts of poor mental health are significant and far reaching and can have a dramatic effect on whole life satisfaction and achievement. Our vision is that everyone in our communities across Cambridgeshire and Peterborough has opportunities for good mental health & wellbeing, and access to resources and information to prevent the onset of mental health problems, especially for those facing the greatest adversity and barriers. This includes those living with and recovering from mental illness.

Mental well-being promotion involves encouraging good mental health, positive feelings such as life satisfaction and happiness, reducing inequalities, building social capital, enhancing the quality of life,

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and enabling optimal psychological and psychophysiological development throughout the life course.

Mental illness prevention involves reducing the incidence, prevalence, and recurrence of mental health problems, as well as reducing the risk factors and the impact of mental illness on the affected person.

The pandemic has changed and disrupted the way many of us live, work, form relationships, participate in activities and enjoy ourselves; furthermore, inequalities have been exacerbated by the COVID-19 pandemic. Coupled with its wider impact on employment, economics, and education it has taken a toll on the populations' mental wellbeing and therefore timely to focus our efforts on addressing this.

In the years following there is more economic uncertainty, bringing greater stresses on individuals and families to cope with challenges such as the cost of living in a changing world. These factors all impact on our mental wellbeing.

By 2030, we want our population to have measurably better mental wellbeing than in 2022.

Long term outcomes

- Reduce the proportion of children and young people who need to be referred to mental health services
- Improve access to help and information to prevent mental health problems escalating
- Increase awareness about what choices can be made to best support people's well-being and the well-being of those they care about
- Implement understanding and awareness of Mental Health and Wellbeing programmes.

Delivery plans: Promoting early intervention and prevention measures to improve mental health and well-being			
Deliverable	Timeline	SRO	Oversight
Theme 1 – Communications, information, and resources Deliverable: Increase people's understanding of what they can do and their choices to best support their wellbeing and those they care about	2024/25		Mental Health Collaborative
Theme 2 – Motivation Deliverable: Increase engagement of people in activities that will encourage, motivate, and support them to improve their mental wellbeing.	2024/25		Mental Health Collaborative
Theme 3 – Relationships Deliverable: Support and foster positive relationships across the life-course for better mental wellbeing and prevention of loneliness	2024/25		Mental Health Collaborative
Theme 4- Wider determinants and leadership			System wide Mental Health Collaborative
Theme 5 - System understanding of Pathways and Resources			System wide Mental Health Collaborative

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Environmentally Sustainable Healthcare

Overview

Our overall carbon reduction targets are:

- An 80% reduction in the emissions we control directly (NHS Carbon Footprint) by 2028-2032, and net zero by 2040 (47% by 2028-2032 from 2020 baseline)
- An 80% reduction in our entire emissions profile (NHS Carbon Footprint Plus) by 2036-2039, and net zero by 2045 (73% by 2028-32 from 2020 baseline)

We will develop a programme of work to involve all our health and care partners and improve the understanding of the links between climate change and poor health outcomes.

What we want to achieve:

- Have a knowledgeable and motivated workforce that understands sustainability, can incorporate it into normal everyday business and feels empowered to act on the issue in the workplace and in their personal lives.
- Build sustainability considerations into all our strategies, policies, processes, and business models.
- Decarbonise our built environment and set the highest standards for new build and refurbishment, regarding use of materials and design of sustainable and flexible workplaces and be prepared for future extreme climatic events.
- Move to relying on energy from sustainable sources and reduce our overall energy use.
- Encourage the use of sustainable modes of transport for our suppliers, workforce, and patients, to improve air quality.
- Work with suppliers, purchasers, and consumers to procure more sustainably, with a circular economy approach.
- Purchase less, increase reuse/recycling/repurposing and increase separation of waste, to be disposed of in the most sustainable fashion.
- Reduce the use of high carbon footprint medication and medical gasses. Optimise use of medications and improve on waste and sustainable disposal of same.
- Support the adoption and development of new technologies and innovation to assist reduced carbon footprint.
- Maximise use of digital technologies and look at whole pathways to adopt the most sustainable healthcare practices.

Delivery plans:

Workforce and leadership

Objectives:

- Raise sustainability awareness across the ICS workforce, that builds confidence, understanding and motivation to 'be' the change.
- Embed sustainability into organisational values, policies, and operational processes.

By 2028 we want sustainability to be embedded in normal everyday business, considerations, and processes.

