Fit for the Future
Working together to keep people well

Cambridgeshire and Peterborough Health and Care System Sustainability and Transformation Plan

October 2016

Contents

Executive summary

I. In Cambridgeshire and Peterborough, the NHS, general practice, and local government have come together to develop a five-year *Sustainability and Transformation Plan* (STP) to improve the health and care of our local population and bring the system back into financial balance. The development of this plan has been led by chief executives, frontline staff, and patients.

II. Cambridgeshire and Peterborough is one of the most, if not *the* most, challenged health systems in England, making it essential that we work together to develop robust plans for long-term change. We have in place strong, visible, collective leadership and a well-resourced programme of work to address:

- the health and care needs of our rapidly growing, increasingly elderly population
- significant health inequalities, including the health and wellbeing challenges of diverse ethnic communities
- workforce shortages including recruitment and retention in general practice
- quality shortcomings, with two thirds of our acute hospitals under severe operational pressure and one in special measures
- inconsistent operational performance, particularly in meeting the four hour Accident and Emergency (A&E) standards
- financial challenges which exceed those of any other STP footprint on a per capita basis, such that by 2021 we expect our collective NHS deficit, if we do nothing, to be £504m.

III. To enable us to deliver the best care we can, we have agreed a unifying ambition for health and care in Cambridgeshire and Peterborough. This is to develop the beneficial behaviours of an 'Accountable Care Organisation' (ACO) by acting as one system, jointly accountable for improving our population's health and wellbeing, outcomes, and experience, within a defined financial envelope.

IV. Through engagement with our staff, patients, carers, and partners, we have identified four priorities for change and developed a 10-point plan to deliver these priorities:

Priorities for change	10-point plan
At home is best	1. People powered health and wellbeing 2. Neighbourhood care hubs
Safe and effective hospital care, when needed	3. Responsive urgent and expert emergency care 4. Systematic and standardised care 5. Continued world-famous research and services
We're only sustainable together	6. Partnership working
Supported delivery	7. A culture of learning as a system 8. Workforce: growing our own 9. Using our land and buildings better 10. Using technology to modernise health

V. Some of our solutions are common across the NHS. Other aspects are specific to our local system:

- **Improving outcomes for older people:** While the Older People's and Adult Community Services (OPACS) outcomes based contract and joint venture may not have lasted, we still believe in the UnitingCare Partnership (UCP) care model's components: building social capital, integrated neighbourhood teams, and a community-based rapid response to deteriorating patients. We are progressing the delivery of these components as part of our STP programme but with a widened scope that includes all adults and has primary and social care as partners in delivery.

- **Care networks:** Our approach is to move knowledge and not patients wherever possible and appropriate. Our acute clinicians are beginning to agree how to work as operational networks of care, sharing protocols for referrals, using best practice to determine treatment, building workforce resilience through an enhanced career development offer, sharing out-of-hours rotas, and offering flexibility to match staffing requirements with available physical capacity.

- **Chief Executive Officers (CEOs) delivering together:** Our system struggles with delivery of plans. However, we are confident that, through collective leadership at system level, we will implement the changes required. We have put in place robust governance arrangements to drive the work and we have already invested staff and money in a cross-system implementation team. We plan to share financial risk from 2017/18 across the CCG, acute hospitals, and community service providers with the ambition to include the ambulance trust and councils in the system gain and loss share arrangements from 2018/19 onwards. In addition we have recruited an independent chair for our Health and Care Executive (HCE) to ensure that all organisations retain their system-wide focus.

- **Exploiting the benefits of new developments:** The Cambridgeshire and Peterborough population is expected to grow by 1.9% per annum over the next five years. There will be new homes, in Northstowe for example, and new and changed businesses including a new healthy ageing campus in Hinchingbrooke and an expanded Cambridge Biomedical Campus. We are inputting into the development of both to optimise the health of our new residents and employees.

VI. We have determined what needs to happen this year:

- relieving pressure on our emergency service provision, particularly on our A&E departments, now and in the coming winter months
- securing clinical and financial sustainability at Hinchingbrooke Health Care NHS Trust, through a merger with Peterborough and Stamford Hospitals NHS Foundation Trust
- ensuring widespread engagement from our General Practitioners (GPs) and that primary care is sustainable, building on the strong relationships already evident in Peterborough.

We are already working in partnership to address the immediate challenges to our acute A&E performance, the resulting impact on referral to treatment times, and the very high levels of delayed transfers of care within our system. We are systematically working through existing service improvement plans to see if more community and social care capacity needs to be commissioned, and to work out a way to fund this investment as a system as this is crucial to reversing the trend of increasing demand on acute services.

VII. We have worked with our patients and the public to develop our proposals and are confident that local residents will benefit from more care delivered in the home or in primary care. Further, the staffing levels and skill mix we will put in place will take account of health inequalities and differing social contexts.

VIII. Our new, networked approach to care will mean that our staff and GPs will be asked to think of themselves as part of the Cambridgeshire and Peterborough system, not just the organisation that employs them. Although this is a new way of working, we believe that it will benefit staff by presenting new career development opportunities, reducing frustrations arising from poor inter-organisational communications, and that it will make our services more resilient, particularly out-of-hours. The relationship between Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and provider organisations will need to evolve from one that is transactional to one that is outcome focused, strategic, transformative, and equitable.

IX. We have explored all possible opportunities to improve our financial position and return it to balance by 2020/21. Through the use of top-down analysis, and by quantifying local opportunities, we have been able to turn the projected £504m NHS deficit into a small projected NHS surplus of £1.3m. We have refined these numbers by modelling future activity and costs and we have used this information to underpin our plans and to ensure that our solutions have a long-term impact.

X. Finally, we are working to break the cycle of poor delivery that this system has experienced in the past. We have considered when and how the different elements of our STP will be implemented and we have produced a comprehensive delivery plan setting out our governance structure and the projects that will deliver the changes required. We have determined what is needed in terms of behaviour, leadership, and capability to drive change and we have set up a new team, a System Delivery Unit (SDU), made up of individuals with the skills we know we need to oversee and ensure delivery of our STP and to maintain the momentum and discipline that we have built over the past year.

XI. While we can achieve most of our solutions on our own, we will need the support of NHS England (NHSE) and NHS Improvement (NHSI) to:

- secure, each year, our share of the Sustainability and Transformation Fund
- change the way they engage with our system to align with our ACO behaviour ambitions
- provide flexibility around changing the financial incentives embedded in contracts, including a system control total and alternatives to the Quality and Outcomes Framework.

Committed to working together as a system

The development of this plan has been led by chief executives, frontline staff, and patients from across our system. The signatures below demonstrate the commitment of our organisations to work together to deliver the changes described in this plan.
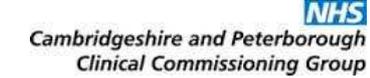
NHS Cambridgeshire and Peterborough Clinical Commissioning Group	Tracy Dowling, Chief Officer	Dr Gary Howsam, Chair
Cambridge University Hospitals **NHS** NHS Foundation Trust	Roland Sinker, Chief Executive	Jane Ramsey, Chair
Cambridgeshire and Peterborough **NHS** Foundation Trust	Aidan Thomas, Chief Executive	Julie Spence, Chair
Cambridgeshire Community Services **NHS** NHS Trust	Matthew Winn, Chief Executive	Nicola Scrivings, Chair
Hinchingbrooke Health Care **NHS** NHS Trust	Lance McCarthy, Chief Executive	Alan Burns, Chair
Papworth Hospital **NHS** NHS Foundation Trust	Claire Tripp, Interim Chief Executive	Prof. John Wallwork, Chair
Peterborough and Stamford Hospitals **NHS** NHS Foundation Trust	Stephen Graves, Chief Executive	Rob Hughes, Chair
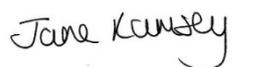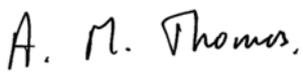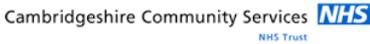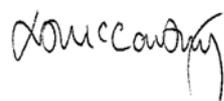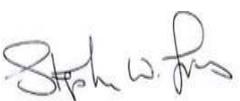
In addition, Cambridgeshire County Council and Peterborough City Council participate in the Sustainability and Transformation Programme with the intention to align their public health and social care services with NHS services in an integrated way for the benefit of local residents. The councils participate in the programme through their officer representatives, recognising that their policy and financial decisions are subject to the constitutional arrangements within their respective authorities. The councils also have a particular requirement to scrutinise proposals for NHS service changes, as elected representatives of their communities, and must ensure the independence and integrity of those arrangements.

Cambridgeshire County Council   PETERBOROUGH CITY COUNCIL

Dr Liz Robin, Director of Public Health

Cambridgeshire and Peterborough Sustainability and Transformation Plan

1. Introduction: what the STP means for us

The NHS, general practice, and local government have come together in Cambridgeshire and Peterborough to develop a five year *Sustainability and Transformation Plan.* This is a unified plan to improve the health and care of our local people and bring the system back into financial balance.

The aim of the Cambridgeshire and Peterborough system in developing this plan has been to consider, from the perspective of patients and local populations, where we can work differently to improve the care we provide. We have collaborated to produce a plan that we feel proud of, one that signals a new steadfast commitment to not just talking about change but to making it happen, and we have come up with a practical, realistic implementation plan to ensure delivery. The challenge we face is daunting, but we are confident that the solutions we have developed match the scale and size of the problems identified.

The development of this plan has been led by chief executives, frontline staff, and patients from across our system. Organisational signatories to the plan are: Cambridgeshire and Peterborough Clinical Commissioning Group (CCG), Cambridge University Hospitals NHS Foundation Trust (CUHFT), Peterborough and Stamford Hospitals NHS Foundation Trust (PSHFT), Hinchingbrooke Health Care NHS Trust (HHCT), Papworth Hospital NHS Foundation Trust (Papworth FT), Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) and Cambridgeshire Community Services NHS Trust (CCS). In addition Cambridgeshire County Council, Peterborough City Council, and representatives from local general practices and the East of England Ambulance Service NHS Trust (EEAST) have actively participated in developing solutions and are key partners for implementation.

2. Our situation: why we need to change the way that we meet local health and care needs

The Cambridgeshire and Peterborough health and care system has much to be proud of. For example, our cancer services are some of the best and most responsive in the country; we are better than many other systems at diagnosing cancer early. Fewer local people die from chronic heart disease compared with the national average and there is a low likelihood of dying early from chronic liver disease. *However, we can and must do better.*

We are struggling today to meet the needs of our 900,000+ local residents. We do not consistently achieve the four hour A&E standard, referral to treatment times, or nationally agreed emergency ambulance response times. We have very high levels of delayed transfers of care and we are frequently unable to discharge patients on time or ensure that the right packages of care are in place when they need to be. Furthermore, too many people within our population use hospitals to provide care that could be delivered in primary care or in the community. There is widespread variation in the health outcomes local people experience, largely due to socioeconomic factors, where increased partnership with local councils and the voluntary sector is needed to address poor health proactively. A further contributor to our operational problems is that our capacity is not aligned to demand; we

have key workforce shortages, especially in general practice, and unused theatre space and closed beds at HHCT. Together with high fixed costs, for example for the Peterborough Private Finance Initiative (PFI), these factors explain our very significant financial deficit. These problems will worsen over the next few years when 100,000+ new homes are built and our population increases and ages.

We face key gaps that will widen if not tackled:

- **Health and wellbeing:** Cambridgeshire and Peterborough is facing increasing demand for local health and care services. We have a rapidly growing and ethnically diverse population that will be 20% higher in 2031 than in 2013. Our elderly population is growing rapidly, increasing the number of people with long-term conditions. We face growing levels of obesity, putting increasing demand on our health services. By 2018, 23.8% of our population will be obese. Obese patients typically have associated diseases requiring significant support, with higher complication rates and longer lengths of stay. Alongside this is an increasing mismatch in expectations. Some people are demanding more and faster access to healthcare but, at the same time, not taking responsibility for their own health and wellbeing by living healthy lifestyles.

  The solutions we implement will need to be tailored to our diverse local populations. Life expectancy is generally higher than the national average in Cambridgeshire although there are variations within Cambridgeshire itself. However the reverse is true in Peterborough. Peterborough has a much higher rate of premature deaths from cardiovascular disease (CVD) than Cambridgeshire[1]. Cambridgeshire has less socio-economic deprivation than Peterborough, although there are deprived areas in Fenland and also in North East Cambridge and North Huntingdon. More than one in five (21.9%) children in Peterborough lives in poverty, above both the England average of 18.6% and the Cambridgeshire average of 12.1%. In Peterborough, 26% of people live among the 20% most deprived areas in the country[2]. Peterborough has a more ethnically diverse population than Cambridge. In 2015 almost half (45%) of school children had an ethnicity stated as not 'white British'. A third (35%) of pupils speaks a language other than English at home, with Panjabi and Polish the second and third most prevalent languages. Areas of Cambridgeshire also face challenges due to the ethnic diversity of the population. A significant proportion of pupils in primary schools in Wisbech, Fenland, speak an Eastern European language at home.

  As a system, Cambridgeshire and Peterborough generally has lower disease prevalence than the UK average[3], however there are large differences in disease outcomes between areas. For example, age standardised mortality from CVD for those under 75 was 58.8 per 100,000 in Cambridgeshire in 2012-14 (statistically significantly better than the national average) but 89.6 per 100,000 in Peterborough (statistically significantly worse than the national average)[4]. Small areas within Cambridgeshire, such as Wisbech, are also known to experience notably high rates of CVD mortality. In total, we estimate that there are around 100,000 people in Cambridgeshire and Peterborough who have multiple long-term conditions which lead to complex health needs[5].

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[1] Public Health and Outcomes Framework, 2015
[2] Cambridgeshire Strategic Needs Assessment Summary Report 2015/ Joint Strategic Needs Assessment: Peterborough
[3] Health and Social Care Information Centre Quality and Outcomes Framework 2014/15
[4] Public Health and Outcomes Framework, 2015
[5] Cambridgeshire and Peterborough Health System Prevention Strategy

We do not always offer our patients care that is of optimal quality[6]. At times, patients and carers feel that their views are not listened to by health care professionals. Those with long-term conditions report that they often experience a lack of coordination in the management of their multiple conditions and their multiple medications. We must address these concerns and do better for the people we serve.

- **Care and quality**: Our staff also face challenges to the delivery of care. Our medical workforce has significant current and future capacity issues. We have a shortage of emergency doctors now. In the future we will face problems with the supply of junior doctors and GPs, and shortages of specialist consultants in areas including emergency care, radiology, stroke, and psychiatry. In addition, current figures indicate that we will see a gap of at least 28% in adult nursing roles by 2021 and we expect this gap to be considerably greater in general practice, where fewer than 1% of newly qualified nurses choose to work. These conditions have meant the system has come to rely, too often, on overseas nursing recruitment. This is high cost and low yield in terms of return on investment, with long-term retention unpredictable. It is estimated that 18% of GPs and 33% of practice nurses will reach retirement age in the next decade, exacerbating our recruitment and retention issues. The current model of general practice does not fit with the career aspirations of many of our younger doctors and nurses. New models of practice organisation, working at scale, networking, and provision for education and training need to be considered, along with any changes to skill mix. There is a shortage of paramedics and ambulance technicians. Roles such as physiotherapists and clinical psychologists are particularly at risk of competition from the private sector. Our workforce problems have a direct impact on our ability to provide streamlined, efficient care to our patients.

  Operationally we often struggle to meet demand. Overall, we have higher non-elective admissions than our peer group, driven by very high emergency bed-day usage by our south Cambridgeshire residents[7]. The result is that we have long waiting lists for some specialties and we do not manage to meet the four hour A&E target, the referral to treatment target, or the nationally agreed ambulance response times consistently. We have significant numbers of delayed transfers of care. We have spare capacity in elective care at HHCT, whereas CUHFT typically operates at very high occupancy rates. Widespread variation in referrals and treatment patterns persist, leading to waste and poor outcomes. Outcomes for some of our services are poor. The root cause of this high level of demand for acute care is historic underinvestment in community and primary care support and treatment for patients with long-term conditions.

- **Finance and efficiency:** We are more financially challenged than any other footprint. Our organisations have a combined deficit of 11% of turnover, with our CCG and three general acute trusts all facing severe financial problems. While Cambridgeshire and Peterborough received approximately £1.7bn to spend in 2015/16, our collective deficit was more than £160m.

