Cambridge and Peterborough ICS

Development Plan

31st March 2021

NHS England and NHS Improvement

Contents

Executive summary

Cambridge and Peterborough have recently been successful in our application for ICS designation. Whilst this is a significant step in our journey as a system, we also acknowledge that there is much work to be done to make the C&P ICS a success.

Our ambition is to launch our ICS in shadow form during Q4 of 2021/22 before the new ICS establishment is formalised in Q1 2022/23. There are a significant number of development steps that we need to take in order to meet this ambition, which have been grouped thematically to include:

- System roles and capabilities
- System leadership and accountability
- System oversight and quality improvement
- Leadership and people development
- Financial framework and use of resources
- System and digital transformation

Each of these themes requires a significant amount of engagement, design work, implementation work, and throughout we must ensure that we continue to deliver business as usual activities and meet our operational and strategic targets.

As a result, we have developed the following plan to set out how we aim to deliver the spectrum of activities required to ensure we progress towards our future vision whilst meeting the current needs of our local population and stakeholders.

Whilst developing the plan, we have ensured it will deliver against five key development areas highlighted to us by the regional team including: finance, regional clinical leadership, workforce, provider collaboration and Local Authority engagement.

System overview

C&P System overview (COA and Maturity Matrix)

Maturity Matrix Self Assessment

Executive Leads	NHSEI Lead
Roland Sinker and Jan Thomas	Alison Clarke

	Domains	Previous score (Aug 2019)	Current score (Nov 2020)	Change	Response level
1	System Leadership, Partnerships and Change Capability	Developing	Maturing	↑	System Partnership Board
2	System Architecture and Strong Financial Management and Planning	Emerging	Developing	↑	Financial Planning and Performance Group
3	Integrated Care Models	Developing	Maturing	↑	System Leaders
4	Track Record of Delivery	Developing	Developing	↔	System Delivery and Transformation Group
5	Coherent and Defined Population	Developing	Thriving	↑	System Partnership Board

Maturity matrix:

C&P are progressing towards maturing whilst it is acknowledged that there is still much progress to be made to become a thriving ICS

Consistent ICS Operating Arrangements Self assessment

	Consistent ICS Operating Arrangements	Delivery progress
1	System capabilities for transformation and performance	
2	Streamlined commissioning arrangements	
3	Shared care record	
4	Leadership	
5	Governance	
6	System plans	
7	Capital and estates plans	

KEY		
	Achieved ICS consistent operating arrangement	G
	Plan delivering significant milestones	GA
	Plan agreed and on track	A
	Plan to be developed in next quarter	AR
	Discussion ongoing	R

Delivery progress:

C&P are delivering against an existing plan for most areas, but still require a finalised plan to be developed for two areas

Progress to date in the C&P system

Cambridge and Peterborough have recently been successful in our application for ICS designation.

Being designated as an ICS is now the start of a new chapter in our system's journey. We have already made progress and in the areas where, a year ago, we were still 'developing', we are now beginning to 'mature'. We have worked together to develop robust plans to meet all of the operating requirements. Our goal, for 2021/22 and beyond, is to 'thrive' as a health and care system.

Over the past five years we have made significant changes to the way that we work together, as partner organisations, to integrate our health and care services and improve the health outcomes of our population.

- We have spent time with the people in our communities learning more about what matters to them and through this approach broadened our **understanding of our population**. We have started to bring together health and care to meet the needs of our citizens closer to home. E.g. "The Big Conversation"
- We have integrated many of our services to improve patient experience, reduce delays in handover, and to ensure patients do not fall through cracks. We have created new partnerships and progressed plans for wider public service reform. E.g Children's Board, MH and LD system wide governance
- We have spent time and effort understanding our **financial position** and developing plans to reduce our historic deficit. E.g. The Drivers of Deficit, McKinsey
- Our Public Service Board has begun to reform our public services, bringing together general practice, community, third sector and wider public services through a **Think Communities approach** which empowers local citizens to shape services.
- Our **acute services in the North and South** have worked closely together to reduce health inequalities across the patch, including staff working across organisations (e.g. joint CUH-NWAFT posts for radiology and neurophysiology, RPH respiratory consultants embedded in NWAFT), mutual aid (e.g. pathology), and new ways of delivering care (e.g. Hub for vascular services, Rapid NSTEMI pathway)
- For mental health, we are a **national pilot site for transformation of community mental health services**, which brings together primary care, mental health specialist provision, voluntary sector and social care, linking with the Think Communities programme.
- We have focused on the OD development of our system leaders, strengthening the oversight of our system as it develops

Our first **Sustainability and Transformation Plan** (STP) (2016) set out changes we wanted to make to health services in Cambridgeshire and Peterborough. It described our core clinical framework: health and care services provided closer to people's homes and excellence in hospital and specialist services. The plan also set out how we would change the way we worked together as partner organisations across the system to implement this strategy.

Our **Long Term Plan** (LTP) (2019) built on the progress made and described our ambition to do more to bring together health care across our system, in our places and through our neighbourhoods as we develop to become an Integrated Care System (ICS).