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Deliverable	Milestone & timeline	Lead/SRO	Oversight group/s
Training & engagement programme for system leaders and staff	• ICB Board training delivered 2023 • GP & Trust staff programmes established 2023 • System champions in place 2023/24	Claudia Iton, Chief People Officer, ICB Fiona O'Mahony, Programme Manager ICS Sustainability, ICB	Green Plan Programme Board, ICB People Board
Sustainability embedded in all processes and policies	• Informed environmental considerations are an integral part of all policy, strategy, and business case development by 2024	Nicola Ward, Director of Strategy and Development, ICB Kit Connick, Chief Officer Partnerships & Strategy, ICB Claudia Iton, Chief People Officer ICB Louis Kamfer, Deputy Chief Executive Officer & Managing Director of Strategic Commissioning, ICB	Green Plan Programme Board
Adaptation plans	• Adaptation lead in place 2023 • Work with LAs on linking all Adaptation/Resilience and Climate Risk plans 2023/24	Kit Connick, Chief Officer Partnerships & Strategy, ICB	Green Plan Programme Board, ICB Audit & Risk Committee
Joint engagement and messaging across the system	• Shared system brand 2023 • Events programme 2024	Laura Halstead, Assistant Director of Communications & Engagement, ICB	LA and NHS Comms Group

Estates and facilities

Objectives:

- Reduce the reliance on fossil fuels for energy and heating
- Increase on site renewables
- Invest in energy saving measures
- Plan for a lower carbon footprint estate

By 2028 we aspire to a more flexible estate, that delivers services as locally as possible (considering both patient and staff demands), working with system partners to maximise space utilisation. An estate that has reduced its carbon footprint and with a worked plan for how it will manage its energy usage and demands for the next decade. Progress with our new build hospitals to be to the highest standards in terms of use of sustainable materials and design.

Deliverable	Milestone & timeline	Lead/SRO	Oversight group/s
Work towards decarbonisation of existing estate	• Identified timed and resourced plan for secondary care estate 2023 and primary care 2024	Kit Connick, Chief Officer Partnerships & Strategy, ICB Alison Manton	System Estates Group

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Deliverable	Milestone & timeline	Lead/SRO	Oversight group/s
		David Parke, Assistant Director Sustainability & Infrastructure, South, ICB Lucy Macleod, Assistant Director Sustainability & Infrastructure, North, ICB	
Align ICS Estates strategy with deliverables in the NHS Estates Net Zero Carbon Delivery Plan	• 2023	Kit Connick, Chief Officer Partnerships & Strategy, ICB Alison Manton, CPFT David Parke, Assistant Director Sustainability & Infrastructure, South, ICB Lucy Macleod, Assistant Director Sustainability & Infrastructure, North, ICB	System Estates Group
Embed circular economy and good design into all new capital developments	• Direct input into new build programmes 2023	Kit Connick, Chief Officer Partnerships & Strategy, ICB Alison Manton, CPFT David Parke, Assistant Director Sustainability & Infrastructure, South, ICB Lucy Macleod, Assistant Director Sustainability & Infrastructure, North, ICB	System Estates Group
Business case for local heat networks for key NHS service hubs	• Established if business case feasible by 2023. If so, developed approach by 2024.	Alison Manton, CPFT Eithne George	System Estates Group

Research and innovation

Objectives:

- Support research and adoption of green technologies and innovations

By 2028 we will have built a strong and ongoing relationship with the local research community in support of the programmes we are working on. We will be in a strong position to trial and spread new innovations, when the opportunities arise, at a range of sites and organisations, across the system.

Deliverable	Milestone & timeline	Lead/SRO	Oversight group/s
Collaborative projects and academic partnerships	• Build connections 2023. • Identify and agree research areas ongoing	Fiona O'Mahony, Programme Manager ICS Sustainability, ICB Phillipa Brice, Head of R&D, ICB	Green Plan Programme Board
Initiatives and partnerships to embed new technologies and innovations	• Explore plastics project 2023-2026	Fiona O'Mahony, Programme Manager ICS Sustainability, ICB Stella Cockerill	Green Plan Programme Board

Active and sustainable travel

Objectives:

- To reduce emissions and improve air quality

By 2028 we will have helped the workforce and patient community reduce reliance on single person fossil fuelled car journeys and consider alternatives as a default position. As a health service, we will have a predominantly electrified fleet supported by charging infrastructure across the system.

Deliverable	Milestone & timeline	Lead/SRO	Oversight group/s
Non fossil fuel fleet & EV infrastructure	• 50% fleet EV 2023 • Infrastructure plan 2023/24	Trust Sustainability Leads/Fiona O'Mahony, Programme Manager ICS Sustainability, ICB	Transport subgroup Green Plan Programme Board
Active travel policies and promotion	• Trusts and ICB 2024 • GP programme 2024/25 • Combined approach with LAs and public transport providers 2028	Trust Sustainability Leads/ Fiona O'Mahony, Programme Manager ICS Sustainability, ICB	Transport subgroup Green Plan Programme Board
Air quality improvement in targeted areas	• Pilot at one NHS site 2023 • Combined strategy with LA 2025 • Adopt Clean Air Hospital Framework at key hospital sites 2028	Trust Sustainability Leads/Fiona O'Mahony, Programme Manager ICS Sustainability, ICB	Transport subgroup Green Plan Programme Board

Supply Chain

Objectives:

- Drive emission reductions throughout the supply chain with a circular economy approach to procurement and waste

By 2028 we will have developed a robust method of evaluating the 10% social value in tenders and a system of monitoring its delivery, working with procurement and contract management staff and the supplier network. We will have a standardised approach to the market across local authority and NHS contractors giving a clear message to the market and suppliers what expectations are for delivery in this system with regards to carbon plans and reducing the impact on the environment. We will have reduced waste through a move to reusable products, better repurposing and recycling and improved waste separation.