  By 2020/21, despite our income increasing to £2.05bn, we expect our collective deficit, if we do nothing and including the ambulance trust and specialised services, to be £504m. The waterfall graph below shows the total provider and commissioner deficit unmitigated by cost improvement programme (CIP) and Quality, Innovation, Productivity and Prevention (QIPP) schemes. For each

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[6] www.cambridgeshireinsight.org.uk/
[7] 2013/14 emergency bed days per 1000 weighted population (Source: Understanding Today, Designing Tomorrow, Cambridgeshire and Peterborough CCG, July 2015 p30)

organisation, the 'do nothing' scenario includes the total income and cost position (projected total deficit) in 2020/21. It includes specialised and ambulance services but excludes Peterborough City and Cambridgeshire County Council figures, on which work is ongoing, and primary care. CUHFT carries the burden of over a third of the system's financial challenge (£225m of £504m), although the CCG's expected deficit is also significant (£118m). Both organisations are in financial turnaround, although our ambition is for CUHFT to come out of special measures for both quality and financial turnaround in the next six months.
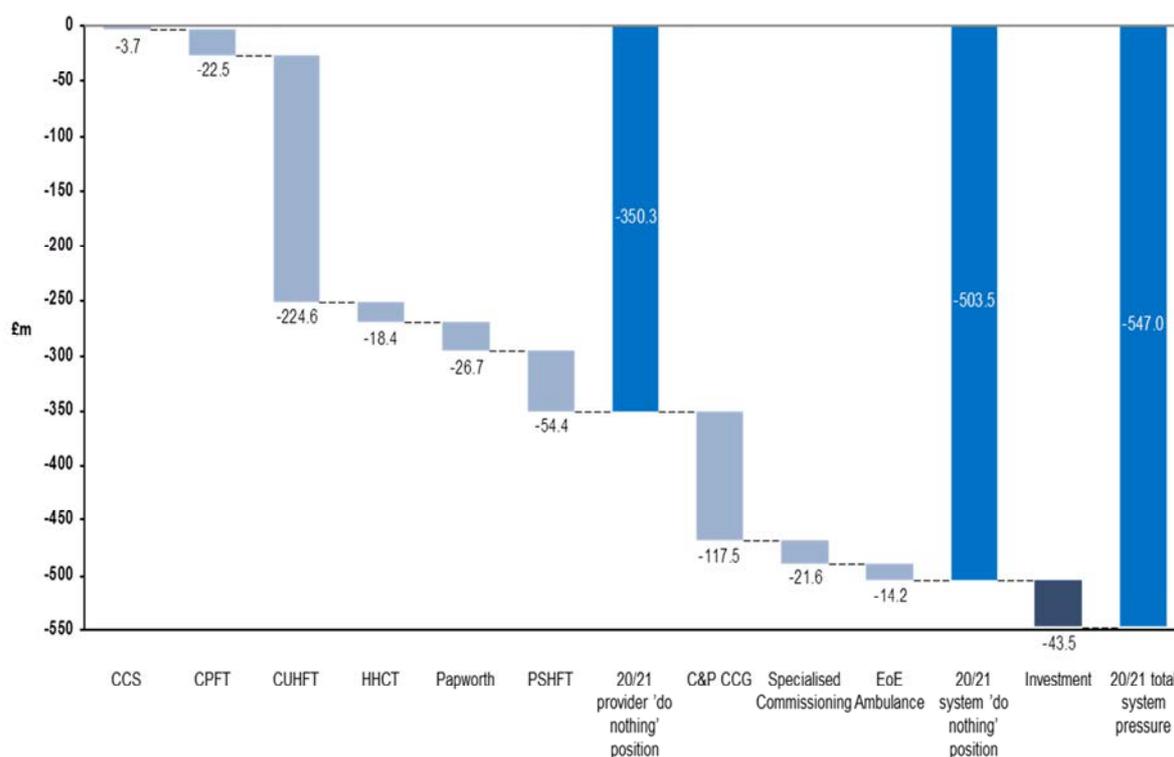
If we were to continue to deliver historic local average levels of CIPs and QIPPs, the system's financial deficit in 2021 would still be as large as £250 million. Therefore we need to do more, as this plan sets out.

While this plan sets out the very many changes we must make ourselves to address our system's financial challenges, we believe there are two reasons for our very large deficit which we have less influence over: structural deficits in three of our acute providers and historical under-funding of this health and care system. Both PSHFT and PFT have expensive PFIs, and CUHFT's e-hospital infrastructure is over three times the cost of less advanced digital patient administration systems. Further, as a system, there has been historical underfunding in both health and social care. Whilst the recently updated CCG allocation formula and population growth allocations have partially addressed this, there still remains some mismatch between financial allocations and population need. This historic underfunding is reflected in poor management of long-term conditions in primary and community care, resulting in high levels of acute activity and expenditure. It will take some years to redress this balance. Similarly, the lack of recent updates to the Market Forces Factor in the national tariff has meant that CUHFT is not adequately compensated for actual local cost of land and buildings, which has increased significantly in the last five years due to local economic developments, and PFT will also be affected by the future

relocation to the Cambridge Biomedical Campus. Taken together, we have quantified the total external funding requirement as £72.4 million.

Finally, we have identified that, by 2020/21, as a system we will need to invest £43.5 million more than we currently do to bring local service standards in line with national priorities, such as seven day services, the GP Forward View, the cancer taskforce, the mental health taskforce, and investments in prevention. When added to our 'do nothing' system financial gap, the total financial pressure we face as a health system is £547m. A further £32.7m of revenue funding is required non-recurrently for the implementation of the local digital road map.

- **Partnership working:** We have not worked as well together as we might. The failure to implement the Older People's and Adult Community Services (OPACS) outcomes-based contract and joint venture aspects of the UnitingCare Partnership is a good example of where we have, as a system, not been able to find a non-adversarial way through the problems we have faced. We are seeking to learn the lessons from this endeavour. Too often we have relied on contractual solutions when better relationships would have improved our collective ability to deal with the problems outlined above.

All of these reasons for change have been summarised in a number of public documents and, in particular, the *Evidence for Change*[8] document we published in March 2016. (See appendix 1).

3. Our approach: working as a system along multiple dimensions

Implementing large scale change is difficult and there have been times in the past when the Cambridgeshire and Peterborough system has not succeeded in turning ideas into reality. It will be challenging to ensure that our STP is a success. However we have put in place what we believe to be the right building blocks including the strong, visible, collective leadership of our executives and frontline clinical, operational, and finance experts. We have designed a robust structure through which to drive the work and recruited a competent team with the range of skills we need to oversee and ensure delivery. This is described in detail in section 8.

We are working on the Cambridgeshire and Peterborough system as a whole, rather than on individual organisations or services. Appendix 2 shows both the governance structure used during the design phase of the programme and the revised governance structure we have designed to deliver our programme of work. We have established a Health and Care Executive (HCE) and appointed an experienced independent chair to oversee this group. The HCE membership consists of the CCG's Chief Officer, provider CEOs, the chair of the Care Advisory Group (CAG), the GP Chair of the Sustainable Primary Care Strategy Group, and the Joint CEO and Director of Public Health for Cambridgeshire County and Peterborough City councils. Both councils are represented on our Financial Performance and Planning Group (FPPG) and CAG. In addition, the HCE has linked with the Cambridgeshire and Peterborough Health and Wellbeing Boards to ensure join-up with the Cambridgeshire and Peterborough Better Care Fund (BCF) plans.

We have involved staff, patients, and the public in the design of our system solutions. We have put in place systems for working with, and engaging, stakeholders including a system of holding Public

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[8] Fit for the Future: Working Together to keep people well – Evidence for Change

Involvement Assemblies (PIAs) across Cambridgeshire and Peterborough to discuss and test ideas and seek opinions and feedback from local people. Appendix 3 provides further details. Our work has constant oversight and support from the relevant national regulatory bodies: NHSE and NHSI.

We have established a well-resourced programme of work, supported by NHSI, through which we have sought to identify all opportunities to improve the effectiveness and efficiency of our system. It is through the work of voluntary organisations, councils, and 200+ clinicians and patients who comprised the membership of the Clinical Working Groups, that our proposed solutions have been developed. They have been tasked, when designing or considering new ways of working, to take a patient perspective, behaving independently of their organisation and abiding by a set of design principles and options appraisal criteria to which the public have had input. These principles demonstrate how important we consider the impact of any changes we make to be on patients and carers. Furthermore, since some of the changes under consideration may alter over time, we have also developed and tested with the public a set of weighted evaluation criteria for ranking ideas. Appendix 4 provides further information.

4. Our ambition: to develop the behaviours of an Accountable Care Organisation

We have not always worked together as a system as efficiently or as effectively as we might have done and we have a lot of catching up to do. As a result our journey will take longer than the five years covered by the STP. To stay focused, we have agreed a unifying vision for health and care in Cambridgeshire and Peterborough. As a local health economy, we are attracted to the beneficial concepts of an Accountable Care Organisation (ACO), with one set of leadership, one set of financial incentives, and one set of clinical motivations. However, through the lessons learnt from UCP, and from a strategic outline case for organisational form changes conducted last autumn, we recognise that it is the *behaviours* of successful ACOs we find appealing including, in time, adopting their contractual or organisational structure.

Our ambition

Our ambition for the Cambridgeshire and Peterborough health and care system is to develop the beneficial behaviours of an ACO on the way to becoming a value-based system which is jointly accountable for improving our population's health and wellbeing, outcomes, and experiences, within a defined financial envelope.

With this ambition in mind, our plan for the next five years aims to make significant strides in two areas. Firstly we must ensure that our services are sustainable and of high quality for local people right now, including prioritising our health offer according to where we can achieve the biggest health gains. Secondly we will take several steps closer to becoming a fully-fledged ACO (or ACOs). In practice, over the next decade, and subject to engagement and approval as appropriate, this will mean:

i.   investment in psychosocial and wider determinants of health and wellbeing in our schools, homes, and communities
ii. a shift from reactive to proactive care, with a holistic approach to care planning, coordination, and delivery that empowers everyone to take as much control of their care as possible
iii. clear points of access, with a consistent response no matter what or when

iv.   hospitals only for those who need access to facilities or skills that can only be provided in a hospital setting; primary and community care strengthened to support this

v.   assets (staff, buildings, expertise) used to exploit scale economies and reduce overheads

vi.   standardised care to minimises unit costs

vii. generous knowledge sharing, breaking organisational and setting silos

viii. technology used to improve modes of interaction/intervention

ix.   collective efforts to leverage the 'Cambridge research' brand and the Cambridgeshire and Peterborough-wide education and business offer to attract investment and make new partnerships, reducing our dependence on public funding in line with current devolution discussions

x.   commissioning across both NHS organisations and local authorities for defined populations (e.g. via alliance contracting and formalised partnership working) taking into account the varying health and wellbeing needs of our diverse local communities.

We have used our ambition to inform the way in which we change care models and, more importantly, we have considered how we could utilise the capacities required of an ACO to move rapidly from the design of solutions to delivery and implementation. We know that some of the solutions we have identified will exceed our expectations and others may not work immediately. We feel that it is crucial that we invest in our capability and build strong relationships to adapt as we go. We have been working together to explore how, through changes to governance processes such as delegating some decision making powers to the HCE, contracted financial flows, including system control totals, alliance, and financial risk mitigation, and a memorandum of understanding (MOU) describing exactly how we will work together, we can further cement our commitment to working together.

We are motivated to work in this way by the scale of the financial challenges we face. It is essential that we identify and capture every savings opportunity available to us and the diagram over the page sets out the opportunities we seek to optimise through working together.

Examples of solutions for change   **Net savings (£m)**

Category	Sub-category	Examples of solutions for change	Net savings
Improve quality	Improve standards	• CQC rating, 7DS, cancer diagnosis, liaison psychiatry services, etc.	£
	Accommodate innovation	• New drugs, diagnostics, other technology	£
	Pathway changes	• Primary care at scale, UEC networks, enhanced pharmacy & paramedic capability	£
Reduce demand growth	Prevention	• Immunisation, screening, health-checks, healthy lifestyle	£
	Self management	• Health coaching, apps, EPP, re-enablement, coaching, shared decision-making, remote care (eg care homes)	£
	Patient stratification & targeting	• Definition of goals for high risk & rising risk patient, allocation of case management responsibility, MDTs with consultant support	£
	Referral & treatment thresholds	• Procedures of low clinical value, shared decision making, check-lists, etc.	£
Reduce costs of care	Reduce variation	• QI culture, clinical networks, rotational rosters, centres of excellence, buddying	£
	Minimise unit cost in each setting	• Productivity (EPR, skill mix, travel, LOS, flow, e-rostering, lay-out), standardisation (QI, checklists, care packages, enhanced recovery)	£
	Minimise input costs (shared CIPs)	• Optimise estates (wards, theatres, other), procurement, shared clinical support services, bank & agency, clinical teams & networks	£
	Provider running costs	• Management structure, IT, facilities, finance, communications, HR, asset disposals	£
Reduce costs of system management	Transaction costs	• Contracting duration, estates, data management (eg fines, coding reviews)	£
	Commissioner running costs	• CCG mergers, integrated health & social care commissioning, lead commissioning, ACOS	£
Clinical income	CCG allocations	• Allocations distance from target	£
	Specialised income	• Designation as specialised centre	£
	Other clinical income	• Re charging non-British and private patients	£
Non-clinical income	R&D income		£
	Education income		£
	Other non-clinical income – revenue and capital	• Land development, capital funding bids, car parking, pay roll services for other public sector bodies	£

Tree structure (left side):

- Optimal system value
  - Improve quality
  - Total cost
    - Reduce demand growth
    - Reduce costs of care
    - Reduce costs of system management
  - Total income
    - Clinical income
    - Non-clinical income
    - Transformation funding

5. Our priorities for change

To take forward our vision, we have identified four thematic change priorities and developed a 10-point plan where we intend to make changes over the next decade.

CHANGE PRIORITY 1: At home is best

The 'Five Year Forward View' sets out a clear requirement for the NHS to take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, physical and mental health, and health and social care. We aim to deliver truly integrated health and social care and capture savings opportunities through reducing demand growth and pathway changes that shift care from reactive hospital-based admissions to proactive local care closer to home, including supported self-care and community-based care. In line with the BCF, we want to help people to help themselves and to have a system that enables the majority of people's needs to be met through community service provision where this is appropriate. The reason that we embarked on the contract for older people was because we have significantly higher non-elective demand than our peers, especially in the more affluent areas of South Cambridgeshire, and because too many older people experienced fragmented care. While the contract did not last, we still believe in the UCP care model's components: building social capital, integrated neighbourhood teams wrapped around groups of GPs, and a community-based rapid response to deteriorating patients. Our STP builds from this, with an enhanced scope, covering all ages and including primary and social care.

5.1 People powered health and wellbeing

Much activity that improves health happens outside formal NHS services. We consider our populations as equal partners, particularly when it comes to health, wellbeing, and the preventative activities that could, in many cases, stop or lessen the impact of an illness and long-term condition. We aim to take a population-based approach to systematic prevention and we have identified a range of areas where we can work differently to prevent illness, build social resilience, and empower people to self-care:

- **Housing and business:** We believe that our communities represent an untapped asset and that by working in partnership with Health and Wellbeing Boards and local populations we can build social capital through exploiting common interests with local enterprise partnerships and businesses to develop employment opportunities. Where possible, as a HCE, we are influencing the design of the housing developments, which will see 100,000+ new homes built in Cambridgeshire and Peterborough, to reinforce active lifestyles and introduce smart technology that promotes independence for older people. In this regard we need to work more closely with district councils. We must also make the most of the inclusion of Northstowe as part of the national Healthy New Towns programme by thinking differently with our partners about how the built environment impacts on health.

- **Prevention:** Implementation of our 'Health System Prevention Strategy for Cambridgeshire and Peterborough' (see appendix 1) is very important to us and will be monitored by the HCE. The strategy seeks to target interventions to specific populations. In Peterborough the number of health checks undertaken is increasing, particularly for 25-39 year-olds from the South Asian population, in the most deprived areas. We are working with the older population to prevent falls.

In the future, lifestyle interventions for those with diagnosed hypertension and at risk of diabetes will be increased along with malnutrition screening and access to stop-smoking services. We will increase the proportion of people accessing information about alcohol, and the number of women with long-acting reversible contraceptives. We will increase the uptake of eligible people accessing and completing cardiac rehabilitation and improve diagnosis and treatment for cardiovascular diseases, such as heart failure and hypertension. We aim to increase the numbers of people with Chronic Obstructive Pulmonary Disease (COPD) on self-management programmes, and we will work with those people in our population who are obese, by maximising the opportunities for lifestyle interventions identified through health checks. Our approach to prevention also includes the implementation of interventions designed to deliver health and wellbeing to staff including investment in mental health, physical health, and smoking cessation programmes, and an aim to reduce absentee rates.