System-identified challenges prior to the development plan

	Description of challenge	Request for support
Tackling our historic financial deficit	• We had a historic deficit of £165m in 18/19 • We developed a pre-Covid plan to deliver **£400m in** efficiencies through a shared transformation programme over the next 4 years but our system will have difficulty in meeting previously set control totals as a result of the pandemic	• Work with other systems and regional/national team to understand national financial architecture going forward and implications for C&P • Work with regional/national team to best use support available under the future NHS Oversight Framework and engage around SOF status • Work with the national specialised/finance team around the **allocation of specialised budgets** on a population basis
Progressing our strategic commissioner and ICP development	• We have agreed to 2 ICPs and development of a strategic commissioner as part of our ICS • We have not yet reached an agreement about how to devolve resources	• Request for information on **strategic commissioning and ICPs** and understanding the **delegated functions from region** • Support in our journey to establishing strategic commissioning and ICPs within our system, including development of plans to delegate operational commissioning to ICPs and cross-fertilisation between ICPs
Progressing provider collaborative development	• Our providers already work across the region in alliances (e.g. cancer) but will need to establish ICPs • We have agreed in principle to provider collaboratives for MH and a Children's but will need to develop the latter with LAs	• Monthly catch-ups with Regional ICS Development team at NHSEI and the National Team to track progress and identify support needs • Clarity on **National expectations** and examples from other systems • Support to develop children's collaborative between NHS and LAs
Progressing place development	• We will need to better understand expectations for place leaders and definition of "place". Place is defined in our ICS application as North and South, with acknowledgement that there are some boundary issues that need to be resolved in line with national timescales • We will need to progress development of our PCNs into INs and agree an ICP operating model considerate of neighborhoods	• Monthly catch-ups with Regional ICS Development team at NHSEI and the National Team to track progress and identify support needs • Support on development of places, including **roles and responsibilities of places** within the system
Developing our PHM approach	• We need to agree what we can standardize across the system and what is best handled at system, place, and neighborhood • We want to adopt best PHM practice from other systems	• Understand where other areas have seen improvement using PHM and how we can replicate • Identify tools other areas are using with positive outcomes

NHSE/I provided us with 5 key recommendations as an outcome of our successful designation approval

1. **Finance** the system needs to demonstrate that they have a deliverable system plan to reduce the underlying deficit, building on the improved financial governance that they have demonstrated over the last year. This needs to incorporate longer term strategic solutions to enable the step changes needed to allow the system to live within its means.
2. **The opportunity of regional clinical leadership** – the system has yet to fully demonstrate the advantage of the unique assets it has at its disposal, including the Cambridge Biomedical Campus, which is envied across the country. The system needs to find new ways to bring out the advantages of having it on their doorstep for the local population.
3. **Workforce** – the system needs to progress on workforce and will need additional capacity and leadership at a system level to fulfil the required ambition on this.
4. **Provider collaboration** – particularly in relation to achieving health equality. The system has not been able to progress sustained acute to acute provider collaboration and this will now need to be addressed rapidly.
5. **Local Authority engagement** will need to be a key feature in future plans and approach.

System Development Progression Tool

(INSERT FEED: currently in development with national team)

C&P development plan

The C&P approach to planning ICS development

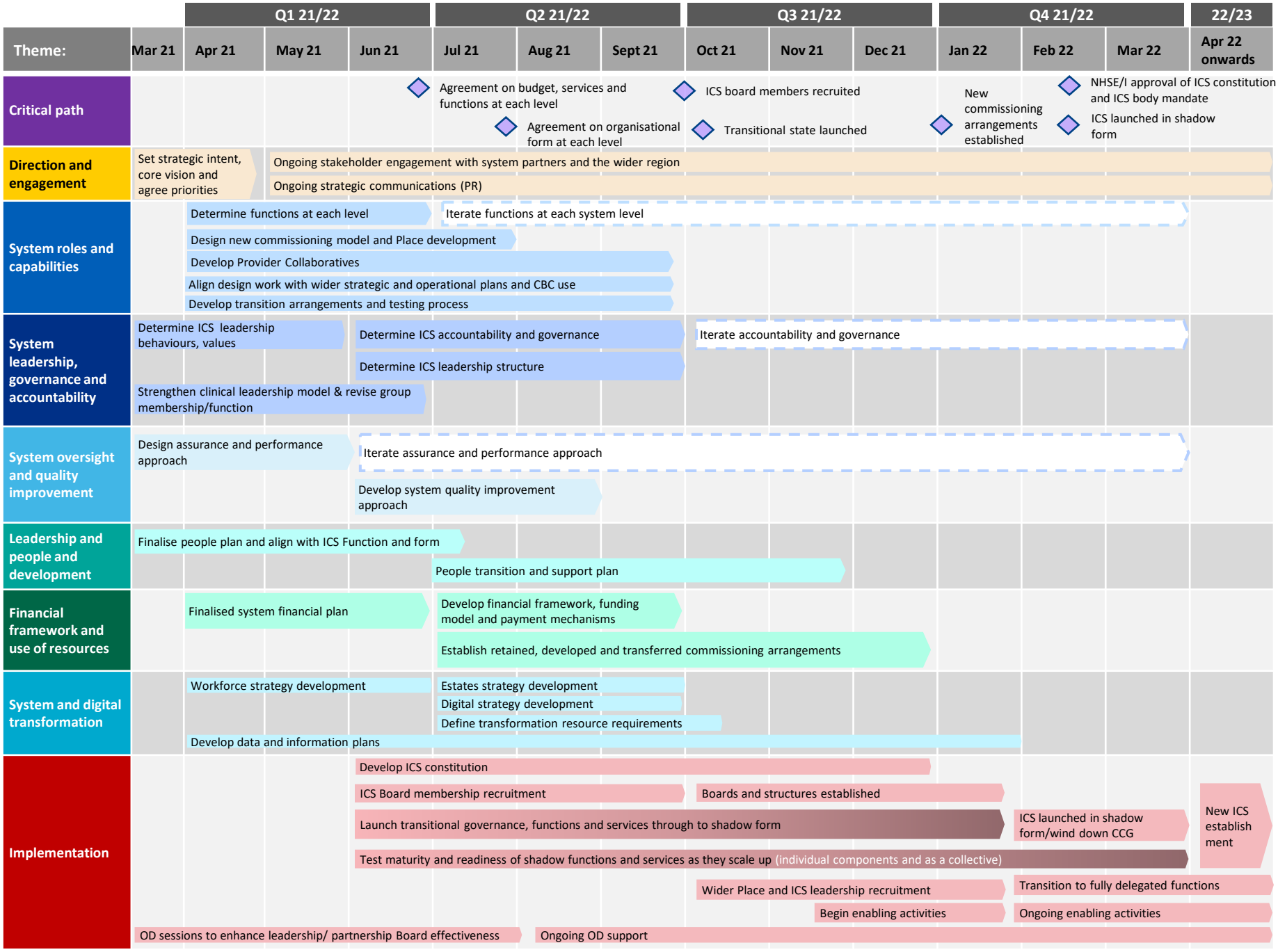
NHSE have provided 6 themes that we wish to align our planning to