Deliverable	Milestone & timeline	Lead/SRO	Oversight group/s
Develop the skills and guidance for procurement staff and contract managers to evaluate and monitor carbon reduction in all contracts	• 100% of Trusts/ICB 10% weighting in all new NHS contracts 2023 • Identify suppliers requiring a carbon reduction plan (contracts over £5m) 2024	Ian Hooper, Director of Procurement and Supply chain, ICB	C&P system Procurement group

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Deliverable	Milestone & timeline	Lead/SRO	Oversight group/s
Develop a sustainable procurement policy for the ICS and seek a joint approach with LAs in social value assessments	• policy statement 2023/24 • joint approach agreed 2024/25	Ian Hooper, Director of Procurement and Supply chain, ICB	C&P system Procurement group
Reduced waste, working with partners to move to reusable products and separate waste more effectively improving recycling and repurposing.	• Identified system wide projects and processes as part of overall Waste Strategy by 2025	Trust Sustainability Leads	Green Plan Programme Board
Explore the potential for a plastics recycling plant locally	• By 2027	Stella Cockerill/Fiona O'Mahony, Programme Manager ICS Sustainability, ICB	Green Plan Programme Board, EoE NHS Regional Team, Combined Authority project group

Medicines, Digital and Sustainable Pathways

Objectives:

- Optimise the use of medicines to deliver health and environmental benefits.
- Integrate sustainability goals in care delivery through QI, pathway, and service redesign.

By 2028 we will have achieved:

A change in the management of asthmatic and COPD patients reducing SABA over-reliance and the prescribing of green inhalers as the default position.

Use of desflurane only in exceptional circumstances and leak-proof systems for administration of NO2 in hospital settings.

A project for waste reduction in medicines working with primary and secondary care prescribers and pharmacists.

A clinician led programme of pathway reviews, to reduce carbon footprint.

Deliverable	Milestone & timeline	Lead/SRO	**Oversight group/s** Chief Pharmacist Leadership Group
Reduce the use and waste of medical gases to as little as practically possible	• By 2025	Sati Ubhi, Chief Pharmacist, ICB	Chief Pharmacist Leadership Group
Maximise prescribing of low carbon inhalers and improve return of used units	• Reduction in use of high carbon inhalers to those with clinical need only by 2026	Sati Ubhi, Chief Pharmacist, ICB	Chief Pharmacist Leadership Group

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Deliverable	Milestone & timeline	Lead/SRO	**Oversight group/s** Chief Pharmacist Leadership Group
	• Programme to collect and recycle used high carbon inhalers by 2024		
Optimise use of medicines: appropriate prescribing, regular meds reviews; greener prescribing	• Review process of providing green prescribing advice looking at data and progress to date in 2024 • Consider including green prescribing indicators within 2024 prescribing incentive scheme	Sati Ubhi, Chief Pharmacist, ICB	Chief Pharmacist Leadership Group
Maximise digital care opportunities across all care settings	• Secondary care outpatients 25% target for phone or video 2023	Nicci Briggs, Chief Finance Officer, ICB Louis Kamfer, Deputy Chief Executive Officer & Managing Director of Strategic Commissioning,	Green Plan Programme Board
Specialty / pathway specific initiatives	• Draft project brief to consider best practice and scope for targeted intervention 2025/26 • Heart Failure Pathway reviewed by 2024	Fiona O'Mahony, Programme Manager ICS Sustainability, ICB Richard Hales	Green Plan Programme Board

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Procurement & Supply Chain

Overview

The procurement & supply chain function is a key enabler in delivery of our system's health and well-being and integrated care strategy (HWICS) and the shared vision around the four priorities:

- to improve outcomes in population health and healthcare;
- tackle inequalities in outcomes, experience and access;
- enhance productivity and value for money;
- help the NHS support broader social and economic development.

The NHS procurement & supply chain functions within the system have an established collaborative workstream in operation, which will be expanded to include ICB and local authority as appropriate in 2023. The NHS functions currently operate as separate entities, with CUH and NWAFT being in-house, and RPH/CCS/CPFT being outsourced to NHS Shared Business Services.

The ICS' Procurement & Supply Chain Workstream (P&SCW) is working together in collaboration with focus on the following three priorities:

1. To develop and deliver best practice procurement & supply chain services to the partners within the ICS.
2. To develop and deliver collaborative approaches to the procurement of common goods and services where of added benefit (financially/operationally) to the system.
3. To support and enable the objectives of other workstreams within the system where procurement and supply requirements are a deliverable.