- **Starting young**: Through joint commissioning arrangements between the local authority and NHS, we are identifying opportunities to embed healthy behaviours from a young age and provide alternatives to A&E for our local parents. We see this being realised through integrated provision of child health services, including Child and Adolescent Mental Health Services (CAMHS) and emotional health and wellbeing services, children's community health services, and local authority provision for those aged 0-19 (which may include children's centres). By taking a whole family approach, including primary mental health support and counselling wrapped around localities, and a range of services such as parenting programmes, we are building resilience in children and young people and supporting their parents. We are developing a new model for emotional health and wellbeing services based on the ITHRIVE framework. This will, we hope, reduce the demand we see later on in life for mental health, specialist health, and social care services. Where urgent care is required, paediatricians and specialist nurses are supporting GPs to offer treatment and advice as an alternative to A&E attendance. To improve our delivery of service improvements in this area we have brought together our clinical working groups and council-led children's initiatives into one single health and care programme of work.

- **Psychological wellbeing:** We have an agreed mental health strategy. We will support implementation of local public mental health and suicide prevention strategies. Public mental health includes working with communities, including through local groups such as parish councils, to reduce stigma, working with employers to run workplace health initiatives, and partnerships with the third sector that address wider determinants of anxiety and depression such as poverty and unemployment e.g. providing debt advice to those who need it.

- **Reaching out:** Our neighbourhood teams, primary care, and social care will work with the voluntary and community sector (VCS) to identify those at risk of poor or deteriorating health. They will deploy community-based workers to support those with a severe mental illness or dementia and to support migrant workers, travellers, and our wide range of diverse communities who may need a different blend and style of intervention that is more socially attuned.

- **Self-care:** Our GPs, consultants, and nurses will make it easier for people with long-term conditions to manage their own care needs by adopting best practice for supporting self-care. This will include systematic use of 'activation measures' (which assess how confident and able someone is to act on the information provided and make required changes to their lifestyle), care planning, expert patient programmes, health coaching, targeted psychological intervention, personal budgets, and increasingly exploiting technology-based platforms. Our vision is that

individuals who are vulnerable, are at the early stages of needing help, or are at increased risk of a health or care crisis, will be able to access the support provided by a 'wellbeing network' which will signpost them to the relevant community-based support or voluntary services. Specialist input directly to patients will be available, but as a back stop. The CUHFT Self Management Support Centre (SMSC), run by a team of expert clinicians and patients, highlights success in the area of self-care. The SMSC has run a number of projects for patients focusing on, for example, supporting those who live with COPD, diabetes, and heart disease, and those who have suffered a stroke. The team has also developed training to increase the skills of clinical staff in facilitating personal health planning and self-management.

- **Ageing well:** We must improve independence and wellbeing in older age and prevent health and care needs from escalating. To achieve this, we will focus on physical activity and reducing falls, holistic approaches, and care for older people's mental health, and strengthening place-based approaches to healthy ageing. We have already begun to make progress in falls prevention, caring for people with dementia, tackling social isolation, loneliness and malnutrition in the community, and prevention of urinary tract infections and incontinence. Increasingly, all council and NHS staff will act as 'eyes and ears', spotting indicators that someone is becoming more vulnerable and referring them to appropriate support. We will build on the outcome of the 2016/17 falls pathway pilot in order to introduce a system-wide approach to falls prevention.

5.2 Neighbourhood care hubs

As much care as possible must be led by primary care, but to achieve this we need to create capacity within general practice. We are supporting our GPs to share best practice, work together at scale, access consultant advice without referral, and wrap community services around them. Over the next three years this will provide the enhanced primary and community care that our local people need. This is fundamental to addressing the high levels of demand for acute care.

- **Time to Care Testbeds**: There is currently widespread variation in the resilience amongst our 105 GP practices. A number of these practices are currently vulnerable from an operational and clinical perspective. Most practices report that they struggle to manage increasing patient demand and have asked for support in improving their operational efficiency to provide better quality of care to their patients. Additionally, there is further variation in how practices interact with their local acute, community, social care, and voluntary sector providers. There is an opportunity to improve how services are integrated around the needs of patients, such that care is proactive and close to home. We will start by working with three 'testbeds' (groups of seven to 10 practices, supporting populations of 30,000-50,000 patients) to improve efficiency by implementation of the 10 High Impact Actions set out in the GP Forward View. With this increased capacity and resilience, our GPs will have the time to work with partners in community, social care, acute, and voluntary sectors to consider new clinical models of care, as well as new organisational forms. Future waves of this programme will allow for the support of all practices over the coming years. This will be an iterative process, with an emphasis on evaluation, agile learning, and scaling of effective interventions across the Cambridgeshire and Peterborough health system in a localised, stepwise manner.

- **Neighbourhood teams:** Neighbourhood teams, staffed by district nurses, matrons, social workers, therapists, and pharmacists already provide integrated care for populations of 30,000-50,000, based around the GP registered list. The teams proactively care for those with long-term

conditions, the dying, care home residents, and mental health service users. Close links with the Joint Emergency Team (JET) service and the ambulance service will enable proactive care plans to be commenced and reduce the need for hospital admission for those with long-term conditions where care can be provided at home. Our 16 teams are less than a year old and are still developing. As they mature we need to ensure that the care they offer systematically uses risk stratification to target person-centred care packages suiting different needs. Four 'trailblazer' neighbourhood teams have been selected to test alternative approaches to case management and care coordination in summer 2016. What is found to work will be rolled out across the other neighbourhood teams. Further improvements are being made by employing 'navigators' to case manage complex patients and by arranging regular structured virtual multi-disciplinary team (MDT) meetings where GPs and community teams obtain advice from specialists. Day-to-day communications are being improved at all levels, including ensuring that phone numbers and rotas are shared and that cross-cover is arranged. In addition, we are implementing agreed, evidence-based care protocols that speed up discharges and enable rehabilitation to start early. We already have more staff allocated to neighbourhoods with older, deprived, or more rural populations but we need to ensure that we resource the teams to address inequalities in health and care provision across our system.

- **Community experts:** To support the neighbourhood teams, which are largely generalist in terms of skills composition, we need an integrated team of community-based experts to care for the more complex patients and provide advice and education. We already provide some access for patients and neighbourhood teams to community geriatricians, psychiatrists and psychologists, specialist diabetes services, community cancer support networks, respiratory nurses, dieticians, and cardiac and pulmonary rehabilitation services. However, more needs to be done to increase equity of access. We also need to make sure that our team can access advice, in particular through well-run virtual MDTs, where clinicians review lists of complex patients together to agree a management plan. This means we must increase current levels of dedicated community consultant time, for example for diabetes, paediatrics, and respiratory, to provide enhanced support for the neighbourhood teams, JET, GPs, and ambulance service paramedics, enabling them to manage more patients safely at home.

- **Sharing knowledge:** Proactive and person-centred care relies on there being one single care plan owned by the patient and their family, one electronic care record accessible by all, one set of best practice protocols all can adopt, and one route through which expert opinion can be accessed day or night. This means we need to share knowledge systematically. We will do this by providing appropriately secure access to patient records to all frontline staff providing direct care, be they the person's usual team or an out-of-hours or urgent response team, and by building stronger relationships between GPs, hospitals, domiciliary care workers, and care homes to speed up discharges. We have an ambition that everyone can access a consistent library of health, social care, and wider information through a variety of formats and platforms including social media, websites, libraries, community hubs, and GP surgeries. This information will consider the needs of our diverse communities.

We will improve information sharing between those involved in patient care in order to smooth the transition home for patients and reduce readmissions to hospital. We will systematically spread best clinical practice, for example in areas including diabetic care planning and uptake of pulmonary rehabilitation and atrial fibrillation. We will ensure that where solutions work well they are shared with others, for example effective use of Dr First triage, patient held apps, and preparation for CQC visits.

- **Embedded mental health:** Our neighbourhoods already have aligned community mental health teams. As part of our system-wide mental health strategy we are considering how to integrate our community and mental health teams further to ensure the psychological needs of people with long-term conditions, and the physical health needs of patients with severe mental illness, are uniformly met. Work is already underway to provide enhanced primary mental health care that supports GPs in identifying psychological needs and primary care led interventions. This, together with support from 'recovery coaches', will facilitate users to step down from secondary mental health and address a commonly held 'fear of a cliff edge' among users and carers.

- **Learning disabilities:** We have been working closely with the councils to implement 'Transforming Lives' for people with a learning disability. In the past year alone we have reduced the number of people in a bed by half. Further, the Collaboration for Leadership in Applied Health Research and Care (CLAHRC), which is hosted by CPFT, is evaluating the use of integrated personal health and care budgets for people with learning disabilities which, if successful, may be rolled out more widely.

- **Your own bed, not a hospital bed:** Recognising that many people prefer to be in their own bed, we are looking at two areas where we need to make changes to enable this preference to be met more often: end of life and intermediate care. Currently 41.6% of people die in a hospital bed. This is below the national average of 47.9% but the proportion is particularly high in more deprived areas. We must focus particularly on our more rural communities where access to hospices is more difficult. To facilitate this we are upskilling neighbourhood teams and GPs.

  We currently have 213 health and social care community beds where patients experience variable levels of rehabilitation and care and with variable lengths of stay. Evidence suggests there is no correlation between longer length of stay and improved patient outcomes. By better defining clinical models of care in community beds, investing in therapeutic input and domiciliary care, and standardising discharge protocols we believe we can make a transition to more effective and patient-centred models of care. This transition would result in a reduction from the current total community bed stock by 2018, releasing funds for reinvestment in home-based services for local people, as part of our own contribution to transformation funding and commitment to improved patient care.

In order for the benefits to be realised, the system must be organised as neighbourhoods and must operate day by day as MDTs. The diagram below summarises how integrated health and care neighbourhood teams can provide proactive care stratified by different levels of need, as determined by both their medical and psychosocial conditions. This brings together previously disparate work on healthy ageing, long-term conditions management, and mental health for the first time.
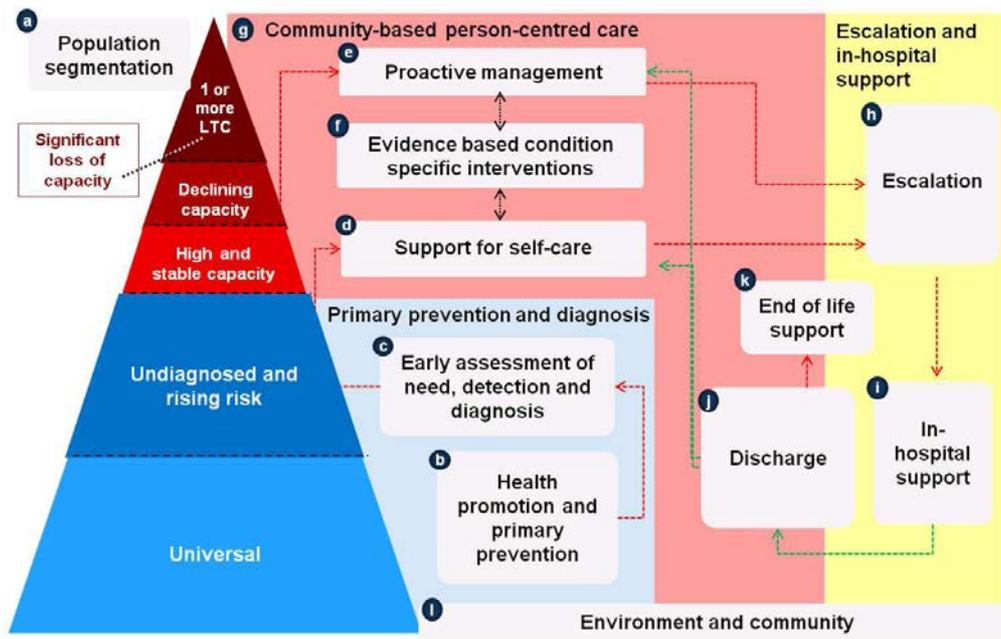
Case Study: Peterborough – leading the way

In Peterborough, an Area Executive Board has been established to oversee nine programmes of work that will triply integrate care for all ages, spanning child health, ageing healthly, and how hospital is accessed. The programme brings together local GP practices in Greater Peterborough, the City Council, PSHFT, and CPFT and is supported by an external company.

The programme has tested increasing capacity and access to primary care on weekday evenings, up to 8pm, at weekends, and on bank holidays (10-10pm) and has made it possible for the 111 service and for GPs operating in PSHFT's A&E at weekends and on bank holidays to book GP appointments directly. It has implemented 24 hour online access to 'WebGP' which contains information about self-care, what community pharmacists can offer, and provides a platform for email and, in the future, e-consultations. It trialled improving capacity in primary care by utilising other professional groups to free up the time of doctors and nurses, for example by creating greater roles for pharmacists, paramedics, and specialist nurses. This approach aimed to attract and retain staff and enable GPs to deliver longer opening hours and introduce new ways of working through different shift patterns.

Over the next three years, building on a principle of subsidiarity, we will roll out similar place-based programmes of vertical integration, which scale and spread the things that work, but also offer opportunities to tailor care models to suit local people's needs.

CHANGE PRIORITY 2: Safe and effective hospital care, when needed

We are starting from a position where two thirds of our acute hospitals are under severe operational pressure and one of our acute trusts is in special measures. Our population is growing and we already have a mismatch between workforce pressures and capacity. We have identified that care networks are the mechanism by which we can deliver safe, effective, and efficient care into the future. Care networks are when, where possible and appropriate, we focus on moving knowledge and specialist expertise rather than patients. Our acute clinicians are beginning to agree how the care networks will work in practice for planned, unplanned, routine, and specialised care. These care networks will share protocols for appropriate referral and best practice treatment and build workforce resilience through an enhanced career development offer. They will share out-of-hours rotas and

offer the flexibility to match staffing with available physical capacity. Improvements in hospital -ased care will enable us to capture savings opportunities.

5.3 Responsive urgent and expert emergency care

It is not good for patients to stay in hospital for longer than necessary; it often impacts negatively on their recovery and ability to maintain independence. For NHS commissioners and providers it can be an expensive, avoidable use of resource. We must make sure that patients in acute beds really need to be there and that they are not delayed when moving through the steps on their care plan. We have been through a process to designate our three A&E departments against the national Keogh urgent care definitions and, following an options appraisal process, we have determined it is in the best interests of our local population to maintain a Specialist Emergency Centre at CUHFT and an Emergency Centre at PSHFT. HHCT will retain its A&E and will continue to be able to manage the current caseload of minor injuries and major medical cases, with a physician-led service. This will enable us to cope with the expected increases in non-elective demand likely to result from new housing, an ageing population, and potential changes to services offered in neighbouring STP footprints. However since PSHFT, CUHFT, and HHCT are already struggling to meet existing levels of emergency demand, and our non-elective activity is significantly above our peers, we need to improve our community-based urgent care and our emergency services radically such that hospital is a last resort. There are several strands to this improvement work.

- **Ambulance:** We are working with our ambulance teams to ensure that only patients who really need to be transferred to hospital are taken there. We are implementing 'hear and treat', 'see and treat', and 'see, treat and convey' systems which allow paramedics, supported by other clinicians, to determine whether options other than transfer to hospital are more appropriate. 'Hear and treat', a service for those who do not need to be transferred to hospital, involves close working between the ambulance service, community and neighbourhood teams, and GPs. 'See and treat' incorporates treatment at home by specialist paramedics and referral to the neighbourhood teams rather than transport to hospital for the same level of care. This approach supports early recognition and clinical intervention in the patient's home so that long-term conditions and acute exacerbations can be dealt with safely and effectively without the need for transfer to hospital. 'See, Treat and Convey' is for those who do need to be transferred to hospital for essential life-saving interventions.

- **Integrated urgent care and clinical hub**: We are implementing an expanded 'integrated urgent care service (IUC) with clinical hub' which replaces the current separate NHS 111 and GP out of hours services. IUC has been operational since October 2016. People must still call 111 first and will be supported to get the right care, first time. The clinical hub provides senior clinical support to NHS 111 call handlers, neighbourhood teams, the ambulance trust, care homes, mental health workers, and individuals/carers currently undergoing community case management. Staff at the clinical hub can access an integrated directory of service and use the information to coordinate an appropriate response, for example a direct booking to a local emergency GP or dentist or a referral to a local public or voluntary service provider. Where appropriate, IUC can arrange for patients to speak directly to a relevant clinician. IUC also offers signposting, healthcare advice, and guidance. If appropriate the patient will speak to, or see, a clinician within four hours. Within the hub there is access to mental health practitioners, GPs, nurses, and pharmacists, significantly strengthening current services. The aim of IUC and the clinical hub is to ensure patients receive the most appropriate care that best meets their needs. This will ensure that our acute hospitals are reserved for serious, life threatening injury or illnesses.