- Theme 1 – System and digital transformation
- Theme 2 – Leadership and people and development
- Theme 3 – System oversight and quality improvement
- Theme 4 – System roles and capabilities
- Theme 5 – Financial framework and use of resources
- Theme 6 – System leadership, governance and accountability

In order to create the most cohesive plan possible, we have ordered these themes to reflect functions and roles followed by underpinning finance and enablers

- Direction and engagement
- Theme 4 – System roles and capabilities
- Theme 6 – System leadership, governance and accountability
- Theme 3 – System oversight and quality improvement
- Theme 2 – Leadership and people and development
- Theme 5 – Financial framework and use of resources
- Theme 1 – System and digital transformation
- Implementation

C&P development plan on a page



Workplan (1/5)

Theme:	Workstream	Owner	Existing C&P timeline (actions and deadlines
Direction and engagement	**Direction & Purpose**	KC	• Align on core purpose, vision and refresh system strategy **Q1 21/22** • Establishment of an effective, streamlined architecture to oversee whole system strategy - **Q1 21/22**
	Engagement	KC/LH	• Develop robust ongoing engagement mechanisms with partners, communities and the public – **June 2021**
System roles and capabilities	**Functions and services (incl. strategic commissioning development)**	KC/JT	• Bring together health, care and the wider public sector services at place and provider collaborative level to define the functions and services they can feasibly be delegated – **June 2021** • Confirm delegated functions at each level - **June 2021** • Complete Strategic Commissioning Framework – **June 2021** • Engage partners on implications and mitigate/revise delegations by **September 2021** • Facilitate work between emerging ICPs and CCG to create plans for implementing new commissioning model **Q4 21/22** • Delegate operational commissioning, including devolvement of full capitated budget responsibility and resources, to ICPs - **Q2 22/23**
	Provider collaboratives and places	KC/EL KC/EL KC/EL FH/EL	**Aligned Place and provider collaborative development:** • Undertake Place engagement and development process – **July 2021** • Undertake provider collaborative engagement and development process – **July 2021** • Develop priorities and set out development expectations for collaboratives and places – **July 2021** • Achieve alignment with system strategy – **July 2021** • Agree framework for system, place and locality and set out development roadmap – **July 2021** • Align Place, provider collaborative and strategic commissioner development – **August 2021** • Set out infrastructure and management arrangements – **August 2021** • Align design work with plans to enhance the benefits of the CBC for the whole system – **August 2021** **Placed based working:** • Establish robust processes for engaging Local Authorities and PCNs - **June 2021/22** • Establish robust processes for engaging broader partners - **June 2021/22** • Determine resources to support development work – **August 2021** **Provider collaboratives:** • Define the approach to engaging primary care and social care – **June 2021/22** • Develop MH model and rollout by end of **Q2 2021/22** • Develop CYP model and rollout by end of **Q2 2021/22** • Engage with Local Authority and children's health providers to develop integrated care model – **Q2 21/22** • System-wide Children and Young People collaborative to operate in shadow form by **September 2021** • Develop Acute and specialist care collaborative plans for NHS providers – **Q2 2021/22** **Population Health Management:** • Finalise PHM strategy - **Q1 2021/22** • Work with emerging ICPs, provider collaboratives and Places to understand PHM needs, define approach to PHM and build local capabilities by **Q4 21/22**
	Transitional arrangements	KC/JT	• Design longer term arrangements to move towards shadow form – **June 2021** • Develop testing process to measure function/ service maturity and maturity of ICS as a whole – **June 2021** • Agree winding down process for CCGs – **Q2 21/22**

Workplan (2/5)

Theme:	Workstream	Owner	Existing C&P timeline (actions and deadlines
System leadership, governance and accountability	**Leadership structure**	System Leaders	• Agree leadership structure at each level of ICS – **Q2 21/22** • Agree accountability for delivery of delegated functions – **Q2 21/22** • Review existing distributed leadership model to align with the future governance structures roadmap – **Q2 21/22** • Chair and CEO (Designates) appointed – **Q2 21/22** • Confirm Place Based Leadership – **Q3 21/22** • Confirm other senior leadership roles – **Q3 21/22** • Appoint System Planning and Strategy role (**complete**), appoint ICP Senior Locality Directors, transition several CCG roles to system roles, and ensure the full ICS leadership team is in place – **Q3 21/22** • Further develop dedicated leadership and change capacity at all levels, particularly ICPs and places by **Q2 22/23**
	Governance	KC/JT	• Determine how the provider collaboratives will link with place and how the strategic commissioner and collaboratives relate, with clear lines of accountability required – **Q2 21/22** • Agree clear delineation between ICS and Strategic commissioner – **Q2 21/22** • Develop inclusive governance arrangements with partners – **Q2 21/22** • Set out local leadership and governance – **Q2 2021/22** • Determine relationship with HWBs – **Q2 21/22** • Identify what sub-committees and groups are needed, develop terms of reference (roles and remit) agree memberships - **Q2 21/22**
	Transitional ICS governance	KC	• Development Plan engagement and ratification with System Leaders group, Partnership Board and other system colleagues to formally sign it off through the current system governance processes – **June 2021** • Design transitional governance through to shadow form – **Q2 2021/22** • Implement governance roadmap to achieve end state governance model by **Feb 2022 – Q2 2021/22**
	Clinical leadership	AG	• Strengthen clinical leadership model and revise clinical group membership and function by **Q1 2021/22** • Refresh the clinical strategy to ensure it maximises the unique assets C&P ICS has at its disposal, including the Cambridge Biomedical Campus - **Q1 2021/22** • 2 Senior Locality Directors, with experience in commissioning, place-based care and service provision, will be appointed to lead each of the ICPs. These posts will be advertised and appointed to by **end of Q4 20/21**
	Assurance	KC/SG/ REGION	• Establish assurance principles, including the establishment of SOAG – by **Q2 2021/22** • Determine outcomes, KPIs and metrics for assurance and ensure alignment with national KPIs - **Q2 2021/22** • Agree independent non-executive input requirements – **Q2 21/22** • Strengthen relationship with NHSE/I and co-create assurance model by **Q2 2021/22** • Augment governance arrangements and capabilities for assurance and be fully prepared for it to be devolved from region by **Q2 22/23**
	OD	TD/KC	• Continue OD development of SL, and widen rollout to other system leadership roles – **Q2 21/22**