Our vision is to achieve best value in the goods and services we procure and enable in support of patient care delivery within the health economy. Whilst aiming to achieve all possible on an 'as-is' basis under a collaborative model, consideration will be given to added value that could be achieved with investment in a fully aligned shared service procurement and supply chain operation for the ICS in the future.

Delivery plans:

Best practice procurement & supply chain services

Objectives:

PTOM 34 Steps

We have adopted the model as developed and set by NHSE's Procurement Target Operating Model (PTOM) for ICS procurement & supply chain identified as the '34 Steps'.

The model includes three stages of maturity:

- Stage 1 – 'Get Informed'
- Stage 2 – 'Get Connected'
- Stage 3 – 'Get Optimised'
- Stage 4 – 'Get Scale'

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The 34 activities (or steps) under each stage of maturity above are rated using the following classifications:

- 'Not Started'
- 'Some Progress'
- 'Great Progress'
- 'Complete'

During 23/24, we will continue to use this model to develop our functions in accordance with Stages 1 and 2 of maturity against the following categories:

- Data, Technology & Performance
    - Identify and agree key data sets.
    - Agree to systematic procurement & commercial information sharing
    - Contribute to and use spend analytic tools to gather information on spend opportunities.

- People & Skills –
    - Identify and allocate category leads where possible.
    - Perform a skills development analysis to allow appropriate sharing of collective resources to support ICS initiatives.

- Policies & Procedures
    - Convene a regular ICS Procurement forum including all Heads of Procurement across working within approved Terms of Reference.
    - Formalise the collaboration via the creation of an MOU, documenting an agreed common line of collaborative action.

- Strategic Procurement
    - Develop a shared ICS level procurement risk register.
    - Undertake a full review of ICS 3rd party spend at project level incorporate any relevant procurement risks and are escalated where appropriate. Continue to review ICS third party spend.
    - Identify "tier 1" shared suppliers and align on a common approach to their management.

- Strategy & Organisation
    - Gain ICS-level executive sponsorship for ICS based Procurement.
    - Nominate an ICS Procurement lead to drive change.
    - Develop a shared ICS procurement strategy

- Supply Chain Management
    - Nominate an ICS Supply Chain Lead to drive visibility.
    - Undertake analysis of supply chain management processes across the ICS.

- Sustainability
    - Nominate an ICS lead for sustainable supply chain and procurement to incorporate sustainability into foundations of ICS delivery.

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- Adopt national approach for incorporating environmental and social value in procurements at ICS level.
- Directly address any nationally communicated Planning Guidance and National Commitments published in this space.
- Confirmed support to central government's approach on eliminating modern slavery in government supply chains.
- Mandatory Government training to be undertaken by all applicable staff.

CCIAF Standards

In accordance with the initiative being driven through NHSE’s Central Commercial Function (CCF), we will continue our development by adopting the national Commercial Continuous Improvement Assessment Framework (CCIAF).

The CCIAF is designed to help drive continuous improvement in commercial practices across the Government Commercial Function (GCF) and wider public sector by enabling organisations to benchmark their commercial operations against good practice.

The maturity ratings for the standards are as follows:

- ‘In-development’
- ‘Good’
- ‘Better’
- ‘Best’

The list below sets out the structure of the framework with the eight themes (within which there are 27 practice areas):

- Theme 1. Commercial strategy, planning and governance.
- Theme 2. Commercial capability and resourcing.
- Theme 3. Commercial lifecycle define: pre-procurement.
- Theme 4. Commercial lifecycle procure: procurement and contracting
- Theme 5. Commercial lifecycle manage: contract management
- Theme 6. Managing categories, markets, supplier relationships, and working with partners
- Theme 7. Commercial systems, reporting and information
- Theme 8. Policy

Deliverable/Milestone	Timeline	SRO	Oversight group/s
PTOM 34 Steps: Stages 1 and 2 of maturity ‘Complete’	Dec 24	Ian Hooper, Director of Procurement and Supply Chain	TBC
CCIAF Standards: Achieve maturity rating of ‘Good’	Apr 24	Ian Hooper, Director of Procurement and Supply Chain	TBC

The NHS partners’ procurement teams within the system will continue to operate on a collaborative basis in the short term as a minimum. An assessment will be conducted to establish the potential benefits (operational and financial) and added value that could be gained through investment in a formal shared procurement & supply chain function (to include requirements for the ICB).

Collaborative approaches to the procurement of common goods & services

Objectives:

We will continue to build on areas of success to date to identify and progress opportunities to drive efficiencies for the system through the collaborative procurement of common goods and services.