- **Minor injuries units:** Following our review of the three minor injuries units, (MIUs), in East Cambridgeshire and Fenland, we have undertaken extensive engagement with the public, providers, and other stakeholders on a range of options for the future. Taking this feedback into account, we have identified significant opportunities to deliver more joined up, effective, and efficient local urgent primary care services, which reflect the rural geography, deprivation, and demography.

  Whilst no formal decisions have been taken, we are now working with local stakeholders to develop the details behind a number of options including the development of three rural urgent primary care hubs which will initially focus on integrating local primary, MIU, and community services, but will move on to include development of point-of-care testing and consultant support via telemedicine links. These hubs will deal with minor injuries as well as extended scope minor illness and urgent care. Our aim is that improved rural urgent primary care provision will reduce the need for those from rural communities to be admitted to hospital simply because there is no alternative care provision available locally. The integrated rural urgent primary care will bring together GPs, nurses, pharmacists, therapists, and others in and out of hours, and will include step up to either community or bed-based intermediate care through integrated pathways. The benefit for local people will be clearer, more consistent, and joined up local access to urgent clinical advice and treatments. The benefit to the local NHS will be more efficient use of staff skills and capacity, support to general practice in line with our primary care strategy, and repatriation of current flows of patients from A&E to the local hubs.

  This work links to our estates development strategy, which includes redevelopment of local community hospital sites to support both the urgent primary care hubs and primary care at scale services in modern purpose built premises over the next three to five years. We intend to develop and test the first phase of the new urgent primary care models over the next 12 months, which will inform further engagement and, potentially, consultation prior to roll out of the subsequent phases. We are also doing an analysis of all options put forward as part of our early engagement work.

- **Embedded mental health:** We are investing £2m of Urgent and Emergency Care Vanguard money in 2016/17 in an evidence-based, community first response service which provides urgent out of hours assessment and support to people in mental health crisis. We are enhancing our model of liaison psychiatry services in our two emergency centres. Too many people experiencing a mental health crisis previously ended up in police custody, and so we have partnered with the local police force and embedded four mental health workers in the police control room to ensure that people are only detained under section 136 when there is no alternative. This is already having a significant impact, saving the police force money and providing a better experience and appropriate care for patients in the community.

- **Discharge:** We have an unacceptably high level of delayed transfers of care. We believe it is not good for patients to stay in hospital for longer than necessary and are putting in place processes to ensure that patients are discharged on time, including on-site social care staff supporting discharge to assess models. We are introducing a discharge to assess model in our hospitals and reviewing our mix of community bed-based and non-bed based provision to enable patients to be discharged as soon as clinically appropriate. Further assessment of their medical/social needs will be carried out in the community or their usual place of residence. Improved information sharing, described above in section 5.1, will support this.

- **24/7 standards:** Our three urgent and emergency care sites will meet the government's seven day services standards with early and daily consultant input driving down length of stay. The standards will be rolled out in CUHFT, PSHFT, HHCT, and out of hospital.

Case Study: Urgent and Emergency Care Vanguard

Cambridgeshire and Peterborough is one of eight Urgent and Emergency Care Vanguards, and through this work we are improving the coordination of urgent and emergency care services in order to provide better and more appropriately located care for patients and reduce pressure on A&E departments. The Vanguard work is being progressed through the Urgent and Emergency Care delivery group. This group is focusing on promoting self-care and management and is helping people with urgent needs to access the right advice and the right service first time, seven days a week. It aims to deliver highly responsive urgent care services outside of hospital, especially for mental health crisis. To enable these changes to happen, the group aims to develop our workforce including GP fellows, advanced nurse practitioner and advanced allied health professional roles, developed community pharmacist roles, physicians' assistants, and staff equipped to meet mental and physical health needs.

5.4 Systematic and standardised care

Evidence tells us that standardised care is often higher quality and lower cost. Clinical networking will help us to deliver the savings opportunities identified through pathway changes that shift care to lower cost settings where appropriate, align referral and treatment thresholds, and reduce costs of care, as well as helping to ensure the additional costs associated with increased clinical standards, especially seven day services, are minimised.

- **Care networks:** Where appropriate, we believe in moving knowledge rather than patients. Our acute clinicians are beginning to agree how to function as operational networks for planned, unplanned, routine, and specialised care. These networks will share protocols for appropriate referral and best practice treatment and will build workforce resilience through an enhanced career development offer, shared out-of-hours arrangements, and flexibility to match staffing with available physical capacity. Our clinicians have worked together to define what networking means in terms of workforce, activity management, protocols and governance, (see table on next page) and defined five levels of attainment across these areas. They have committed to working as networks and it has been agreed that all areas will aspire to achieve level five, although it is recognised that some specialties will arrive at this more quickly than other areas.

Level	Workforce	Activity management	Clinical protocols guidelines	Governance
5	• Formalised cross-working arrangements for all clinical staff, driven by anticipated activity management	• Centralised activity management system and process for all providers within network for specific specialties • Single operational oversight	• Formalise and standardise patient pathway procedures and policies	• Formalised joint-working governance arrangements with integrated cross-provider quality reporting • Single clinical director
4	• Formalised cross-working arrangements for all clinical staff (including Consultant level)	• Centralised activity management system and processes for specific cohorts of patients between providers	• Formalise and standardise patient pathway procedures and policies	• Formalised, regular performance meetings • Jointly led by Consultant and Exec sponsor. Ops / div attendance
3	• Formalised staff-sharing arrangements for all (non Consultant level) clinical staff	• Access to each providers live patient lists and capacity	• Informal standardisation of patient pathways and protocols with joint collaboration	• Formalised, regular performance meetings / discussions, jointly led by Consultant
2	• Access to consultant advice to meet service requirements • Some shared staffing arrangements to meet patient demand for particular staffing groups in high-demand	• On-going formal collaboration in patient management and capacity planning	• On-going informal provider to provider feedback and sharing of best practice	• Formalised, regular performance meetings / discussions • Consultant-led, with ops / div management attendance and co-ordination
1	• Informal and voluntary staff sharing arrangements to meet patient management requirements • Agreements on minimum staffing requirement	• Sharing of capacity information • Informal collaboration of patient management at peak periods	• Awareness and sharing of policies and protocols • Agreed outcome measures / PROMS	• Informal ad-hoc performance meetings / discussions • Ops. / div. management-led, with consultant attendance on a rota basis
0	• No shared working	• No management collaboration	• No shared protocols or policies or outcomes	• No shared performance meetings

Increasing integration

For all specialties, including those where it does not make sense to consolidate provision onto a single site, such as ophthalmology and obstetrics, the service will increasingly be run as one across the acute sites making the most of the expertise we have in some providers. Networking will address unwarranted variation in primary care by facilitating peer review and standardising pathway documentation. It will see the implementation of e-referrals and decision-making aids, offer GPs direct access to a consultant opinion, and enable pathways to be rearranged so that the necessary diagnostics occur before a consultant opinion. Clinical audits will be conducted in a uniform manner to identify best and worst practice. Unnecessary touch points will be reduced and, we hope, ultimately removed, and there will be increased nurse-led care. For example specialist opinions could be made available at HHCT and PSHFT for neurology, cardiology, and dermatology through technology such as video-conferencing.

- **Patient choice hub:** The business case for a new patient choice hub is being developed with the aim being to improve quality of referrals, ensuring that clinical thresholds are adhered to, align capacity and demand across available providers, and manage activity across the system rather than in organisational siloes. The hub will include clinical advice to GPs, offer a range of choices for patients, such as first appointment or named consultant, local NHS, out of area NHS or independent sector, and potentially employ psychological input to identify and provide treatment options for people with medically unexplained symptoms.

- **Clinical scale:** We need to create centres of clinical excellence that utilise standardised patient pathway procedures and policies across all providers and, where volume drives efficiency, consolidate aspects of clinical care across our four acute sites. For instance, in ear, nose and throat services, a proposal is being reviewed for elective day cases to be concentrated at HHCT and emergency and elective inpatient work at CUHFT and PSHFT. This would allow HHCT to focus on an effective day case model of care, and for the system to use its workforce more effectively without the pressures relating to running three sites requiring out-of-hours care.

We have identified quality and efficiency benefits from consolidating much, but not all, of the following procedures to exploit clinical scale:

Orthopaedics: We have developed our proposals for orthopaedic services following extensive engagement with clinicians across all provider organisations and following reviews of other high performing services, such as the orthopaedic services in Northumbria and Brighton. We are considering centralising specialised orthopaedic trauma services (such as fragility fractures) at PSHFT and CUHFT, to achieve a higher standard of care. We are also investigating the case for reconfiguring planned orthopaedic services, by increasing the number of low-complex procedures at HHCT (for example routine knee and hip replacements for patients with few comorbidities), and centralising high-complexity orthopaedics at PSHFT and CUHFT. These reconfigurations are expected to improve the quality and sustainability of services at all three sites. We expect to consult with the public on these proposals in 2017.

Stroke: National analysis of stroke indicators shows that Cambridgeshire and Peterborough performs below the national average on a number of leading stroke indicators, including thrombolysis rates and access to specialist rehab and early supported discharge. Provision of inpatient and community bed-based stroke and neurological rehabilitation care is fragmented across multiple sites in our system. In order to improve the services offered to patients we are considering delivering all bed-based stroke and neurological rehabilitation on a single site and to establish a properly resourced enhanced supported discharge team, so many more patients can receive rehabilitation and support at home. The creation of dedicated hospital and community based rehab teams will lead to increased staffing specialisation and better outcomes for patients. In addition, there will be financial benefits around volume of staff required and average length of stay reductions. We expect to consult with the public on these proposals in 2017. We have also considered whether we need one or two hyperacute stroke units in Cambridgeshire and Peterborough and have concluded that at present we should retain two hyperacute stroke units. We will enhance provision to ensure that patients are seen and treated rapidly by investing in our workforce, including enhancing our stroke consultant cover at both CUHFT and PSHFT. We are considering creating an early supported discharge service across Cambridgeshire and Peterborough to ensure stroke patients are discharged home at the earliest opportunity, thereby improving outcomes for patients and reducing length of stay in our hospitals.

Women and Children: We have reviewed provision of obstetric and neo-natal services across our hospitals. Like elsewhere, our main challenge is workforce and ensuring that we have enough staff to maintain safe inpatient services. We have considered the viability of our three obstetric units, each with a co-located midwife led unit, and concluded that all three should remain. However, we need to enhance networking between units to share best practice, standardise pathways, promote home births, and offer improved access to perinatal mental health and continuity of care to expectant mums and one-to-one care from midwives whilst in labour. We also need to manage capacity and demand sustainably and address workforce recruitment and retention challenges.

We have reviewed the common acute pathways for children and young people. We aim to standardise care across the whole system from primary through to secondary care. Parents will be supported to self-care for their children where possible and appropriate. Hospital stays for children and young people should be kept to a minimum and this will be achieved by developing a community model of care with enhanced community nursing and integrated working between GPs and paediatricians. We will invest in extra capacity for children's care at CUHFT by

developing a paediatric assessment and observation unit. We will focus on perinatal care, on specific disease pathways (asthma and continence), mental health support for children, 0-19 universal services for 0-19s, and specialist disability services covering health, social care, and education.

5.5 Continued world-famous research and services

Much specialised care is already centralised at our two world renowned hospitals: CUHFT and, for cardio-thoracic care, PFT. For this reason, major changes to specialised services do not feature significantly in our STP. However, there are some specific areas where we can improve, especially due to growing demand.

- **Cancer:** Cancer incidence is increasing. The number of people living with cancer will double by 2030. We are working to implement the recommendations of the 'Cancer Taskforce Strategy' and to achieve world class cancer outcomes. The establishment of 'Cancer Alliances' is crucial to this. We are reviewing cancer pathways and focusing in particular on prostate, lung, ovarian, colorectal, oesophageal, and gastric cancers. We are working to improve the percentage of patients diagnosed at stage one and two and targeting our interventions at patients most likely to benefit. With Public Health England and Cancer Research UK we want to ensure that our screening programmes, in particular for breast and bowel screening, are appropriately targeted and optimally utilised. Where uptake could be improved we will work with specific GP practices and promote screening as part of health checks. We have already implemented a new two week wait referral proforma which lowers the referral threshold in line with new National Institute for Health and Care Excellence (NICE) guidance and we are working with trusts to redesign pathways to enable earlier diagnosis by, for example, reviewing access to diagnostics. We are working to improve long-term quality of life through the implementation of a 'recovery package' and risk stratified follow-up pathways. We are reducing admissions and length of stay and tackling the health inequalities that exist within our footprint.

- **Specialised mental health:** We provide limited specialised mental health locally: a small number of low secure beds and limited CAMHS tier 4 services. The East of England region has been identified as one of three areas without a mother and baby unit for those with severe mental health problems following childbirth. We aim to address this, and our mental health strategy also prioritises the development of perinatal mental health services in the community.

- **Cardiology:** Cardiology services will be provided in a highly networked fashion across Cambridgeshire and Peterborough. PFT which, following the move to the Cambridge Biomedical Campus next to CUHFT, will lead the service across both organisations, together with PSHFT, will provide a vital role in supporting improved 24/7 access to cardiology opinion at secondary care level, as well as community-based services that focus on prevention. PFT and PSHFT are investigating the clinical and financial case for potential expansion of percutaneous coronary intervention and complex devices services being provided locally in Peterborough.

CHANGE PRIORITY 3: We're only sustainable together

None of our organisations can be sustainable acting alone; our financial challenge is too great. In order to bring about the changes to care models in our communities and hospitals, we need to work

together in a way that we have never done before. In addition to new ways of team working, and a new relationship between clinician and patient, we can do more to exploit synergies in our non-patient facing cost centres, including back office and clinical support services, and we can realise further savings opportunities by reducing both duplication and non-value adding transaction costs.

5.6 Partnership working

Collaboration between commissioners, including the CCG and local councils, NHS providers and general practices, is crucial. There are examples in our system of where this is already happening and, through the HCE, members of these organisations have already begun to work together as equal partners to a far greater extent than ever before. The new relationships between providers and commissioners have already started to pay off, for example in the partnership working to address capacity pressures at CUHFT. However there are also many areas where there is scope for organisations to work together more effectively.

- **General practice at scale:** Many of our GP practices recognise the benefits for sustainability of working at scale, covering registered lists of 30,000 or more. Many are already beginning to implement new ways of working at scale, through networks as well as organisational form changes, with the development of federations, super-partnerships, and vertical integration. By December 2016 we will have developed our GP Forward View strategy which will describe our approach to improving capacity, resilience, and access to services. Over the next year we will build on the work of the CCG to support both primary care at scale and the Primary Care Workforce Development Programme. This is a collaborative programme between the CCG and Health Education England (HEE) which has designed a programme to support and develop a sustainable primary care workforce capable of delivering new models of quality patient care, and has developed the infrastructure to increase the supply of future workforce. This will enable a blend of support and incentives to stabilise current primary care services and improve processes within practices.

- **Acute consolidation:** A Full Business Case (FBC)[9, 10] setting out how patients in Huntingdonshire, Greater Peterborough, and South Lincolnshire will benefit from the services provided by staff working in one single hospital foundation trust, based on three hospital sites, (Hinchingbrooke, Peterborough, and Stamford Hospitals), was approved by the boards of both PSHFT and HHCT at the end of September 2016 (subject to consideration of feedback from the independent local Clinical Senate on the integration of clinical services, and staff and public engagement sessions held in October and November 2016). The FBC has been referred to NHSI for review and the boards of both trusts will meet again, separately, at the end of November 2016 to review all feedback to ensure it is reflected in the FBC and the accompanying implementation plan. They are then expected to ratify the FBC in readiness for the merger to take place on 1 April 2017. In the interim, both trusts are working together to provide safe services, particularly in areas identified as being fragile. Some benefits will be achieved by April 2017, with full benefits delivered by autumn 2020.

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[9] https://www.peterboroughandstamford.nhs.uk/_resources/assets/attachment/full/0/2575.pdf
[10] https://www.peterboroughandstamford.nhs.uk/_resources/assets/attachment/full/0/2659.pdf

PFT is preparing to move onto the Cambridge Biomedical Campus in 2018; this will lead to further formal collaboration with CUHFT in due course.

- **Back office:** We have started to rationalise overheads and support services, starting with Human Resources (HR). We will establish a shared HR back office function that includes healthy workforce. In addition we will implement a joint HR and back office delivery plan that will describe how we can deliver further workforce efficiencies. For example, we will put in place protocols to make it easier for staff to move between our organisations including a staff passport and common induction programme. This is described in more detail in section 5.8. Having analysed each of our organisations' Carter savings, we have identified procurement as our next priority. We will develop a single approach to procurement during 2017/18 and pilot this new approach within orthopaedics through joint procurement of all joint kits.