Workplan (3/5)

Theme:	Workstream	Owner	Existing C&P timeline (actions and deadlines)
System oversight and quality improvement	**Target operating model**	LK/KC	• Draft operating plan by **early March 2021** • Final operating plan during **April 2021** • Transitional ICS structure – **Q2 2021/22**
	Quality and performance	SG/KC/ REGION	• Confirm system-level quality oversight - **Q1 2021/22** • ICS assurance and performance process in shadow form – **Q1 2021/22** • Launch new performance and monitoring once new operating model is in place **Q2 2021/22** • Develop quality improvement dashboard that shows performance against quality indicators at the system, place, and individual organisation level – **Q3 2021/22**
	Risk management	KC/SF	• Implement Strategic Risk Oversight process to support transition – **Q1 2021/22** • Quality risk management system implemented by **Q3 2021/22**
Leadership and people and development	**Single People Plan**	TD/LM	• **2021/22 People Plan is in place**
	Place based partnership	KC/EL	• Further develop dedicated leadership and change capacity at all levels, particularly ICPs, places and clinical leadership - **Q2 2022/23**
	Supporting people to transition	KC/JT	• CCG Transition Plan in place by **Q1 2021/22** • Wider system transition plan in place, supported by OD in place by **Q2 2021/22**

Workplan (4/5)

Theme:	Workstream	Owner	Existing C&P timeline (actions and deadlines
Financial framework and use of resources	**System wide financial framework including capital**	LK	• Complete reforecasting by **end of March 2021** • Develop a system capital investment plan for 21/22 and beyond, building on the system first approach in 20/21 and finalise strategies for estates, primary care, and clinical - **Ongoing, to be completed by March 2021** • Agree financial settlement by **April 2021** • Complete financial plan early **Q1 2021/22**
	Collective risk management structures and mechanisms	KC/SF	• Implement Strategic Risk Oversight process to support transition – **Q1 2021/22** • Quality risk management system implemented by **Q3 2021/22**
	Allocation approach to places, collaboratives and organisations	KC/EL	**ICP enabled integrated care delivery:** • Phase 1 (**Q1-Q4 21/22**): We will agree outcome-based contracts for initial cohorts, for which ICPs will take responsibility of planning and delivering services using a ring-fenced budget based on current spend and population needs (such as health inequalities) • Phase 2 (**Q1-Q2 22/23**) will see ICPs take responsibility for additional cohorts • Phase 3 (**Q3 22/23 onward**) will see ICPs take responsibility for all cohorts/priorities in their locality and full budget responsibility
	Financial resource management and mechanisms	LK	• Define the contracts between levels of the system and within each level • Budget pooling • Risk share/ gain share All to be defined by the target operating plan **(to be completed April 2021)**

Workplan (5/5)

Theme:	Workstream	Owner	Existing C&P timeline (actions and deadlines
System and digital transformation	**Covid response and recovery**	JT/GW	• Finalise system recovery plan – **Q1 2021/22** • Drive cooperative working after COVID peak to focus on elective recovery – **Q1 2021/22** • Implement Covid-19 Restoration and Recovery plans, including reduction of elective backlogs – **Q2 2021/22**
	Digital	SP/AR	• Refresh digital strategy – **Q2 2021/22** • Phase 1 of our Integrated health and care record solution, which will deliver the Shared Care Record MVS 1.0 by **Sept 2021** • Implementation planning – **Q3 2021/22**
	Data and information	SG/REGION/ LK/KC	• Establish common KPIs and agree reporting structure – **Q2 2021/22** • Create and implement new information sharing agreements between providers and between providers and the CCG - **Q4 2021/22** • Collection and sharing within system and to regulators – **Q4 2021/22**
	Estates	AM/KC/JT	• Capital plan agreed (aligned with operational plan) – **Q1 2021/22** • Update estates strategy – **September 2021** • Implementation planning – **Q3 2021/22**
	Workforce	TD/LM	• Workforce strategic plan developed – **Q1 2021/22** • SWIM report and action plan – **July 2021** • Implementation planning – **Q3 2021/22**
	Integrated care delivery (incl. Clinical strategy)	AG	• Refresh the clinical strategy to ensure it maximises the unique assets C&P ICS has at its disposal – **Q2 2021/22** • Explore the benefits of the CBC for the whole system in planning and strategy development – **Q2 2021/22** • Implementation planning – **Q3 2021/22**
	Transformation approach	KC/JT	• Understand our resources and how we should best distribute them across priorities, including PMO, analytical, and clinical resources - **Q2 21/22**

We have ensured that each concern raised by the region and by C&P internally has been addressed by the plan

Workstream	C&P identified priorities:			NHSEI identified priorities			Shared priorities	
	Progressing ICP and strategic commissioner development	Progressing Place development	Progressing PHM development	Clinical leadership	Workforce	Local Authority engagement	Finance	Provider collaborative development
System direction and engagement	✓	✓	✓	✓	✓	✓	✓	✓
Functions and services	✓	✓				✓		
Provider collaboratives and places		✓	✓			✓		✓
Transitional arrangements	✓	✓	✓	✓	✓	✓	✓	✓
Leadership structure	✓	✓	✓	✓	✓	✓		✓
Governance	✓	✓	✓	✓	✓	✓	✓	✓
Transitional ICS governance				✓		✓		
Clinical leadership	✓	✓	✓	✓				✓
Assurance								
OD		✓		✓	✓	✓		✓
Target operating model	✓	✓	✓		✓		✓	
Quality and performance	✓	✓	✓			✓	✓	✓
Risk management	✓					✓	✓	
Single People Plan	✓	✓			✓			✓
Place based partnership		✓		✓	✓	✓		✓
Supporting people to transition					✓			