- Using the already implemented platforms (Adviseinc and NHS Digital's Spend Comparison Service) to load AP/PO data to compare costs and prices across categories and identify validated opportunities.
- Using the already implemented Atamis Procurement Pipeline Management platform to capture workplans and identify potential areas for collaboration.
- Identify and progress opportunities for the collaborative procurement of common clinical and non-clinical goods where of benefit operationally and/or financially. In 23/24, focus is on the portfolio of medical/surgical product categories procured via NHS Supply Chain. Scoping activity is on-going, with some examples of projects identified as follows:
    - Procedure packs
    - Orthopaedics
    - Ward based consumables
- Identify and progress opportunities for the collaborative procurement of common clinical and non-clinical services where of benefit operationally and/or financially. Scoping activity is on-going, with some examples of projects identified/progressed as follows:
    - Non-emergency patient transport
    - Laundry & linen
    - Electronic Patient Record (EPR)
    - Interpretation & translation

Deliverable/Milestone	Timeline	SRO	Oversight group/s
Implement and utilise spend data platforms	Complete	Ian Hooper, Director of Procurement and Supply Chain	TBC
Implement and utilise procurement pipeline management platform	Complete	Ian Hooper, Director of Procurement and Supply Chain	TBC
Progress opportunities for the collaborative procurement of common clinical and non-clinical goods	Ongoing	Ian Hooper, Director of Procurement and Supply Chain	TBC
Progress opportunities for the collaborative procurement of common clinical and non-clinical services	Ongoing	Ian Hooper, Director of Procurement and Supply Chain	TBC

Support and enable the objectives of other workstreams

Objectives:

- Provide professional advice, guidance and support to other workstreams where procurement and supply chain requirements are a deliverable, with active engagement on 'Digital' and 'Green' so far.

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- In 23/24, much of the support available from the P&SC workstream will be focussed on Sustainability and the ICS' Green Plan; a key objective within the relevant workstream's delivery plan being to: "Drive emission reductions throughout the supply chain with a circular economy approach to procurement and waste"

  Extract from the Green JFP Delivery Plan: "By 2028 we will have developed a robust method of evaluating the 10% social value in tenders and a system of monitoring its delivery; working with procurement and contract management staff and the supplier network. We will have a standardised approach to the market across local authority and NHS contractors giving a clear message to the market and suppliers what expectations are for delivery in this system with regards to carbon plans and reducing the impact on the environment. We will have reduced waste through a move to reusable products, better repurposing and recycling and improved waste separation."

Deliverable/Milestone	Timeline	Lead/SRO	Oversight group/s
Develop the skills and guidance for procurement staff and contract managers to evaluate and monitor carbon reduction in all contracts	• 100% of Trusts/ICB 10% weighting in all new NHS contracts 2023 • Identify suppliers requiring a carbon reduction plan (contracts over £5m) 2024	Ian Hooper, Director of Procurement and Supply Chain	C&P system Procurement group
Develop a sustainable procurement policy for the ICS and seek a joint approach with LAs in social value assessments	• policy statement 2023/24 • joint approach agreed 2024/25	Ian Hooper, Director of Procurement and Supply Chain	C&P system Procurement group
Reduced waste, working with partners to move to reusable products and separate waste more effectively improving recycling and repurposing.	• Identified system wide projects and processes as part of overall Waste Strategy by 2025	Trust Sustainability Leads	Green Plan Programme Board
Explored the potential for plastics recycling plant locally	• By 2027	Fiona O'Mahoney, Programme Manager ICS Sustainability	Green Plan Programme Board, EOE NHS Regional Team, Combined Authority Project Group

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Organisational Development, Culture and Leadership

Overview

We need to make a transformative cultural shift from individual organisational and silo working to a systems and partnership approach where we are collectively responsible, and we help each other to improve the health and wellbeing of our residents.