- **Financial incentives:** Having committed to shared planning assumptions and transparency in tracking CIP and QIPP delivery in 2016/17, we will look at mechanisms for sharing risk and aligning financial incentives including a system control total, alliance contracting, and a local alternative to QOF.

- **Health and social care:** The CCG and local councils are collaborating with the aim of aligning commissioning arrangements for mental health and healthy child services. Building on existing joint commissioning arrangements for children and young people these organisations intend to further integrate physical and emotional health and wellbeing services as well as pathways and processes. For example, redesign of emotional health and wellbeing services for children and young people is underway, using the 'ITHRIVE framework'; the CCG is one of 10 NHS accelerator sites for this. We will build on this relationship and collaborate to deliver services through the BCF and through the development and implementation of our two joint BCF plans. We aim to build on the positive working relationships and collaborate to deliver more integrated services through greater joint working with our statutory and non-statutory partners including our vibrant VCS community.

The formal integration of health and social care is limited in Cambridgeshire and Peterborough, particularly for adults and older people. The CCG and local authorities are considering appointing a joint Director to lead health and social care integration across the STP footprint, and to accelerate progress in this area. We will draw on more established collaborations in the young people's and mental health pathways to embed functional integrated working between acute, primary care, neighbourhood teams, and social care. This will assist both the NHS and local councils to deliver relevant savings and performance objectives and ensure decisions about changes to services are considered in the round, avoiding blunt cost shifting.

We intend to build closer relationships with all public services through engagement in wider initiatives including the proposed Cambridgeshire and Peterborough 'devolution deal'. The devolution deal includes a commitment to work across health, skills, and employment to improve outcomes and life chances for all residents and to enable timely health-based support. HCE members will contribute to engage with the devolution deal, informing and shaping proposals and ensuring that it can meet its ambition to build on existing integration between health and social care to make the most efficient and effective use of public resources to meet the demographic challenges that lie ahead.

- **Working with the voluntary and community sector and support for carers**: Key to the reduction of admissions is coordinating support for people who do not yet meet the threshold for statutory services or formal interventions. Many relevant services and interventions are provided by VCS organisations. VCS provision is therefore becoming increasingly valuable and all commissioners are seeking to work more closely with the VCS. The joint director post across Cambridgeshire County Council and Peterborough City Council is responsible for joint commissioning and will allow greater coordination of such services, which has benefits across the health and wellbeing system. Under the Care Act 2014 the CCG has a duty to support carers through the VCS, through initiatives such as the Carers' Prescription. The provision of such support to carers plays another key part in the reduction of non-elective admissions.

CHANGE PRIORITY 4: Supported delivery

To enable the changes outlined above to take place, and to ensure that the improvements and efficiency savings are realised, we have identified four key enablers which will underpin our work across the system: a culture of learning as a system, workforce: growing our own, using our land and buildings better, and using technology to modernise health. It is through changes to these enablers that further savings opportunities will be realised by further reducing the cost of provision and allowing us to improve quality within a constrained resource envelope. Some of the changes described in sections 5.7 to 5.10 take cost out recurrently, while others represent one-off divestments that can be reinvested in transformational changes that will further reduce the ongoing costs of care.

5.7 A culture of learning as a system

None of our providers can claim to excel in the manner of Salford Royal NHS Foundation Trust, Frimley Health NHS Foundation Trust, Newcastle Upon Tyne Hospital Foundation Trust, and Northumbria NHS Foundation Trust. Learning from these outstanding providers, we know we must invest in a single system-wide capability for quality improvement, the creation of a frontline culture that values deliberative practice, and stable leadership through a deliberate approach to talent management.

To be successful, our system must develop a shared understanding of all the interrelated issues and be able to explain what it means to us as individuals and as organisations. Our plans must be understood by all our staff and patients. During the design phase of our STP we established Clinical Working Groups (CWGs). To support our delivery phase of work we have put in place a new governance structure. This is described in detail in section 9.5 below. These groups have started working towards a shared understanding, but they have a long way to go. To support them, we are developing a system quality improvement (QI) and organisational development (OD) plan that will include coaching, conflict management, and opportunities to experience new ideas together. In time the QI/OD focus will be rolled out so that we have, increasingly, a common culture and set of values across Cambridgeshire and Peterborough. Ultimately we want our staff to not only identify with their professional group and employer but as a key partner to the Cambridgeshire and Peterborough health and care system's long-term sustainability.

To build on our research heritage, a core part of our cultural identity will be 'learning'. We will continue to strive for excellence in the care we provide for the patients of today. We also need to be at the forefront of adopting new therapies and delivery models for the patients of tomorrow. For

example, PFT will continue as a centre of expertise in cardiothoracic care and lead research in heart and lung specialty areas of care. The Heart and Lung Research and Education Institute (HLRI) is scheduled to open in 2020 and will be adjacent to the new Papworth hospital. CUHFT will continue to focus on neuroscience, metabolic medicine, transplantation, and musculoskeletal disorders, including potentially establishing a Movement Centre to research the application of regenerative medicine for early stage arthritis. CCS will continue to develop its research and innovation in sexual health, HIV care, and children and young people's services. CPFT, which now houses a dedicated clinical research facility on site, will continue to engage with the research agenda to ensure that all CPFT patients have the opportunity to take part in clinical trials. And through its role as a partner in the National Institute for Health Research's CLAHRC East of England, CPFT will continue to focus on innovation and evaluation. Cambridge University Health Partners (CUHP), currently being redesignated as an Academic Health Science Centre, will continue to deliver world-class excellence in healthcare, research, and clinical education to improve the health of local people.

5.8 Workforce: growing our own

Improving the shape and size of our current and future workforce is crucial to closing the gap in relation to health and wellbeing, care and quality, and finance and efficiency. Section 2 sets out the workforce challenges faced by our system. These include high vacancy levels, skills gaps across all professional groups, difficulty moving staff and resources around in our system to address workforce needs, training gaps, and systems that do not make it easy to share data between organisations. In determining how to move forward we have looked elsewhere to see what works and who we can learn from. The Sutton and Nottingham Care Home Vanguards both have innovative models for staff development, while Torbay has put in place significant training to ensure that MDT working is successful. Triangulation of workforce data and intelligence has provided us with building blocks to design a workforce and transformation strategy. Under the themes of planning, leadership and OD, training and development, and general practice development, we have designed solutions to address the challenges we face relating to improving the size and shape of our workforce, particularly those being faced by general practices. Quality improvement, talent management, and supply improvement will allow us to make improvements by flexing staffing across the system and designing new roles.

- **Training new staff:** In the short term we have developed a whole systems approach to 'grow your own' and 'earn as you learn'. We are building on the existing Supply Improvement Programme run by HEE and developing career pathways that begin at apprenticeship level and take individuals all the way through to registrant or advanced practitioner level. Our goal is for Cambridgeshire and Peterborough to provide high quality placements for those in training and to become one employer of choice enabling us to retain those we train.

- **Skills development of existing staff:** Over the longer term our system needs to work differently to ensure our staff are appropriately supported and retained. Over a quarter of our workforce is aged 51+ years. Retention of organisational memory and expert clinical knowledge is one of our priorities. We must ensure that the contribution of our mature workforce is retained and that they help us to develop competence and confidence in newer members of staff. We will enhance our skill mix and provide development opportunities and opportunities for extended roles at all levels.

  Working in partnership with HEE we are developing a STP workforce and transformation strategy across the local health and care economy. It will focus on the skill mix required of both existing and future workforce to support new models of care, ensure local commissioners and providers are employers of choice, and prioritise workforce investment across the health and care system.

It aims to support the system to move to a new model of education commissioning as a mechanism for delivering their system transformation plans.

> **Case Study: Skills for people-powered care**
>
> We have made progress towards training and developing our staff to deliver new roles:
> - research funding from HEE is supporting training and research on integrated working between health and social care for the neighbourhood teams
> - a new integrated care work role, funded by the Cambridgeshire BCF and the CCG, is currently being established as part of a new intermediate care tier
> - an Early Help Team has recently been established by Cambridgeshire County Council to provide help to individuals at an early stage of need within the community
> - care home educators, funded by the Cambridgeshire BCF, have begun working in our system building on learning from a local pilot and the Care Home Vanguards. Their objective is to educate care home staff to support patients to remain at home where hospital admission is not the right option.
>
> We have bold ambitions to deliver further change going forward:
> - we plan to support our local carers through training, advice, and support to keep people healthy and well at home
> - we will engage further with higher education providers to develop and deliver the training programmes we need for our future workforce
> - we plan to use an 'Apprenticeship Levy' to create roles that promote integration.

- **Skills flexibility:** Many of the emerging new models of care, including our aspiration to operate in care networks, require both the current and future workforce to work more flexibly across locations. We will seek to develop the flexibility of our workforce and to normalise working patterns that, at times, may see individuals working in different organisations at different times in line with the demand for our services and our capacity to deliver them. Section 7 describes our ask of staff in more detail. Similarly our HR model will need to become more flexible and, where possible, we will do things in common, for example via staff passports, and establishing clinical networks, to enable staff to move between organisations more easily.

5.9 Using our land and buildings better

We have many community estate sites, some of which are poorly utilised. This provides us with the opportunity to rationalise the numbers of buildings used and potentially develop new primary and community care facilities on the larger freehold sites. This rationalisation will also promote co-location and shared working spaces which can bring teams together and foster integrated care delivery across health and social care agencies. We have already started to work in a more coordinated way, not only across health and care but also with partner agencies including the fire and police services. Better use of technology, rather than creating physical space, will support new ways of working.

We have the opportunity, when practices' leases expire and with new housing and hospital campuses in development, to use our estates to support new models of care. This could be through the creation of larger, modern, family and frailty friendly hubs where GPs can work alongside social care and community staff, have direct access to diagnostics and specialist advice, and are enabled to diagnose and care for more patients without the need to refer on. Over time we expect these hubs to replace much of outpatient care. Furthermore, to bring NHS and local health and care resources together under one literal social/community/mental health/primary care roof will go a long way to ensuring proactive care at the source of the problem, rather than reactive care in hospital as an acute

episode. Similar changes are possible as back office services begin to collaborate more fully. The sites at Princess of Wales Hospital in Ely and North Cambridgeshire Hospital in Wisbech are obvious locations for these new neighbourhood hubs. Outline plans, which will help us respond to a growing population, local health needs, and poor current infrastructure, have already been drawn up for these sites. Further, with so much building development happening in Cambridgeshire there are opportunities for new commercial ventures and strategic partnerships on, for example, the HHCT campus

5.10 Using technology to modernise health

Currently, uptake of technology across the CCG is variable but our ambition, supported by the Local Digital Roadmap vision, is that by 2020 'patients and citizens, health and social care staff have access to quality, timely and accurate information regardless of place or time to enable improved decision making and ultimately better outcomes for both the individual and the community'. We will deliver this in six themes.

i.   **Data and information sharing**: We intend to implement an IT platform which will allow, where appropriate and with appropriate consent obtained, access to a number of providers' patient information systems. This single view of the patient record will integrate primary care, mental health, community care, and social care patient information via the NHS number. Initially we will develop this for our urgent and emergency care teams (NHS 111/Clinical Hub) and JET through hand held devices, as well as in A&Es where we will allow access to core patient data about diagnoses, medication, prior health encounters, and resuscitation status to help minimise inappropriate non-elective admissions. In time improved IT functionality will improve access to this information for paramedics.

ii. **Health apps:** We will support the introduction of health apps which are relevant to both our ageing population as well as those with long-term conditions. These apps give advice about symptom significance and management and, in some circumstances, can foster introductions to wider disease-specific patient self-help circles. This project will be closely allied to the Prevention Strategy and aligned with that of public health, local and district councils.

iii. **Telehealth/remote monitoring**: With partner providers of telehealth and monitoring equipment we will develop virtual clinics for long-term conditions. A range of wireless-enabled devices will be used to give both active patient monitoring during exacerbation (e.g. COPD) and patient reassurance and security when they are isolated.

iv. **Interoperability:** A component part of data sharing is developing the IT links between providers. This will include expanding access to a patient portal, giving patients full access to their records as well as the opportunity to transact with the hospital to, for instance, arrange appointments. Web-based portals will be available for community clinicians to access records and consult with clinicians regarding the care of the patients.

v.   **Real-time information exchange**: We will have access to person-level operational data on utilisation, cost, and, potentially, even outcomes. This will allow both monitoring of the day-to-day status of services within the health and care system and system surveillance of financial and clinical performance.

vi. **Health analytics:** We will adopt a population-based approach to health analytics which will enable us to track patients across the system, particularly those with poor outcomes and incurring high costs, with the aim of understanding what we could change to improve the way we provide care. This will also allow us to predict who to target with intensive proactive case management. It will be essential to turn population data into information that allows for intelligent patient insight and effective decision making.

6. What these changes mean for local people

In line with our ACO ambition, the solutions we have developed aim to maximise population health. We have considered the impact that the changes outlined will have on the different groups within our local population and in particular on the patient groups who we feel could receive better services from us - namely those in relatively more deprived areas, those with multiple long-term conditions, and the frail. We have engaged with the public, and with patients and carers, when designing solutions to the problems we face and worked with them to come up with proposals that are beneficial to our population, such as providing more care closer to home utilising proactive community-based models.

We published our draft STP summary in July: 'How health and care services in Cambridgeshire and Peterborough are changing'[11]. The summary outlines our 10-point plan and what we aim to deliver and improve across the system. The document was provided to staff, stakeholders, and the public. We held inclusive dialogue with the public in the summer of 2016 (in particular in relation to the MIUs in East Cambridgeshire and Fenland) and have continued to engage with patient groups, Health Scrutiny Committee/Health Committees, and Health and Wellbeing Boards. We will continue to involve our patient groups where potential major changes are being considered, using their contributions to inform quality and inequality impact assessments of our proposals and to help us consider the implications of any changes. This will include consideration of the impact of service changes to people living not only within Cambridgeshire and Peterborough but also those who might be affected within neighbouring footprints.

Our forthcoming engagement with the public has three key aims:

i. **Publicising our plan**: We will continue to articulate our vision for health and care, telling a compelling story which describes the benefits of our proposals for patients and local people – in describing what it means for patients in more detail. This will help us to achieve the transformational changes required.

ii. **Co-designing care models:** We will continue to work with our health and care users, including those who require the most intensive support, to ensure that the care we design is person-centred and promotes independence. We will need to engage fully with the public about service redesign that will change how and where they access services. We aim to develop a patient choice hub to ensure the care we offer is person-centred and promotes independence. This is described in more detail in section 5.4.

iii. **Supporting behavioural change among patients and residents**: We will work with the public to promote healthy behaviours and individual responsibility for health and wellbeing, stressing to our population the importance of leading healthy lives. We see ourselves as partners with the public; we have a joint role in keeping healthy and we want to be sure that our local population is equipped with the tools they need to keep fit and well for as long as possible. We will provide education around appropriate and effective ways of using services including self-care, urgent care, and A&E. We will re-educate people that A&E is only for serious or life-threatening injury or illness.

The following patient stories demonstrate how the changes impact on local people positively.

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[11] http://www.fitforfuture.org.uk/wp-content/uploads/2016/06/How-health-and-care-services-in-Cambridgeshire-and-Peterborough-are-changing_Fit-for-the-Future-Summary_July-2016.pdf

Better safe than sorry

When, on a Sunday morning outing, eight year old Olivia fell off her bike and banged her head, her mother Gemma didn't know what to do. She thought about driving to A&E or dialling 999 but remembered seeing posters saying that 111 was a better option for injuries that were not serious or life-threatening. She called 111 and they arranged for Olivia to see a GP later that morning. The GP, Martin, examined Olivia and, because there was detailed protocol in place between 111 and the local Paediatric Assessment Unit (PAU), Martin used this to advise Gemma about what to look out for following a head injury, and what to do if Olivia's condition changed. Martin directed Gemma to the NHS Choices website for further information.

In the afternoon, and using the information that she had been given, Gemma became concerned that Olivia was getting worse and not better. Following the advice that GP Martin had given her earlier she took Olivia to the PAU. The PAU already had Olivia's notes and details of what had happened so Gemma didn't need to repeat her story. Olivia was observed for six hours and discharged fit, well, and keen to get back to playing with her friends.

Looking forward – keeping active

Mark gave up playing rugby after a broken wrist and had become an armchair fan at the age of 39. He still enjoyed regular evenings out, and was ashamed to admit that his smoking had increased since he gave up sport. But Mark remained convinced he was still fit and healthy – with nothing to worry about. Aisha, Mark's GP, was not so sure.

Responding to an invitation for a regular check-up, Mark was told that he was significantly overweight, with warning signs that suggested he was at risk of developing diabetes. Aisha knew that persuading Mark to make the lifestyle changes he needed would require both a plan and support.