How we are addressing regional feedback

	Regional team feedback	How we are addressing it
Finance	The system needs to demonstrate that they have a deliverable system plan to reduce the underlying deficit, building on the improved financial governance that they have demonstrated over the last year. This needs to incorporate longer term strategic solutions to enable the step changes needed to allow the system to live within its means.	• We are in the process of developing a deliverable system wide financial plan including capital, due to be finalised by the end of Q1 2021 • Our financial plan, combined with our plan to develop robust resource management mechanisms for the ICS will enable us to live within our means
Workforce	The system needs to progress on workforce and will need additional capacity and leadership at a system level to fulfil the required ambition on this.	• We have a clearly articulated plan for ensuring the necessary leadership is in place at each level of the ICS • We have also described our approach to developing an ambitious workforce plan, underpinned by the SWIM model and system-owned leadership for this
Provider collaboration	Particularly in relation to achieving health equality. The system has not been able to progress sustained acute to acute provider collaboration and this will now need to be addressed rapidly.	• We have outlined in detail our approach to ensuring the effective development of Provider Collaboratives as well as how these collaboratives interact with Place and ICPs
Local Authority engagement	Local Authority engagement will need to be a key feature in future plans and approach.	• In the design of both Place and Provider Collaboratives, the engagement strategy, as well as in the development of strategic commissioning, we have made it a priority action to have a robust process of engagement with Local Authorities as well as other system partners
The opportunity for regional clinical leadership	The system needs to find new ways to bring out the advantages of having it on their doorstep for the local population.	• We have listed the actions we plan to take to establish an enhanced clinical leadership for our future ICS • We are also planning to refresh our clinical strategy to ensure it maximises the unique assets C&P ICS has at its disposal • We will build into our planning and clinical strategy the ways we can maximise the benefits of the CBC for the whole system

Asks of the region

There are several areas of support we have identified where the region can assist us in our ICS development and implementation efforts:

Oversight and regulation steer	• What is required by the ICS to support the 'system by default' approach to oversight and regulation • Flexible regional support that encourages a localised approach and takes into account local issues
Cross system relationship building	• Opportunities to form collaborative development approaches with neighbouring ICSs in the region • Support to develop provider collaboratives across system boundaries
System development support	• Commissioning arrangements • Options on placed based partnership arrangements • Models for place leadership • Options for ICS's to delegate resources to Places • Guidance on leadership development and appointment in places • Models for at scale provider collaborative arrangements • Guidance on provider collaborative governance options
ICS Boards	• Support to agree expected role of both the ICS Board and the Health and Care Partnership • Discussion on how best to maintain appropriate and diverse representation on the ICS Board • Discussion on the membership of the Partnership Board and its relation to the ICS Board and with local HWBs to take account of JSNAs
Statutory ICS establishment support	• ICS constitution guidance • The ICS NHS body establishment process • The process for making board appointments • Resources on the transfer of CCG functions
Delegation of regional functions support	• Guidance on the process for transferring regional commissioning functions including: - Primary care - Dentistry - Specialised services • Support to understand finance and resource delegation framework to the ICS

Statements of risk

We have defined our development risks under several key themes that we will continue to develop in detail. Whilst we have summarised the themes and some of the key associated risks in the below, our board assurance framework contains more detail regarding specific risks we have identified.

Maintaining a population/ patient focus	• Maintaining a patient centric perspective during ICS development • A systemised approach to planning and implementation of Population Health Management • Ensuring a meaningful impact on health inequalities
Effective Governance	• Ensuring boards have clarity on all key areas across all ICS levels • Ensuring there is leadership in the right places, supported by robust and streamlined governance
ICS Capabilities, capacity and infrastructure	• Ensuring the balanced distribution of access to health and care resources across the patch • Achieving effective ground-up, local place-based infrastructure • Alignment of geographical units at each level of the ICS • Effectively managing the safe transition from planning to operational delivery • Delivering core quality, operation and financial performance
Managing relationships	• Resolving tensions resulting from changes • Nurturing new relationships and enabling mature conversations across all ICS levels • Investing enough time in looking outside our system and adopting a continuous cycle of learning
Collaboration	• Developing effective ways of working with and between district, county and city councils, primary care and acute partners to benefit our system
Workforce	• Engagement with the clinical workforce and bringing them to the core of system decision-making • Retaining the senior commissioning team and the inter-dependencies of system role recruitment • Approach to Chair and system leadership team turnover – retaining stability of the ICS • Developing a workforce plan that is truly ambitious and addresses the system needs
Opportunities for change	• How best to push the transformation agenda and harness the opportunities that have arisen as a result of the pandemic • How to secure the investment to maintain the changes in clinical practice we have made during pandemic
Regional ways of working	• How to work with NHSE/I to develop an approach to support that is flexible and accounts for our local issues

Financial framework and use of resources

We have a clear understanding of what activities we need to be working on to develop and deliver our financial plans. We intend to begin work on delivering these asks during the first quarter of 2021/22:

- **0.28% efficiency** applicable to **NHS contracts** and **deducted** from the system allocations
- System **allocations** are based on actuals **as at Q3 20/21**
- **No adjustment** has been made **for inflation or distribution of growth** funding. Systems will need to plan collaboratively to determine the distribution of these resources
- Plans will implicitly assume the continuation of the Q3 distribution of system funding (comprising allocations, system top-up, COVID-19 allocation and SDF) to organisations and will **not include the distribution of new funding**
- CCGs are advised to set aside a **contingency of up to 0.5%** of their allocation to support risks to expenditure that may not otherwise be mitigated, **if not** done so then this requires **regional assurance**
- **System operational plans have to demonstrate a balanced position** and if currently a deficit against Q3 then the plan needs to demonstrate improvement to achieve breakeven against the Q3 levels (links to the ICS authorisation letter expectation re finance for C&P). It is possible to rebalance organisational funding across the system
- Organisational plans must reflect and even month by month distribution (although there will be a very short window to make **net neutral** adjustments before M2 reporting)
- Separate **Mental Health template** and operational plan template which **MUST align**
- **Mental Health Investment Standard (MHIS)** is still **required** to be met
- Systems will also be able to **access elective recovery funding** in addition to the H1 funding which shall also **include IS funding**
- **Contracts are not required** between NHS organisations in H1
- They have published the consultation on **payment system reform** which is looking likely to be **aimed at implementation in H2**
- **PPE** will continue to be **procured nationally**, funded and overseen by DHSC until at **least the end of June 2021**
- There is a **system development fund (SDF)** for a range of priority areas listed
- **Cash** for the month will be **paid in month** (e.g. April in April)