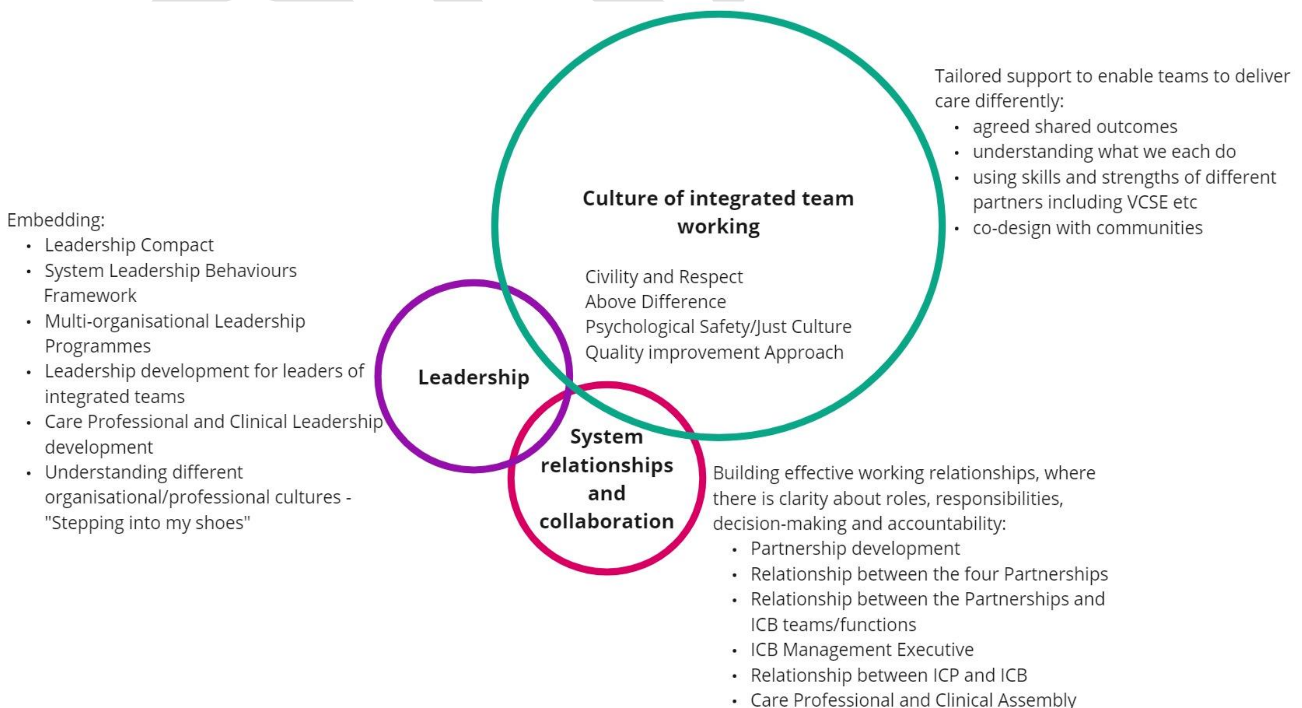
Organisational Development (OD) will be an important enabler to achieve this. As the system matures, different parts of the ICS architecture will be developing at different rates and so their OD focus will be dependent on where they are in their development cycle. For this reason, it is anticipated that all parts of the ICS (ICB, Partnerships, Provider and stakeholder organisations) will have their own OD plan, tailored to meet their specific needs; this will mean that OD interventions identified in individual plans may be similar, but the timing of when these are implemented will be different.

To oversee the delivery of OD across the ICS, we have established a System Development Forum that reports to the ICB Management Executive and as with the OD framework that we have produced, this board will:

- Identify areas where OD support is required.
- Highlight areas where we can work together as a system to design and deliver OD interventions that can be applied to the whole system.
- Ensure that there is a level of consistency in approach, where it is applicable.
- Share learning and good practice.

Objectives: Our OD priorities

Our OD interventions will be prioritised, to focus on the areas of culture of integrated team working, leadership development and system relationships/collaborative working.



Measuring the impact of OD interventions

The overarching measure of success for OD interventions is that we are working differently together and are delivering this Joint Forward Plan.

For each of the interventions/deliverables that we have identified, we have identified a number of outcomes we anticipate they will help achieve. To help us evaluate impact, we will use a range of measures that will draw on the Kirkpatrick model of evaluation (reaction, learning, behaviour and results).

Delivery Plans

The design and delivery of some of the priority OD interventions will be supported by the Leadership and Culture subgroup of the People Board. The work plans for the other subgroups of the People Board will also play a significant part in helping us achieve the culture shift we require (see workforce section).

The ICB is also leading on the design and delivery of several system wide programmes including a Just and Learning Culture, Continuous Quality Improvement, Civility and Respect, Above Difference and Delivering Environmentally Sustainable Healthcare. These programmes have been noted in here because they are key to the culture shift that we need and are therefore important OD interventions in themselves. Detail of delivery will be managed through other parts of the JFP delivery plan.

Given the complexity, uncertainty, and ambiguity that we are operating in, it is important that our delivery of OD is dynamic and is both proactive and responsive. A range of key OD interventions have been identified but these may evolve over time as the needs of the ICS and its constituent parts develop. We will also embed an ethos of continuous improvement in how we identify, design and deliver our OD interventions.

System Relationships and Collaborative Working

OD interventions will support the achievement of the following outcomes:

- The ICB and the 4 Partnerships have high-performing and effective Boards/Executive Groups, so that they are effectively undertaking their strategic role in the ICS and delivering the Health and Wellbeing/integrated care strategy and priorities, with:
  - Clarity about vision, scope, objectives, and TOR
  - Clarity about roles, responsibilities, and accountability
  - Collective decision-making
  - Collaborative working values, culture, and behaviours
  - System leadership and working across organisational boundaries.
- Boards are operating effectively as a partnership/collaborative and are delivering its priorities and delegated functions.
- There is a strong working relationship between the ICB, and the Partnership Boards and they are working as equal partners in the ICS; there is a culture of mutual support and accountability.
- Executive Groups are working effectively leading the delivery of the ICB/Partnership delivery plans to achieve the ICS priorities.
- ICB and Partnership Board Members, ICB and Partnership Executives and Senior Leaders are operating as compassionate and inclusive, system leaders, operating as representatives of the ICB/Partnership and their communities and not the needs of their own organisations.