First, she connected him to the local smoking cessation service, which organised drop-in sessions Mark could easily get to, and put him in touch with a fitness coach who could recommend an exercise programme to suit him. She also realised that Mark's smartphone was his window on the world, and suggested some websites and a wellbeing app to help him plan and stick to his diet and fitness regime.

Care shaped around the patient

After she turned 80, Doreen found her health deteriorating. Doreen has diagnoses of diabetes, emphysema (COPD), as well as early stage dementia. She lives with her husband, Roy, who is 82, who also has diabetes but is otherwise fit and cares for her. Paul, her GP, invited Doreen for her annual assessment.

Based on her increasing frailty, he accepted her onto the caseload for complex, case-managed patients who are supported by a multidisciplinary team in the community. Angela, a member of the community team, is her care coordinator. Paul and Angela worked with Doreen and Roy to create two plans. The first was a care plan which summarised Doreen's health needs according to her preferences and priorities, and what she and Roy would want in the event of a crisis or deterioration in health. The second, a self-care plan, allowed Doreen to describe her goals and needs for caring for herself safely at home, and identified how she could be supported in doing so by Roy and the health system.

Living beyond psychosis

Jack was becoming increasingly isolated; he had stopped attending school and seeing his friends and had complained of hearing voices. Following a comprehensive assessment at which he was considered to have developed an early onset psychosis, he was referred to the early intervention service.

He began a three-year programme tailored to his needs. The service worked with Jack to deliver a holistic care plan. Family therapy enabled Jack and his family to understand more about his experiences and to begin to resolve them.

Jack is now aware that he can choose to access a wealth of insight and to share experiences through social media. He is actively involved in monitoring his state of mind, and has discussed in advance what he would like to happen in a crisis and understands what to do if he becomes unwell again. His GP and the practice team are very involved with his care plan and can call on a range of support for Jack. Perhaps the most important connection was with an employment project – which supported Jack through his college application. Now in the second year of his course, Jack can see a much brighter future.

7. What these changes mean for our staff

We have worked through our solutions as if we were the leadership team of an ACO. The staff we have involved in developing solutions have been tasked with putting patients first, over and above organisational or professional interests. With the STP now developed, it is important that we are clear about what the changes mean for us as individual organisations. The biggest change will be for the 20,000+ staff employed by our providers. While the proposals themselves have been developed by approximately 200 frontline staff, we have already started to plan how we will engage with staff more widely because we know that none of the changes we want to implement will happen unless our staff understand their new roles, buy in to our rationale for changes, and see the benefits to them and their patients. We understand that some staff may be concerned about these potential changes, but by putting our patients at the centre, now and in the future, we are confident our staff will respond positively and feel that the opportunities presented are career enhancing. We are asking staff to think of themselves as part of the Cambridgeshire and Peterborough system, serving Cambridgeshire and Peterborough patients and their families, not just the organisation that employs them or the professional group with which they are affiliated.

We know that our workforce will need to grow in order to cope with our increasing population and growing numbers of people with complex health needs. This means that there will be an increase in staff numbers over the next five years, but this growth in head count will be less than it would need to be if we were not working as a system. The type of skills we will recruit will also differ in recognition of the need to supplement primary care with non-clinical staff who can focus on care coordination and provide social support, and that we need to make the best use of our most expensive and often scarce consultant workforce by sharing posts where appropriate, for example on-call and/or through offering remote consultation. Staff often train in our organisations but do not choose to stay because housing is too expensive, particularly in Cambridge. We are keen to address this and will seek to influence the planned new housing developments so that they include sufficient affordable homes. It is imperative that the HHCT campus and other developments have more key worker housing to attract staff to this area and ensure we retain them.

- **Health and care provision**: Our move towards a networked approach will see significantly greater collaboration between organisations. This may mean that we ask staff to work in different locations, with different work patterns and work methods to now. We will work with staff with the aim of alleviating any concerns they might have around this and we will ensure the benefits of this new approach are made clear.

  There will need to be significant changes within our general practices and we know that these changes will have an impact on our GPs, nursing staff, and other health professionals. Our GPs will collaborate increasingly, through the creation of organisation models such as federations and super-practices, meaning that individual practices are likely to come together and that working methods and processes begin to change as new, larger organisations form.

  Further changes will take place to enable us to deliver our aim to provide more services in the community. A range of services currently provided in secondary care, including some outpatient and diagnostic appointments, will be moved into the community and this will mean a change for the staff delivering those services. We expect an increase in multi-disciplinary working, greater collaboration between professional groups, and an increase in extended job roles. For GPs there will be the opportunity to specialise more, something we know is an attractive career proposition to many. GPs may find themselves challenged to surrender some of their clinical autonomy by working as teams in order to increase their influence on the design and operational performance of the health and care system for their and their patients' benefit.

- **Commissioning**: For our commissioners there will be increasing emphasis on population-based commissioning driven by the need to change or influence outcomes for specific population groups. Although contracts will need to be monitored, this will be to ensure that the outcomes are being achieved. The relationship between commissioners and providers will be different, moving from one that has been, up to now, transactional to one that is collaborative and transformational.

8. Our approach to implementation

8.1 Why this time is different

We know that there have been times in the past when we have not delivered plans in the way we intended to. This time it will be different because we have been able to work together, as equal partners across the system, to build collective awareness that a problem exists, fully comprehend the root causes of this, and use this information to identify solutions, build commitment for implementation along the way, and thoughtfully prepare for action. We are committed to behaving differently, listening more, being clearer about principles for decision making, and getting better at making whole-system decisions together. The following diagram summarises our approach:

Awareness	Comprehension	Commitment	Action
• Collective awareness of the challenges we face • A shared understanding that standing still is not an option • Agreement that the scale of the challenge is so significant that unless we work as a system we will not make any sizeable difference to our finances	• Working together, with staff and patients to diagnose the underlying root causes and co-design solutions • Development of solutions designed to promote health, deliver consistent person-centred care and restore financial balance • Horizon scanning for solutions and where they are none creating our own	• Exploring external factors to reinforce the system focus, building on inherent motivations to 'do the right thing' • Building on the oversight and support of the bipartite received to date, into a regulatory regime aligned to the system • Resilient and robust commitment to delivering change	• Utilising a range of tried and tests service improvement methods to drive the change • Up-skill our teams as necessary • Establishing a disciplined process for tracking the delivery of our programme to ensure that we remain on track

8.2 System leadership, system working

We recognise the importance of partnership working in order to implement the changes described in our STP. This includes partnership working across our provider and commissioner organisations as we move towards greater joint health and social care commissioning and integrated service delivery. We have written a MOU to describe how we will work in partnership, to bind our organisations explicitly, and to enable us to take the first steps towards developing further our ACO ambition. Our MOU describes our approach to working together as a system. This has been signed by the CCG, CUHFT, PSHFT, CCS, HHCT, PFT, Peterborough City Council (MOU annex 1 only) and Cambridgeshire County Council (MOU annex 1 only). In future we anticipate that others will join or become more formally affiliated with the partnership embodied in the MOU including EEAST, GP federations, practices, or third sector organisations.

The MOU, which is attached in Annex 1, comprehensively describes how all members of the HCE will support and promote system behaviours for the benefit of local residents and healthcare users including: working together and not undermining each other; behaving well, especially when things go wrong; engaging in honest and open discussion; keeping our promises – small and large; seeing success as collective; and sticking to decisions once made. The MOU describes a set of commitments in relation to delivering the STP as follows:

Commitment 1: One ambition: to return Cambridgeshire and Peterborough to financial, clinical, and operational sustainability by developing an ACO, acting as a single leadership team, with mutual understanding, aligned incentives, and coordinated action with external parties (e.g. regulators).
Commitment 2: One set of behaviours: all partners agree explicitly to exhibit the beneficial behaviours of an ACO.
Commitment 3: One long-run plan: we are collectively responsible for delivering the STP and capturing the saving opportunities identified. We believe in the plan we have submitted.
Commitment 4: One programme of work: all system projects will be aligned to the HCE, and under supervision of a delivery or design group.
Commitment 5: One budget: within NHS contracting, a number of financial incentive design options will be considered.

> **Commitment 6: One set of governance arrangements**: the HCE and the groups reporting to it (AEB, the CAG (and strategic sub-committees), the FPPG and the eight Delivery Groups), will be the vehicle through which system business is conducted.
>
> **Commitment 7: One delivery team:** resources are in place to deliver the STP.
>
> **Commitment 8: One assurance and risk management framework:** crucial to strengthening trust and creating a sense of shared accountability will be evolving the HCE from a forum for making strategic decisions to one where partners can be assured of the delivery of system-wide improvements

Our MOU provides the first step towards developing further our ACO ambition. In time we will seek consent from Boards to delegate some decision making powers to the HCE through amendments to our terms of reference and a new negotiated relationship with governing bodies. We will begin formally sharing financial risk from 2017/18 onwards. To support the local and national ambition to develop ACO behaviours across the system, we will begin shadowing formal governance arrangements for managing the system control total in Q4 2016/17, including the governance of system investments. These governance arrangements will be supported by improved health informatics capabilities that will be developed through our SDU.

8.3   STP governance arrangements

We have determined the governance structure required to support and enable the successful delivery of our work. Reporting to our HCE is a number of executive boards, delivery boards, delivery groups, and strategy groups, each one with a clear remit and role to play in the delivery of the STP.

- **Area Executive Boards:** Three Area Executive Boards (AEB), for Greater Peterborough, Huntingdon and the Fens, and Cambridge and Ely, are responsible for ensuring implementation of projects (including savings realisation) where a common design needs to be tailored locally. The projects supervised include a mix of proactive care (e.g. integrated neighbourhoods) and reactive care (e.g. in-hospital flow, attendance avoidance).
- **A&E Delivery Boards:** We have three A&E Delivery Boards whose remit is to fulfil the nationally defined responsibilities of A&E Delivery Boards.
- **Delivery Groups:** We have established eight delivery groups covering UEC, elective, primary care and integrated neighbourhoods, women and children, workforce and organisational development, digital, shared service, and system delivery. These groups are responsible for ensuring implementation, including benefits realisation, designing projects and delivering projects (where implementation needs to happen consistently across our footprint). Delivery groups are also tasked with horizon scanning to identify future opportunities that support system sustainability
- **Strategy Groups:** We have three cross-cutting strategy groups for Sustainable General Practice, Mental Health, and Ageing Well. These groups are responsible for steering/quality assuring projects that span multiple delivery groups and, in particular, implementing the GP Forward View, mental health strategy, and aspects of BCF implementation. These groups may develop business plans for future savings and investments that pertain to more than one project group, across multiple delivery groups.

The CAG, which during our design phase was our Clinical Advisory Group, has a key part to play in the next phase of work and will continue but will renamed as a 'Care Advisory Group'. Its role is to review care model design proposals from the delivery groups, horizon scan for innovations, and reconcile differences between programmes of work. Similarly, the system's Financial Directors will meet as the FPPG. The FPPG's remit includes the development of a framework for contracting and

incentives, aligning planning assumptions, quality assuring savings and investment proposals, and tracking savings progress.

These groups are structured as follows:
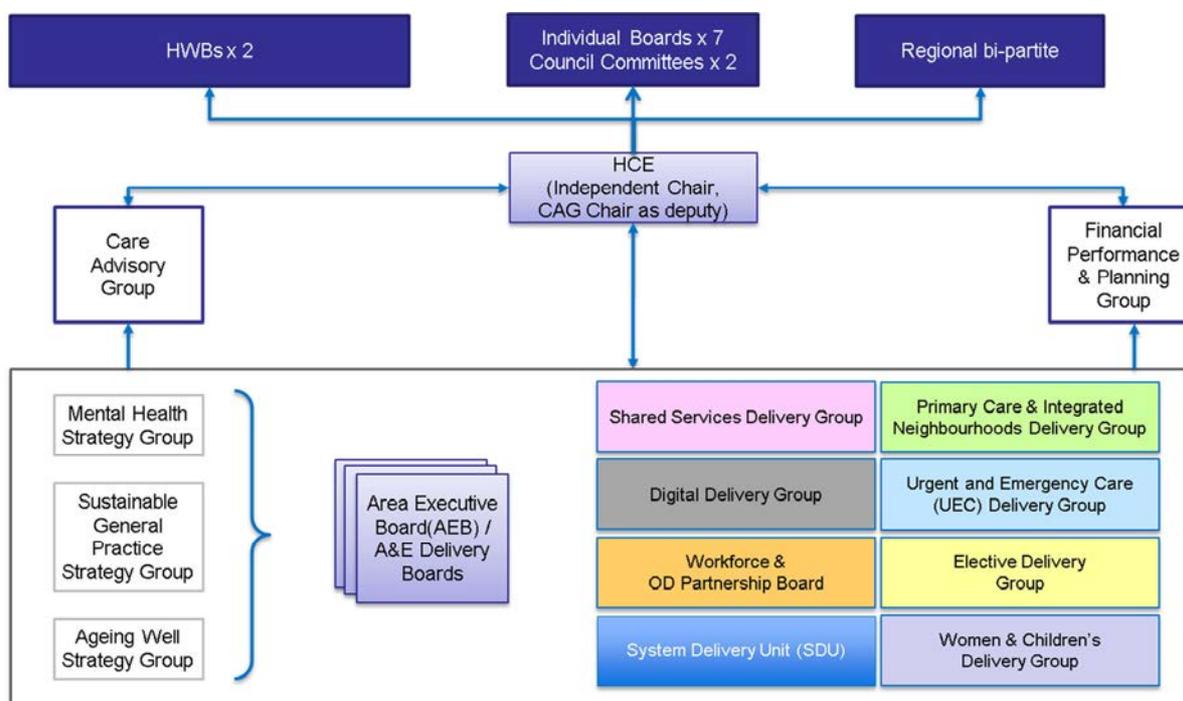
8.3 STP programme of work

We have translated the STP into a programme of improvement projects, each of which reports to a group or board in our structure. The table below sets out the improvement areas that fall under each of the groups:

Shared services	• Back Office • Procurement • Estates	• Clinical support services • Market forces factor • Productive/healthy workforce
UEC	• Ambulance efficiencies • Stroke pathway • Acute frailty and ageing recovery pathway	• Out of Hospital Integrated Urgent Care • Psychiatric Liaison • New care models
Women and children	• Perinatal care • Urgent care (with acute) and community nursing expansion • Specific disease pathways (asthma and continence)	• 0-19 universal services • Mental health support for children • Specialist disability services (Health, social care, and education) • Maternity developments
Elective	• ENT • Ophthalmology • Other specialties • Patient choice hub	• Cardiology • Orthopaedics • Improved referral pathways • Outpatients
Primary Care and Integrated neighbourhoods	• Long term conditions: diabetes • Long term conditions: respiratory • Long term conditions: CVD/ stroke • Self-care	• Healthy ageing • Mental health • PCP Specification

Digital	• Direct cross community care (primary use) • Secondary use	• Investing in people • Technology and infrastructure
Workforce	• Workforce planning • Leadership OD • Training and wider development	• General Practice workforce development
SDU	• Systems planning • Impact tracking and evaluation • Consistent messaging	• System analytics • Aligned incentives • Spreading a QI culture
Area Executive Boards	• Area based Integrated Urgent Care	• Time to Care test beds and roll out
A&E Delivery Boards	• In-hospital flow	

Each improvement area has a named Accountable Officer, who is a member of the HCE, a clinical lead, a finance lead, an HR lead, and a communications lead.