Gap analysis

C&P overview

Current SDPT themes	
1 – system and digital transformation *2 – leadership and people development* *3 – system oversight and quality improvement*	*4 – system roles and capabilities* *5 – financial framework and use of resources* *6- system leadership, governance and accountability*

Source documents
COA *ICS Designation*

Consistent Operating Arrangements		Summary of Current Arrangements	Development areas	SDPT theme
System Functions	***System capabilities in place to perform the dual roles of an ICS, to co-ordinate system transformation activity and collectively manage system performance, clearly defined at system, place and neighbourhood.***	• Appointed System Planning and Strategy role • ICS development plan outlines approach to growing system capabilities in terms of roles and strategic and operational planning • ICS is working on an 18 month development programme with an aim to implementing a governance roadmap by April 2022 • In place – capability for transformation and performance, shared care record, leadership and governance • In development – Streamlined commissioning, Systems plans and system level capital and estates plans • Commitment from systems partners to address financial deficit with system finance lead in place	• Detailed system planning to provide the framework to support the execution of duel ICS roles • Clear targets for system, place and neighbourhood • Buy in and alignment around the system vision and purpose • An engaged and informed clinical group • Patient engagement plan to maintain the voice of their population through their ICS journey. • Approach to data collection, KPIs, reporting structures to enable ICS duel roles to be executed effectively • Develop approach to shared learning across the system and more widely to ensure best practice is embedded • Maximise the benefits of the CBC for the whole system	1
	Streamlined commissioning arrangements, including one CCG per system with clearly defined commissioning functions at system, place and neighbourhood.	• One CCG already in place • Operational commissioning to happen at place level by February 2021 • Working with region on performance management • System is committed to financial profile agreed by the CCG	• Detailed system design work to determine what commissioning functions will sit at what level • A robust commissioning framework • ICP and place-based partnership development approach • CCG wind down approach • Agreement with NHSE/I about how commissioning functions should be delegated to the ICS • Timescales around transfer of primary care delegation	4

C&P overview

Current SDPT themes	
1 – system and digital transformation *2 – leadership and people development* *3 – system oversight and quality improvement*	*4 – system roles and capabilities* *5 – financial framework and use of resources* *6- system leadership, governance and accountability*

Source documents
COA *ICS Designation*

Consistent Operating Arrangements		Summary of Current Arrangements	Development areas	SDPT Theme
System Planning	***Shared Care Records***	• Digital and innovation programme planned • Shared Care Record is well progressed with forward planning in place to bring it to fruition	• Agree and clarify budget (not yet identified for phase 2 onwards – what are the mitigations in place for this and the plans would benefit from more detail and timescales) • Person centred workstreams that have engaged patients • How good practice and knowledge will be shared	1
	System plans that reflect the key local recovery, performance and delivery challenges and that incorporate a development plan for the system.	• System recovery planning under way • System operational plan in development • Development plan drafted • Delivered plans include: Outpatient transformation, Health inequalities / prevention, Integrating out of hospital care, Redesign care pathways, Urgent and emergency care, Covid-19, workforce, mental health and learning disabilities, children's and young people's services • We are working on refreshing our LTP in light of the pandemic and are in the process of developing operational plans and a financial framework, which we will submit to the region by Q1 21/22 • Planning in place for confirming ICP functions with a plan to engage partners • The principle of subsidiarity applied to system plans, starting with the patient • Draft Alliance plans	• Detailed planning to identify and address key local challenges • A framework for place based development and provider collaborative development support that acknowledges their varying local issues • Alignment between strategy and operational plans and Place based development plans • Acceleration of cooperative working between providers • Approach to collaborating with external partners • Place based strategy that describes how services integrate to drive the redesign of clinical pathways • Detailed planning of enablers and their implementation at each level of the ICS	1, 3, 6
	Capital and estates plans / significant service level changes agreed at a system level	• Capital investment plan for 21/22 is based on ‘system first’ approach • Estates plan due to be revised by Q2 2021/22 • Prioritising patient safety is top of the themes which is a good indicator of the driver for an estates strategy	• Revised estates strategy to describe in detail the estates requirements and capital plans of system transformation and how capital will be managed • A development plan for place based integration and the estates and capital requirements • Align capital and estate plans with wider system design efforts	5

C&P overview

Current SDPT themes	
1 – system and digital transformation *2 – leadership and people development* *3 – system oversight and quality improvement*	*4 – system roles and capabilities* *5 – financial framework and use of resources* *6- system leadership, governance and accountability*

Source documents
COA *ICS Designation*

Consistent Operating Arrangements		Summary of Current Arrangements	Development areas	SDPT theme
System Leadership and Governance	***A leadership model for the system, that explicitly includes the following; (a) ICS core leadership team, (b) Place leadership arrangements for each place within the system and (C) Provider collaborative(s) lead arrangements for hospital systems, ambulance services and acute mental health systems.***	• Have a proposed leadership structure at each ICS level • Joint execs, independent chair and ICS partnership board in place • OD development of SL, and a plan to widen rollout to other system leadership roles • Applied lessons learnt on the importance of clinical and managerial ICS leadership, assigning an an exec lead, NED and clinical lead to each workstream/ priority/ enabling function • Over next 12 months alliances will develop into ICPs and appoint two senior locality directors • ICPs are set to be responsible for capitated budgets from April 2022. Place based development to take place over 21/22 incl. leadership • Plan to embed primary care and specialist clinical leadership in the ICS Clinical Group • Plan to refresh the system clinical strategy	• Clear function delegation and associated leadership accountability at each level of the system • Arrangements to support a cohesive transition to ICS form • A transitional leadership structure until April 2022	6
	System-wide governance arrangements to set out clear roles of each organisation and enable a collective model of responsibility, and nimble decision-making between system partners. These arrangements will include a system partnership board that sits in public and should be complemented by a public engagement approach that ensures full transparency of decision-making.	• Roadmap for end state governance structure outlined • A defined governance approach to supporting Covid impact and recovery, and delivery of system priorities • Work to begin on the role of quality group once the operating model is in place • Plan to develop a joint accountability framework for performance, finance, quality and system transformation • Adults Positive Challenge Programme – system wide approach to change • Draft operating plan in development	• Articulate the membership for the interim governance groups and their roles and responsibilities • Governance model to be developed in detail once ICS levels are fully defined • Quality workstream roadmap to be defined • Development of accountability framework • LA engagement to determine how the system can build on local authority leadership at place • Define the public engagement strategy and how will the voice of patient experience be expanded and embedded at all levels of decision making • Strengthen clinical leadership at all levels of the ICS	