- There is a strong cross-working and collaborative relationship between all Partnership Boards and the MOU that sets out roles, priorities and expectations between the Partnerships is working effectively; there is a culture of mutual support and accountability.
- There is a strong cross-working and collaborative relationship between the ICB teams and the Partnerships teams and the MOU that sets out roles and expectations between the Partnerships and the ICB teams is working effectively.
- The Care Professional and Clinical Assembly is operating effectively and the ICB and Partnerships are informed by strong and representative care and clinical advice and decision-making; Care Professionals and Clinical leaders are operating as representatives of their professions and not only their organisation.

Deliverable/Intervention/Milestones	Timeline	SRO	Oversight Group
ICB Board Development **Partnership Board Development** **ICB Management Executive Development** **Partnership Management Executive Development** For all the above, key milestones will be: • Initiate suite of activities/interventions • Review and evaluate impact of interventions. • Refine and deliver interventions. • Embed changes. • Ongoing development as required.	2023-2024 and ongoing	Jan Thomas, CEO, ICB Partnership Managing Directors	System Development Forum
Partnership collaborative working programme. Key milestones will be: • Initiate suite of activities/interventions • Review and evaluate impact of interventions. • Refine and deliver interventions. • Embed changes. • Ongoing development as required.	2023-2024 and ongoing	Partnership Managing Directors	System Development Forum
ICB teams and Partnership teams collaborative working programme Key milestones will be: • Initiate suite of activities/interventions • Review and evaluate impact of interventions. • Refine and deliver interventions. • Embed changes. • Ongoing development as required.	2023-2024 focus and ongoing as required	Claudia Iton, Chief People Officer, ICB Partnership Managing Directors	System Development Forum

Leadership Development

OD interventions will support the achievement of the following outcomes:

- Leaders are demonstrating the ICS leadership behaviours and values in all their interactions.
- Leaders are demonstrating system leadership behaviours.
- ICB and Partnerships are informed by strong and representative care and clinical advice and decision-making.
- Groups of leaders from different organisations are working collaboratively on specific transformation projects – working as system leaders and not as individuals representing their own organisational needs.
- Managers of integrated teams – whether these are cross-organisational or cross-professional – have the skills to lead and manage teams with different organisational and professional cultures that are focused on providing care for specific patient populations.
- Members of the integrated teams are working together as "one team," and feel empowered by their leaders to identify improvements and make changes needed.
- Differences are valued and diversity is embraced. Senior Leaders are:
  - Culturally intelligent
  - Value driven leaders who transform cultures
  - Intentionally inclusive leaders
  - EDI change catalysts
- There is a developing culture of inclusivity across the ICS where behaviours and attitudes embrace and enhance diversity.
- Leaders from different organisations can collaborate effectively as they have an understanding and appreciation of other professions, roles, services, and organisations.
- Multi-professional working is effective.

Deliverable/Intervention/Milestones	Timeline	SRO	Oversight Group
Embed **Leadership Compact and System Leadership Behaviour Framework** and Self-assessment and **Environmental sustainability** in all organisational and system leadership programmes	2023-2024 and then ongoing	Claudia Iton, Chief People Officer, ICB	Leadership and Culture subgroup
Bespoke Leading Beyond Boundaries Leadership Programme Key milestones: • Commission programme • Identify teams to participate and deliver. • Evaluate • Embed	2023-2024 and then ongoing	Chair, Leadership and Culture Subgroup	Leadership and Culture subgroup
Bespoke leadership programme for leaders of integrated teams Key milestones:	2024-2025 and then ongoing	Chair, Leadership and Culture Subgroup	Leadership and Culture subgroup

Deliverable/Intervention/Milestones	Timeline	SRO	Oversight Group
• Design and Commission programme • Deliver • Evaluate • Embed			
Care Professional and Clinical Leadership Programme(s) Key milestones: • Design and Commission programme • Deliver • Evaluate • Embed	2023-2024 and then ongoing	Carol Anderson, Chief Nurse, ICB Other SROs to be confirmed	Leadership and Culture subgroup
Above Difference Programme Key milestones: • Deliver • Evaluate • Embed	2023-2024	Chair EDI subgroup	EDI subgroup
Stepping in your shoes - programme	2023-2025	Chair, Leadership and Culture Subgroup	Leadership and Culture subgroup

Culture of Integrated Team Working

OD interventions will support the achievement of the following outcomes:

- Service transformations and improvement priorities identified in this JFP are successful as teams involved are working in a collaborative and integrated way, working across organisational and professional boundaries.
- Members of the integrated teams are working effectively together as "one team."
- People can demonstrate that they are empowered to do the right thing for residents, are able to say yes, feel included in decisions and are thriving in their roles.
- There is a culture that enables residents to contribute to and coproduce the development of services.
- People have the skills to support:
  - Collaborative working
  - Working across organisational boundaries
  - Managing both technical and adaptive challenges that complex, system working involves.
- There is a culture of compassion and inclusivity, and people are treating each other with compassion, civility, and respect.
- There is a developing culture of continuous improvement where people feel empowered to identify and make improvements to meet the care and health needs of residents.