As a system we have planned timescales for change, immediate priorities, and the anticipated impact that our changes will have on our system financial position. We are confident that the leadership and governance arrangements we have put in place, described below, will ensure implementation is successful. Our phased roll-out is described, at a high level, below. A more detailed timetable is set out in Appendix 5 and a comprehensive Delivery Plan is attached in Annex 2.
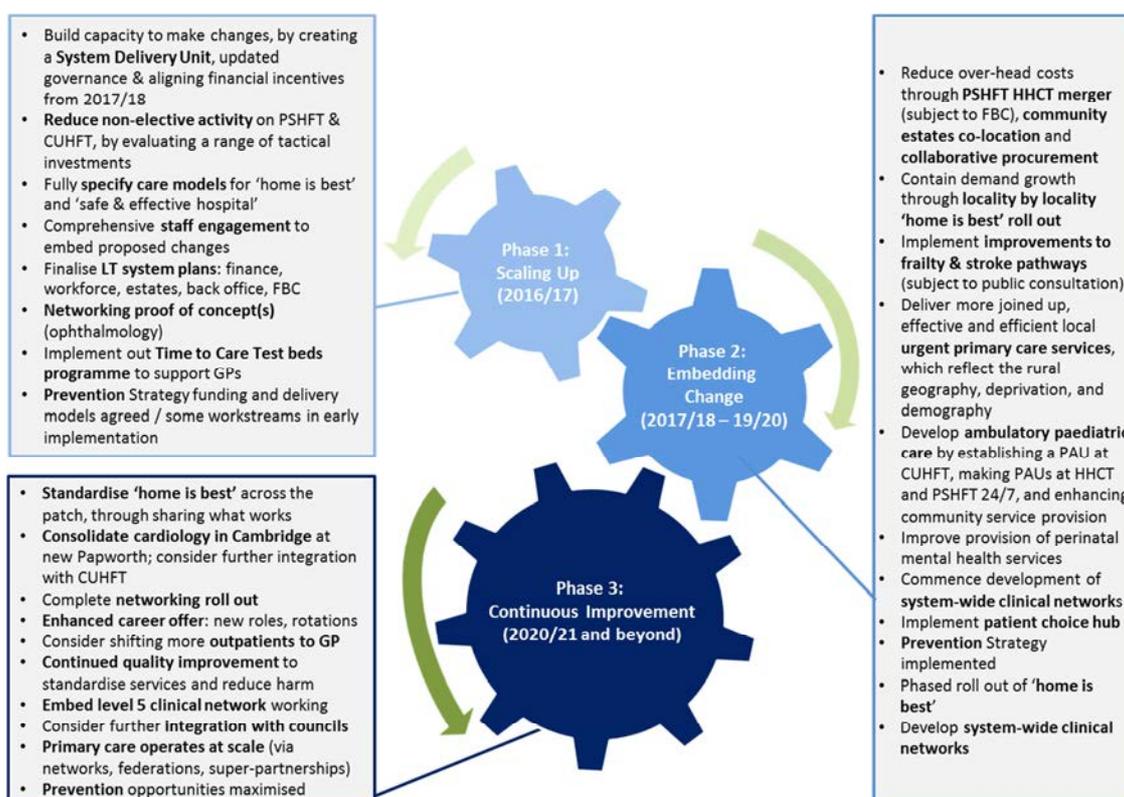
We recognise that the programme we have developed is far-reaching and that to ensure delivery we need to tackle the changes in bite-sized chunks. We are unlikely to succeed first time in every change we make, so we must build in scope to learn and adapt as we go. Implementation of the STP will be system-led, provider-led, or commissioner-led. The system-led work will focus initially on the changes that need to be delivered by working together either at a local level, as described by the Peterborough case study in section 5.2, or across the entire patch. Many of the STP solutions would

benefit from being taken forward together, and as we develop our relationships and build confidence in system-wide, collaborative working, the scope of system work will broaden over time. In the interim, where things are taken forward independently, they will be tracked at a system level to ensure alignment to our STP. Regardless of who leads, both trusts and commissioners must invest more time and effort into ensuring actual CIP and QIPP delivery, not just plans for delivery. This will be a significant practical challenge, particularly given that CUHFT and the CCG are in turnaround.

8.4   Sustainability and transformation resourcing

Prior to the June STP submission, we committed to establishing a central system improvement team to oversee this large programme of system transformation and provide a central pool of expertise for designing, testing, evaluating, and scaling new ways of working. We have now determined how the team should look, recruited to the majority of posts, and the team - the System Delivery Unit (SDU) - launched on 1 November 2016.

Appendix 6 shows the structure of this new team. SDU members will maintain an overview of STP delivery and track savings realisation across all programmes of work, support the design, testing, and scaling of identified system solutions to care delivery or enablers, put forward the system perspective where there is tension with individual organisational objectives so the right balance can be found, and initiate widespread cultural change in line with the learning system enabler above. The SDU is led by an experienced, executive level Programme Director and overseen by the HCE, led by the independent Chair. The Programme Director will be invited to regularly attend the CCG Governing Body and all provider Boards to ensure visibility, accountability, and access to the accountable bodies of the organisations where change is taking place.

The skills employed include system leadership, project management, delivery support, problem-solving, population health analytics, quality improvement, change management, finance and activity modelling, and communications and engagement. The team will deliver programme oversight and culture change, care model solutions delivery, finance, evaluation, health analytics, and enablers to change. The team will be expected to work closely with the East of England Academic Health Science Network and Cambridge University Health Partners. The payroll will be administered by CUHFT and team members have been locally employed for a period of up to three years. Implementation of the STP is the full-time day job of these members of staff. The CCG has also been restructured to align teams with the work programmes of the STP.

The cost of the team, including the independent Chair, is £1.94m. Partner organisations have all contributed to the costs by providing cash but also by seconding staff who are already working on transformation and improvement opportunities. Going forward, the SDU will also be used to deliver discrete products as required, for example the build of a system-wide person-level linked data warehouse for providing population health analytics and ensuring we can track progress. Embedded clinical engagement, from the beginning, is essential to success and we plan to recruit clinical quality improvement experts and a network of 'change champions' to influence their peers and help enable change to be delivered. Patients and the public will be involved in all of our projects and we will continue to engage with our population through a variety of methods.

8.5 Tracking delivery

We have developed a set of monitoring metrics which will provide the HCE with a system-wide overview on progress towards system sustainability. The starting point for metric development was the CCG Improvement and Assessment Framework[12] as this has been designed to monitor improvements in health, care, and value across a whole health system. We have ensured that our indicators represent the perspectives of a wider partnership view so they have been further developed in conversation with our local authorities and Finance Directors group. The resulting set of metrics provides an overall assessment of health outcomes, system sustainability, and key operational areas. Individual delivery groups will use a more detailed set of indicators that are relevant for their particular area to monitor improvements, as well as being responsible for monitoring improvements to the HCE level indicators allocated to their delivery group.

	Implementation metrics for HCE	
1	**Sustainability**	• YTD % variance to system control total (allowable deficit)
2	**Urgent and Emergency Care**	• Emergency hospital admissions for falls in persons aged 65+ annual DASR per 100,000 population • The number of patients admitted, transferred, or discharged from A&E within four hours (% of total). • Delayed transfers of care attributable to the NHS and Social Care crude monthly rate per 100,000 population • Non-elective admissions for respiratory conditions for people aged 18 years and over • Non-elective admissions for respiratory conditions for people aged under 18 years • Total bed day crude monthly rate per 100,000 registered population • Emergency admissions crude monthly rate per 100,000 registered population
3	**Operational indicators**	• Referral to treatment % in 18 weeks • BCF: Non elective admissions variance to plan • Overall patient experience of GP services • Extended access to GP services on a weekend and evening • Time to third next available appointment • Patient satisfaction with opening times
4	**Priority indicators**	• Staff Sickness Absence Rate
5	**'System Health' indicators**	• Mental health - completed therapy and are moving to recovery • First episode of psychosis starting treatment with a NICE-recommended package of care treated within two weeks of referral • Out of area placements for acute mental health inpatient care – transformation • Reduction in the inequality between mortality in the areas of poorest Coronary Health Disease (CHD) health compared with area of best CHD health • Staff Satisfaction/Workforce Survey • Governance and Leadership tbc

Appendix 7 sets out our proposed balanced scorecard that will be used to track these indicators. Project initiation documents (PIDs) will be completed for every improvement area described in our Delivery Plan. The PIDs describe the challenges that the improvement area will address, overall delivery approach, key success measures, financial impact of the improvement area, a detailed

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[12] https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/03/ccg-iaf-mar16.pdf

delivery plan, interdependencies with other improvement areas, and risks to delivery. All PIDs have a comprehensive sign-off process that includes a quality impact assessment and finance review. The Delivery Group Accountable Officer has final sign-off of the PID prior to commencing implementation. An example PID is attached in Annex 3.

We have developed a comprehensive reporting cycle that provides detailed oversight of each improvement area at Delivery Group level and a high level view of progress within each Delivery Group and HCE level. We have developed a standardised reporting template to enable each of the Improvement Area Senior Responsible Officers to capture progress to date and risks to delivery. These reports are aggregated to provide a single Delivery Group report for the HCE. Further information is provided on an exception basis for high risk (red rated) improvement areas, where these areas have already slipped or are at risk of slipping against planned delivery.

9. What these changes mean for our finances

We hope that section 3, 'Our Approach', makes it very clear that we have left no opportunity unexplored for improving the financial position of our system and returning it to financial balance by 2020/21. We have been able to close the £504m 'do nothing' gap to a small NHS system surplus position of £1.3m. We have done this by using top-down analysis, including benchmarking local performance against Right Care, Better Care Better Value, Carter indices, and quantifying local opportunities such as estates and the impact of pathway changes, which we have tested with our clinical working groups, peer review among our finance directors, and working up increased specificity of the 2017/18 and 2018/19 schemes as part of operational delivery planning. The following waterfall sets out those opportunities, demonstrating the different categories that the savings fall into:
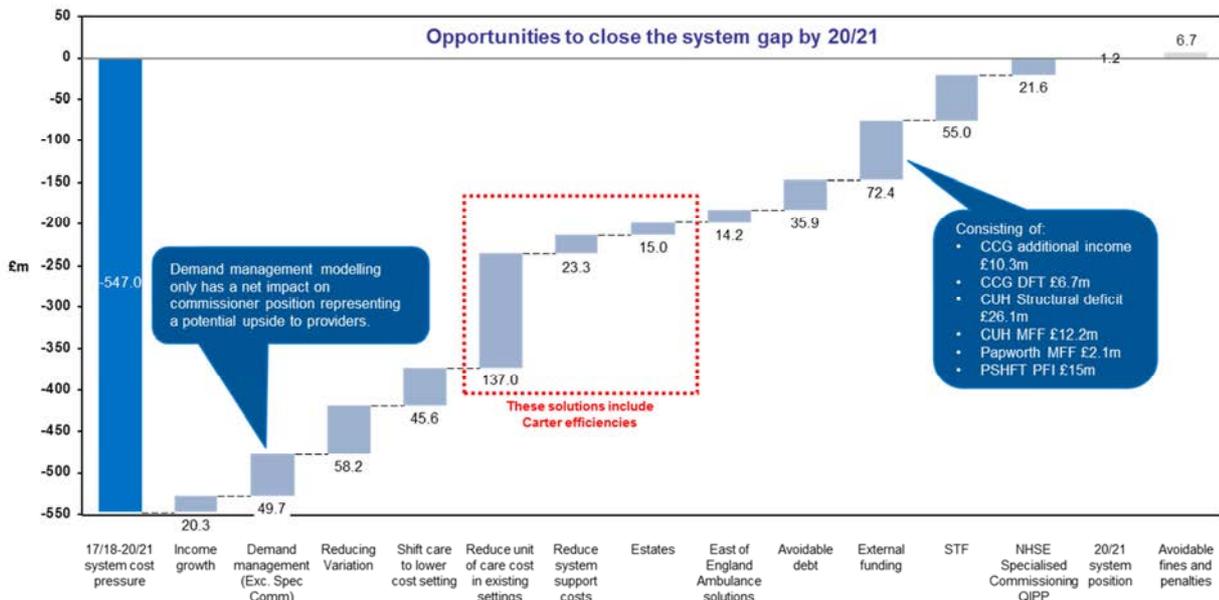
Appendix 8 contains more detailed explanations of the savings opportunities we have identified and the sources of these savings. The capacity of our provider organisations is already constrained and the health needs of our growing population will only further exacerbate system quality and operational and financial pressures. We need to absorb the additional demand from population

increases without building new hospital capacity. The work we have done with our clinical working groups has demonstrated that the alternative, consolidating hospital capacity, would be much less desirable from a patient perspective and would require significant capital investment. Closing or significantly rebuilding any of our main acute hospitals (outside of the already planned relocation of Papworth to the Cambridge Biomedical Campus) is not part of our five year plan.

Instead, we believe that success lies in reducing demand, and meeting the ambulatory care needs of sick children, people with long-term conditions, and the frail elderly, in primary and community care settings, reducing hospital length of stay, improving our workforce utilisation, and taking our overhead costs in line with Carter. We are confident that there is significant scope both to improve patient flow through reducing variation in care delivery and to deliver care more effectively outside of hospitals, totalling £175m. Our organisations do not uniformly benchmark as among the most efficient of their peers (as demonstrated by the Carter and Better Care Better Value indices). With a relatively crowded provider landscape among both NHS and GPs, we feel that there is also scope to reduce clinical support services costs and running costs through sharing back office costs and, in extremis, organisational mergers where beneficial, totalling £190m. Finally, there are a number of areas that we believe should yield additional benefits including growing income commercial opportunities, and by reducing the cost of debt repayments, totalling £56m.

Overall, this means that we will be able to hold acute inpatient spells roughly static over the next five years and see an 8% reduction in first and follow-up outpatient appointments from current acute activity levels. With reductions in length of stay, acute hospital occupied bed days should reduce from current levels by about 50,000, enabling a much needed reduction in occupancy levels of up to 5%. This will help to improve hospital flow and safety, with additional potential for the repatriation of activity that we are not currently able to provide.

9.1 Financial trajectories and control totals

As a system, we have a plan that balances over the five year period and should allow us to locally fund the additional investments required to meet locally identified deficiencies in service models and bring our services in line with national priorities. Initially, funding these investments locally will be limited to using the CCG's 0.5% contingency and provider cost savings due to the very challenged financial position of the CCG. However, the control totals indicated for the system in 2017/18 and 2018/19 have set us the collective challenge to improve our individual positions quicker, especially that of the CCG. The only way we can do this is with pump-priming investment in primary care-led demand management schemes, and recognition of our system's particular structural deficits.

Below we set out our projected system position over each of the next five years[13]. The trajectory assumes incremental increases in local investments, as each year investments become self-sustaining and system solutions release cash for investment in service enhancements.

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[13] NOTE: the 2016/17 deficit position presented excludes local providers' share of national sustainability funding, worth up to £34m

System net position by year
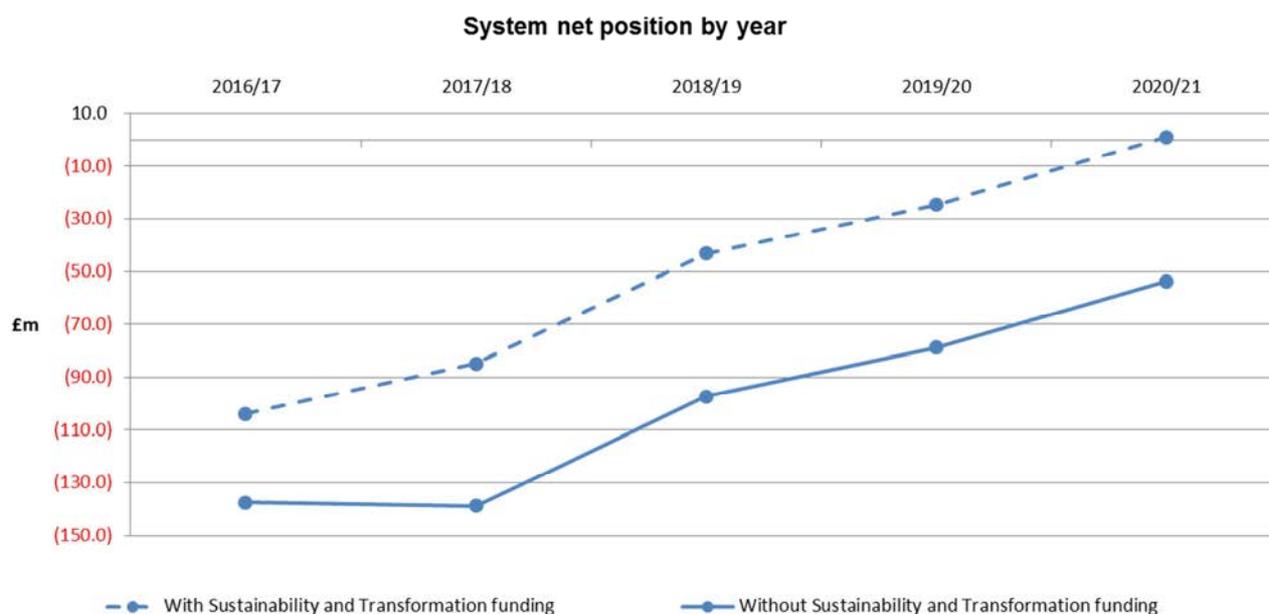
System net position by year	2016/17	2017/18	2018/19	2019/20	2020/21
Without Sustainability and Transformation funding	(137.6)	(138.9)	(97.3)	(78.7)	(53.7)
With Sustainability and Transformation funding*	(137.6)	(84.8)	(43.2)	(24.6)	1.3

*Estimates have been made for 2018/19 and 2019/20 in line with 2017/18 allocations.