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Source documents
ICS Designation Paperwork March 2021 *COA*

'Integrating Care' Themes		*Summary of Current Arrangements*	*Development areas*	*SDPT themes*
Provider Collaboratives	***Provider organisations will play an active and strong leadership role in systems. This will happen in two main ways:*** • ***Within places (for example, between primary, community, local acute, and social care)*** • ***between places at scale where similar types of provider organisation share common goals.***	• Integrated a number of services to improve patient experience, reduce delays in handover, and to ensure patients do not fall through cracks. We have created new partnerships and progressed plans for wider public service reform such as a Children's Board and Mental Health and Learning Disability system wide governance. In April 2020 we rapidly established a Testing Centre in addition to providing a regional surge centre for critical care beds and on-call respiratory rotas for the East of England. COVID has driven new ways of working, such as a pilot for a mental health response car supported by East of England Ambulance Service NHS Trust (EEAST) and CPFT.	• Acute to acute provider collaboration • Collaboration with LAs • Detailed design of provider collaboratives in line with place and strategic commissioning development • Engagement with system partners to establish universally agreed approach	1, 3. 4
Place-based partnerships	***Strong and effective place-based partnerships between sectors. The roles will include:*** • ***Support the development of PCNs*** • ***Simplify, modernise and join up healthcare.*** • ***Coordinate the local contribution to health, social and economic development.***	• A plan has been drafted to develop places in detail • Appointed an Independent Chair and established a Partnership Board and a System Leaders Group. • Responding to COVID, the system is working more cohesively as an integrated system at place – based level. • Two ICPs have been defined as the highest level of placed based working	• Detailed design of place-based working with all relevant partners engaged • Progress the development of our PCNs into INs and agree an ICP operating model considerate of neighborhoods • Local Authority engagement plan • Alignment with system operational and strategic plans to ensure they deliver what is required • Clinical leadership	1, 3, 4, 6
Clinical and professional leadership	***ICSs should embed system-wide clinical and professional leadership through their partnership board and other governance arrangements, including primary care network representation. This should include:*** • ***Primary care clinical leadership*** • ***Specialist clinical leadership*** • ***Wider clinical and professional leadership***	• The system have established a distributed leadership model to best utilise their clinical leaders and non-executive directors and are currently appointing to two VSM roles to lead their ICPs at place. They also have clinical directors in post to lead their Primary Care Networks, Established Systems Partnership Board, and System Leaders Group. Work is ongoing to further embed clinical leadership throughout our governance structure in line with our distributed leadership model. There are plans to review this model and align it to emerging ICS thinking • 2 Senior Locality Director roles have been defined, with experience in commissioning, place-based care and service provision, and will be appointed to lead each of the ICPs • Plans to strengthen clinical leadership model and revise clinical group membership and function	• Refresh the clinical strategy to ensure it maximises the unique assets C&P ICS has at its disposal, including the Cambridge Biomedical Campus • A detailed review of the systems clinical leadership model aligned to ICS design work	2, 6

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Source documents
ICS Designation Paper March 2021 *COA*

'Integrating Care' Themes		*Summary of Current Arrangements*	*Development areas*	*SDPT themes*
Governance and accountability	***Good partnership working must be underpinned by mutually-agreed governance arrangements, clear collective decision-making processes and transparent information-sharing. In addition to the COAs systems must define:*** • ***'place' leadership arrangements*** • ***Provider collaborative leadership*** • ***Individual organisational accountability***	• System Partnership Board in place as part of consistent operating model, with agreed ToR and attendance from councillors, VCS and the Police as needed. Two legislative options in place for review in June 2021. In the meantime, an agreed transitional governance structure is in place. This structure reflects a distributed leadership model. • A system risk register is now in place and is being further developed into a Board Assurance Framework. This incorporates all risks from all partners across Health and Care	• Robust engagement with system partners • Define in detail local leadership and governance required • Determine relationship with HWBs • Identify what sub-committees and groups are needed, develop terms of reference (roles and remit) agree memberships • Establish data collection and reporting mechanisms • A joint accountability framework for performance, finance, quality and system transformation. These frameworks are in progress and have been delayed due to operational pressures from the COVID pandemic. • Community engagement	6
Financial framework	***We will increasingly organise the finances of the NHS at ICS level and put allocative decisions in the hands of local leaders. Future financial frameworks will include:*** • ***Delegation of significant budgets to place level*** • ***Move away from activity based payments***	• Continuing development of an ICS financial framework – this is supported by Financial Planning and Performance Group composed of system FDs • Drivers of deficit review has provided recommendations to prioritise for delivery • Specific work underway for estates and capital with significant investment in future planning work	• Six-month workplan in place which includes reestablishment of system financial baseline, through the following areas; - To identify recurrent financial position for end of year - Have clearer understanding of 21/22 projections - Make decisions on recurrent/non-recurrent investments in line with need for investment to underpin transformation delivery against need to maintain resources - Support development of operational plans which will incorporate system priorities • A robust system plan to deliver sustainability to the system	5
Data and digital	***To fulfil the potential of digital and data to improve system working and drive patient outcomes that systems will need .***	• Cross system digital plan in place with some areas accelerated due to the pandemic • Integrated Health and Care project is moving at pace to deliver a solution in line with ShCR MVS 1.0 - delivery of phase 1 of shared care record due by Sept 2021	• System is working to overcome the challenges in the implementation of their digital strategy including funding, upskilling of staff and digital inclusion • System's Digital Enabling Group (DEG) will revisit current digital strategy as some areas of activity are now further advanced than planned. Updated policies and standards are in development	1, 4