Deliverable/Intervention/Milestones	Timeline	SRO	Oversight Group
Tailored interventions to support cross organisational teams who are working on transformation projects. Key milestone: • Partnerships identify cross organisational teams. • Undertake diagnostic. • Design interventions. • Deliver interventions. • Evaluate impact of interventions	2023-2024 and ongoing	Partnership Managing Directors	System Development Forum
Civility and Respect (and embedding Leadership Compact) Key milestones: • Design and deliver Conference (week) • Evaluate and capture any key actions for follow up	2023-2024	Carol Anderson, Chief Nurse, ICB	Leadership and Culture Subgroup
Culture review Key milestones: • Commission and undertake culture survey. • Identify key actions for improvement (Partnership, Organisational and team level) • Undertake follow up survey, 1 year later.	2023-2024	Carol Anderson, Chief Nurse, ICB	Leadership and Culture Subgroup
Just and Learning Culture Programme Key milestones: • Deliver Human Factor Training • Deliver Just Culture Training • Patient Safety Framework	2023-2024	Carol Anderson, Chief Nurse, ICB	TBC
Continuous quality improvement programme Cross-reference to CQI delivery section and Environmentally Sustainable Healthcare			

Continuous Quality Improvement Strategy

Overview

Cambridgeshire and Peterborough has developed its first system-wide Continuous Quality Improvement Strategy, which sets out our aspirations and approach for improving quality of care through a more consistent and joined-up approach to continuous improvement across all our health and care sectors. The implementation of this strategy will be overseen by the system wide Quality Improvement & Transformation Group using a clear delivery plan.

The strategy outlines the ICB's responsibility to support all our partners across care and health to adopt a QI/CI culture that is lived and owned from the Board and our most senior leaders to those delivering care or support services to individuals. The strategy does not mandate a specific tool/methodology to be used but focuses on the elements of a good QI culture. The aim is to support and empower our teams to deliver improvements to achieve high quality care, share and celebrate learning.

Our CQI Strategy

Our CQI Strategy has six elements, which are the building blocks to achieve improvement maturity.

- Strategic intent for CQI: Supporting leaders to explore and identify CQI opportunities linked to strategic and annual planning.
- Patients and staff at the heart of delivering our CQI Plan: Sharpen the focus on delivering high-quality patient care and aligning improvement activity to outcomes and patient and staff experience.
- Leadership for CQI: To provide clear leadership for delivering quality improvements. Senior leaders, who model appropriate improvement focussed leadership behaviours and visible hands-on-approach.
- Building CQI skills at all levels: To demonstrate an accessible approach to providing CQI to every level of the System.
- Building CQI engagement all levels: We want to be more inclusive in our approaches, ensuring everyone has a voice in making improvements.
- System view for CQI: Working as one team to deliver improvements that we can share and celebrate.

There will be an Annual CQI Delivery Plan produced as part of our business planning process and linked (for NHS partners) to the NHS operational and planning guidance. Through the planning processes, we will be able to identify existing, new, and emerging themes for improvement aligned to the System's vision, ambitions, improvement programmes, strategic and tactical priorities.

Action	Timeline	Oversight Group/s	SRO
Agree all provider and wider system CQI projects against each of the 6 elements	June 2023	QITG	Gary Howsam
23/24 CQI Project progress and outcomes delivery report	April 2024	QITG	Gary Howsam
CQI Strategy Review 24/25	Sept 2024	QITG	Gary Howsam

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Measuring Success

Success factors for the System and our Partners organisations will include:

- Staff who are passionate about the delivery of improving high-quality care for our patients.
- Staff and leaders at all levels across all organisations that are engaged, confident and committed to making improvements.
- Collaborative ways of working with patients and key stakeholders in driving system improvements.
- Clear links from local improvements to our vision, ambitions, and priorities.
- Integrated improvement planning with our strategic, business and performance management planning.
- Sharing opportunities with peers and internal networks to build skills and knowledge transfer.

Our success will be measured by all the improvements we make. We will ensure that we can collate the benefits from everyone who undertakes an improvement activity, to include it in our CQI Knowledge Hub and play back all the improvements we have made. This will also provide a wealth of learning to be shared.

We will provide regular updates on the progress of delivery of this Strategy and the supporting actions to demonstrate that we are achieving improved patient care through our Governance mechanisms.

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