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Source documents
ICS Designation Paper March 2021 *COA*

'Integrating Care' Themes		*Summary of Current Arrangements*	*Development areas*	*SDPT themes*
Regulation and oversight	***Regulation best supports our ambitions where it enables systems and the organisations within them to make change happen. This means a focus on how effective local arrangements are at implementing better pathways, maximising use of collective capacity and resources, and acting in partnership to achieve joint financial and performance standards. Systems will need to plan to embed strong participation in ICS and provider collaborative arrangements.***	• System has been working increasingly with Regional NHSEI colleagues which has facilitated a collaborative and embedded assurance approach • The current transitional governance structure provides evidence of a robust approach to oversight of the system priorities • NHSEI colleagues attend System Partnership Board and other key system groups supporting regulation and oversight • An ICS Development Lead is in place and is working alongside the system to support transformation • List of system requests to NHSE/I has been drafted	• Align system reporting to regional and national KPIs • Codesign approach with regional colleagues to agree devolved responsibilities to C&P system and the approach to the transition	3
Commissioning Changes	***Commissioning functions need to focus on how effective local arrangements are at implementing better pathways, maximising use of collective capacity & resources, and acting in partnership to achieve joint financial and performance standards by ensuring a single system wide approach to strategic commissioning.***	• Streamlining of plans is underway, evidenced by the sole CCG for system becoming the ICS strategic commissioner over next 18 months with CCG roles becoming system roles • For the interim period, the CCG will maintain a partially integrated commissioner function to develop the commissioning strategy whilst assisting with the delivery of CCG functions • Agreement for CCG resources to be aligned to ICPs and ICS Strategic Commissioner	• Detailed system designed work to determine what functions will sit at what level • Develop commissioning frame work • Joint/aligned commissioning with LA and others will be further developed where it adds value to patients and residents	4

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ICS Designation Paper March 2021 *COA*

'Integrating Care' Themes		*Summary of Current Arrangements*	*Development areas*	*SDPT themes*
Population Health Management	***The system has well-established population health management capability at place and system level.***	• We have Primary and Secondary Care data linked in Eclipse Vista (SUS data flow of secondary care data).Working with Prescribing Services Ltd who run Eclipse to automate the flows of information from primary care into the system. This will reduce the burden on primary care and ensure up to date information is available. • Primary Care data flowing into DSCRO was underway at the start of the pandemic. We are now discussing actioning locally vs GDPPR & GPDfPR flows that NHS Digital are implementing March 2021, respectively. We do have Secondary Care, MH and Community data in our DSCRO with a consistent pseudonym. • A system wide analytical network with CCG analysts supporting North and South alliances as well as a joint post with the Local Authority for PHM. Plans to get more analysts aligned to the work from our acute and community providers who also have PHM on their digital roadmap. • Eclipse Vista rolled out across the CCG in July 2020. Combines Primary Care and Acute data to enable risk stratification and patient segmentation. The tool has various modules e.g. Diabetes & Covid. It also has a over 1000 pathways available e.g. COPD, Angina. In this early stage of deployment, they have activated the top 25 pathways used across the Eclipse Vista customer base. • We work with Local Authority partners and they have an open source data platform called Cambridge Insight. This allows them to view housing, deprivation, and other datasets in relation to our populations to build onto the NHS data already available. • PHM leadership aligned to Integrated Health & Care Record (IHCR) programme so is owned at STP leader level. It is also a key element of the CCG work programme and has been taken through Governing Body (pre-Covid-19) in terms of key deliverables. PHM has also been discussed with PCN Clinical Leads	• Develop and devolve responsibility • Agree what to standardise and what is best done at system, place and neighbourhood. • Undertake PHE skills audit mapping • Work with ICPs to understand PHM needs and build local capabilities • Sign off PHM strategy • Understand funding and capacity requirements for PHM shared care record • Further roll out Eclipse Vista for end of life care and cancer screening • Use insight from 22 week PHM programme to understand needs • Adopt best practice PHM from other systems • Complete Phase 1 IHCR Sept 21 • Secure additional funding for further phases by Q3 Phase 3 PHM March2022	• 1, 4

Next steps

Next steps

Performance and Accountability

- Agree milestones in the Development Plan with the regional team, setting out expectations quarter-by-quarter
- Assign owners to each ICS development workstream with appropriate support
- Determine quarterly checkpoint process on ICS development and agree how this will be effectively monitored
- Set out functions that will be delivered at each level in the ICS (place; provider collaborative; ICS-wide; inter-ICS)
- Seek support in areas such as financial framework development and set out intended delegations
- Begin design of the system assurance process

Workforce and Development

- Work with other ICSs within the region to agree areas for joint development and support (including support from C&P ICS with respect to the role of the biomedical campus)
- Use our local People Plan to inform the approach to movement of resources and engagement with staff
- Mobilise the work to begin the refresh of our clinical leadership model and revision of the clinical leadership group

Governance & Leadership

- Discuss, update and sign off Development Plan with System leaders, Partnership Board and other system colleagues
- Set out options for the makeup and responsibilities of the ICS Board and Health and Care Partnership
- Create leadership roles and responsibilities for the ICS, places and provider collaboratives and determine local preferred options to take forward
- Begin development of a draft C&P ICS constitution

Engagement

- Continue the process of engagement with system partners
- Develop an ICS Engagement Strategy that sets out a clear approach to the way in which we will work with our communities and all system partners

Strategic planning

- Begin our clinical strategy refresh to ensure it maximises the unique assets C&P ICS has at its disposal
- Build into our planning and clinical strategy the ways we can maximise the benefits of the CBC for the whole system