At this time, as a system we currently have a £48m difference between our estimated system financial position and the system control total in 2017/18. Based on preliminary analysis we are cautiously optimistic that the provider side of this gap (c £30m per annum) can be closed by the time operational plans are submitted if central funding and/or control total amendments are made to reflect the structural challenges identified above (namely, the PFIs and e-hospital), fines are not levied, interest rate charges are minimised (in line with provider control totals being accepted) and the merger transaction costs are funded.

However, this leaves a c£18m underlying CCG financial gap next year, which is clearly not in line with NHS England commissioning business rules and therefore is not a sustainable system planning position. We are willing to commit to making in-roads into this gap, but we do need financial help to do so. We expect to deliver at least 1:1 return on investment in the year received. We intend to use the indicatively allocated £17.7m transformation funding to invest in bringing our services in line with national priorities (see next sub-section for more detail). However in 2017/18, the only local investment we can afford is to spend the CCG's non-recurrent transformation reserve (c£5 m); in 2018/19 for the providers to match the CCGs non-recurrent risk reserve; and for 2019/20 for each to contribute £7.5 million. However, this leaves a shortfall in relation to digital investments related to implementing our LDR, for which we will need national support.

We are working to assess rapidly the feasibility of more dramatic changes to local service offerings and to accelerate the scale and pace of primary care-led demand management interventions. For example, we know that by bringing the bottom half of our GP practices in line with the median, we can save up to £40m on acute care, and that if we compare the CCG's acute expenditure with peer CCGs, there is a further £35m opportunity per year. This analysis demonstrates that the CCG gap, can be closed theoretically, but the question remains of what can be done quickly and how we can encourage local GPs to engage more fully with the system's challenges. One idea being explored is a gain-sharing arrangement with GP practices who work together at neighbourhood team level.

Work is underway to prepare an investment case that validates our working hypotheses that:

- We can develop robust and detailed implementation plans for already identified demand management interventions.
- Any knock-on effect of more dramatic reductions in demand levels on the acute providers, which would affect their revenue levels, would be mitigated by exploring a combination of:
  - gain-sharing contracts
  - that any spare capacity could be used to repatriate sub-contracted activity to the private sector, and/or
  - additional shared services cost improvement solutions can be captured (for example relating to pathology, procurement, or estates)
- GPs sign up to the gain-sharing offer once developed further.

CCG and provider plans will set out the conclusion of this work.

9.2 Investment for service improvement

The opportunities presented above are gross opportunities exclusive of the planned £43.5m for recurrent investments that we believe are needed to deliver the planned financial savings and achieve our vision. We have developed an outline proposal for this investment, of which almost all is related to national priorities. As set out above, our local investment priorities are uniquely focused on demand management and relate to increasing the capacity in primary care and in the community, including community-based integrated urgent primary care. We have also considered our investment requirements in relation to the LDR. More detailed cost estimates are set out in Appendix 6, but in summary these allow for the following revenue investments (recurrent and non-recurrent) in both national and local priorities (cumulatively over the period 2017/18 – 20/21):

Investment area	Total (£ m)
Seven day services	£37.7
GP Forward View	£37.9
CAMHS and Eating Disorders	£3.6
Mental Health Taskforce	£21.3
Cancer Taskforce	£4.2
National Maternity Review	n/a
Prevention	£20.8
Local Digital Roadmap	£32.7
Local Priority: Quality Improvement Capability Building	£1.5
Local Priority: Elective transformation	£1.6

Further work is required to develop the detailed business cases behind each of these proposals and to ensure that we have prioritised ruthlessly in implementing those interventions that will yield the most rapid return on investment and particularly benefit the CCG's financial position in the short-term.

9.3 Ensuring benefits realisation

As part of developing a delivery plan for 2017/18 and 2018/19, we have allocated savings to delivery groups (as explained in section 8). Further work will be done to validate savings and investments by project, in preparation for submitting aligned operational plans by organisation. By March 2017 we commit to developing detailed modelling of activity, capacity, and return on investments for each

project in the delivery plan to ensure we hit the ground running on 1 April 2017. The waterfall below sets out the two-year gross savings, by delivery group:
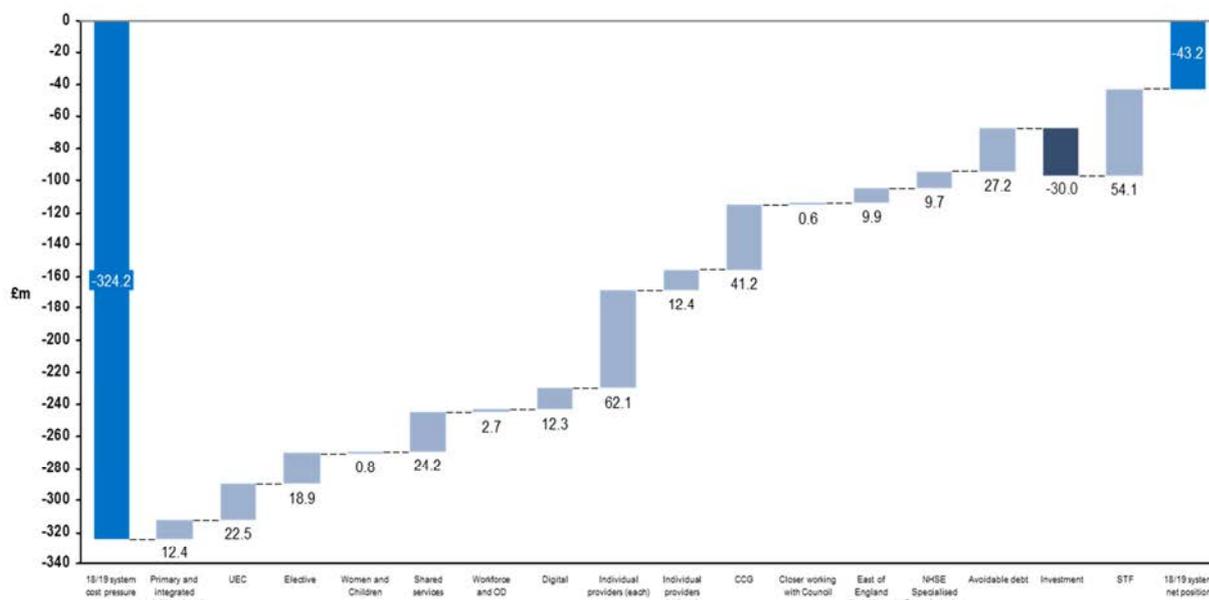
We recognise the scale of the financial challenge and as a system have committed to working together, through the MoU, to deliver solutions that deliver significant financial benefits to the system over the next two years. These include, for example:

Priorities for change	Commitment	Saving Opportunity
At home is best	First phase of prevention strategy	£9.6m
	Social care functional integration	£1.3m
Safe and effective hospital care, when needed	Reduced delayed transfers of care	£14.3m
	Common pathways (frailty, stroke, ophthalmology, ENT, cardiology, and orthopaedics)	£5.3m
	Consistent urgent and emergency care in right place	£27.2m
We're only sustainable together	Collective procurement	£18.8m
	Pathology hub	£7.5m
	Merger of PSHFT and HHCT	£6.4m
Supported delivery	Single plan for estates and workforce	£29.6m
	Improved workforce recruitment, retention, and staff satisfaction (developing a productive and healthy workforce)	£5.5m

Our delivery groups will oversee the production of PIDs using logic models to help understand the impact of their ideas and to enable centralised tracking of progress, both against milestone delivery and benefits realisation. For each project, we will be able to articulate the medium-to-long term financial and quality impact, as well as the anticipated activity trajectories associated with proposed solutions, thereby providing our HCE with assurance that the savings identified can be delivered and operational challenges addressed in a timely manner. A logic model approach will also be used to support implementation planning by describing the steps required to implement changes, enabling the early identification of interdependencies between solutions and/or key enablers (such as workforce, estates, or technology), and ensuring implementation silos are avoided. An example of the

PID for shifting the care of patients with minor eye conditions from secondary care outpatients to a primary care-led service is attached as Annex 3.

9.4 Capital

We have developed a capital plan that aligns to our five year system plan. The total sum of capital we would like to spend is c£800m over the period to 2021. This capital plan is almost entirely to fund 'business as usual' investments, rather than to support solutions, for example the long-planned building of 'new' Papworth on the Cambridge Biomedical Campus to address many years of maintenance backlog at CUHFT, as well as to support integration of primary and community care premises.

10.   Risks and barriers to implementation

In identifying the risks to delivering the plans set out in our STP we have considered a range of factors from within our health and care system as well as external factors. The risks can be broadly grouped into financial, workforce, and political risks. Our HCE has identified these risks and agreed potential mitigations that will enable us to manage these risks appropriately. These risks and mitigations are set out in the table below:

Risk	RAG rating	Mitigation
Financial risks		
Risk that STP financial recovery does not match pace required by national planning guidance – especially for the CCG	🟥	• Robust financial modelling that enables the health and care system to target the savings opportunities in areas with the greatest potential for delivering savings • We are able to set individual control totals that set a realistic trajectory for capturing the savings identified and fit within a system control total
Risk that release of national funding is not aligned to our delivery timetable and/ or we are unable to find a way to work across organisational and financial boundaries (e.g. with social care) leads to an inability for us to deliver the planned change in services within the anticipated timescales	🟧	• The national bodies support the proposals set out in the STP and approve the release of STF funding to support implementation within the health and care economy
Risk that we are unable to implement a new payment model that is acceptable to acute providers because of the current financial climate leads to challenges for the system to manage the system control total appropriately	🟧	• Regulators support our ambition to develop ACO behaviours by changing the way they engage with our system • We are granted flexibility around QOF and support to rebalance process targets with outcome measures, for example replacing the QOF with a local outcomes framework for integrated neighbourhood services
Workforce		
Risk that clinicians do not support the service models set out in the STP due to disengagement in the design process and lack of ownership in the proposed solutions leads to a failure for us to implement the solutions as planned	🟥	• Enabling staff to co-design service delivery models and implementation planning • Effective staff engagement throughout the implementation planning and implementation phases • Identifying local champions to support implementation
Risk that insufficient staffing capacity	🟧	• Comprehensive workforce modelling that sets

and capability due to failure to recruit or grow our own staff leads to an inability for us to implement and deliver the planned service models		out the workforce requirements to deliver our service models
Political		
Risk to delivery caused by political opposition to the solutions set out in the STP relating to reconfiguration of services, particularly from: • local councillors in East Cambridgeshire who may be opposed to changes to MIUs and community beds given that many of these are located there • councillors in Peterborough who may be concerned that local health inequalities are not being adequately met and may be exacerbated by any centralisation, particularly considering already poor outcomes for stroke and cardiovascular disease leads to an inability for us to deliver our proposed solutions in our STP		• The national bodies provide "political cover" and support our planned changes.
Risk that delays in implementing our proposed solutions caused by national political or other external factors damages existing strong relationships between health and care organisations in Cambridgeshire and Peterborough leads to an inability for us to deliver cross-system solutions		• The national bodies support the implementation of the proposals set out in the STP
Risk to delivery because patients and the public do not support our proposed solutions		• Enabling patients to co-design service delivery models and implementation planning • Clinical senate review of our proposals, as applicable • We will undertake public consultation where appropriate prior to undertaking any service changes

We understand the steps that we need to undertake to manage these risks safely and we encourage the national bodies to recognise the risks to delivering the plans set out in our STP successfully. We are confident that, with the support of the national bodies, we will be able to manage these risks successfully and deliver the plans that we have described in our STP.

Appendix 1 - Reference documents

List of public documents in which reasons for change for the Cambridgeshire and Peterborough system are set out.

- Fit for the Future: Working Together to keep people well – Evidence for Change
  http://www.cambridgeshireandpeterboroughccg.nhs.uk/downloads/Sustainability-Transformation-Programme/Evidence-for-Change.pdf

- Cambridgeshire and Peterborough Health and Care System Transformation Programme Understanding Today, Designing Tomorrow Change Document 2015/16 to 2019/20, July 2015
  http://www.cambridgeshireandpeterboroughccg.nhs.uk/downloads/System%20Transformation%20Programme/22-07-2015-Change%20Document_Main%20Body.pdf

- Joint Strategic Needs Assessment for Long Term Conditions, Housing and Older People
  http://www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports

- Cambridgeshire and Peterborough Health System Prevention Strategy
  http://www.cambridgeshireinsight.org.uk/health/healthcare/prevention

- General Practice Forward View, April 2016
  https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

- Public Health Outcomes Framework, 2015
  http://www.phoutcomes.info/

- NHS Atlas of Variation in Healthcare – 2015
  http://www.rightcare.nhs.uk/index.php/atlas/nhs-atlas-of-variation-in-healthcare-2015

- Care Quality Commission report for Cambridge University Hospitals NHS Foundation Trust
  http://www.cqc.org.uk/sites/default/files/new_reports/AAAD0110.pdf

- Care Quality Commission report for Hinchingbrooke Health Care NHS Trust
  http://www.cqc.org.uk/sites/default/files/new_reports/AAAE4699.pdf

- Cambridgeshire Public Mental Health Strategy
  http://www.cambridgeshire.gov.uk/site/custom_scripts/consultations-document.aspx/361/Public%20Mental%20Health%20Strategy%20v19%20FINAL.pdf

- Joint Cambridgeshire and Peterborough Suicide Prevention Strategy
  http://www.cambridgeshire.gov.uk/downloads/download/215/suicide_prevention_strategy

- Cambridgeshire Joint Strategic Needs Assessment Summary Report 2015
  http://www.cambridgeshireinsight.org.uk/jsnasummaryreport

- Joint Strategic Needs Assessment: Peterborough
  https://www.peterborough.gov.uk/healthcare/public-health/JSNA/

Appendix 2 - STP governance structure

Governance structure – delivery phase (1st November 2016 onwards)
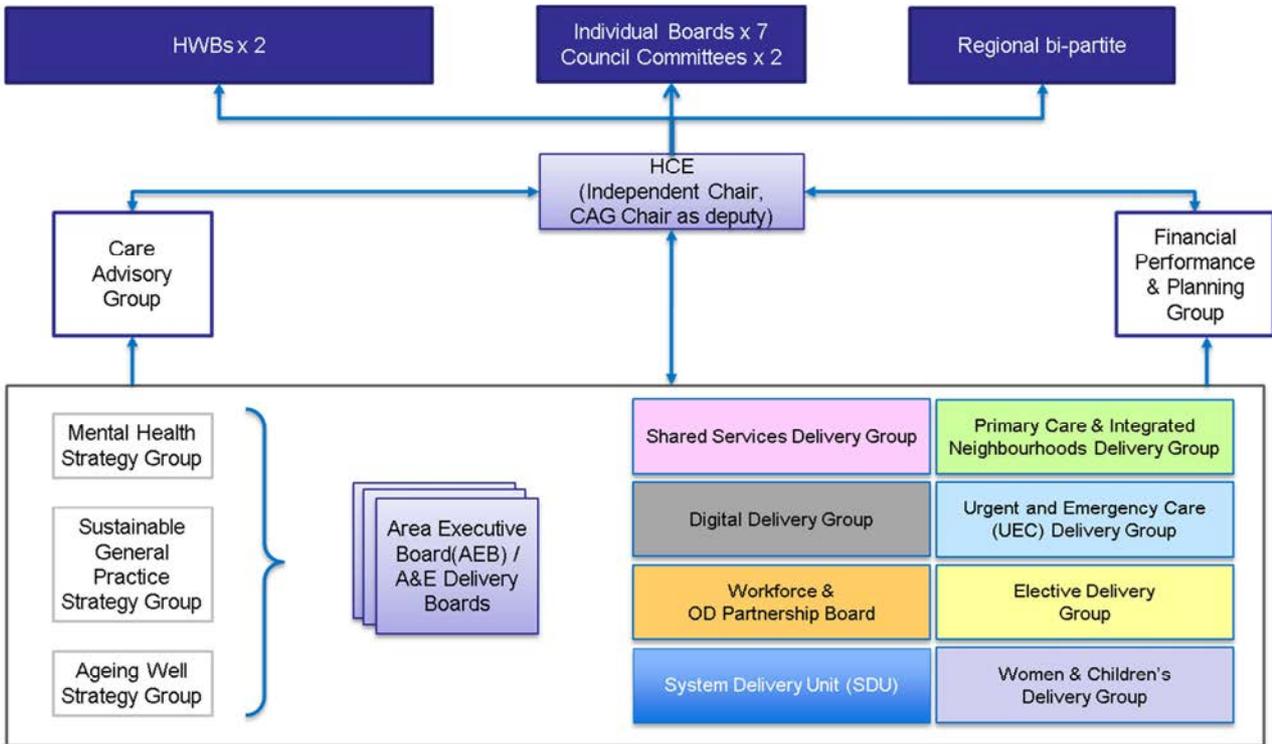
Governance structure – design phase (prior to 1st November 2016)
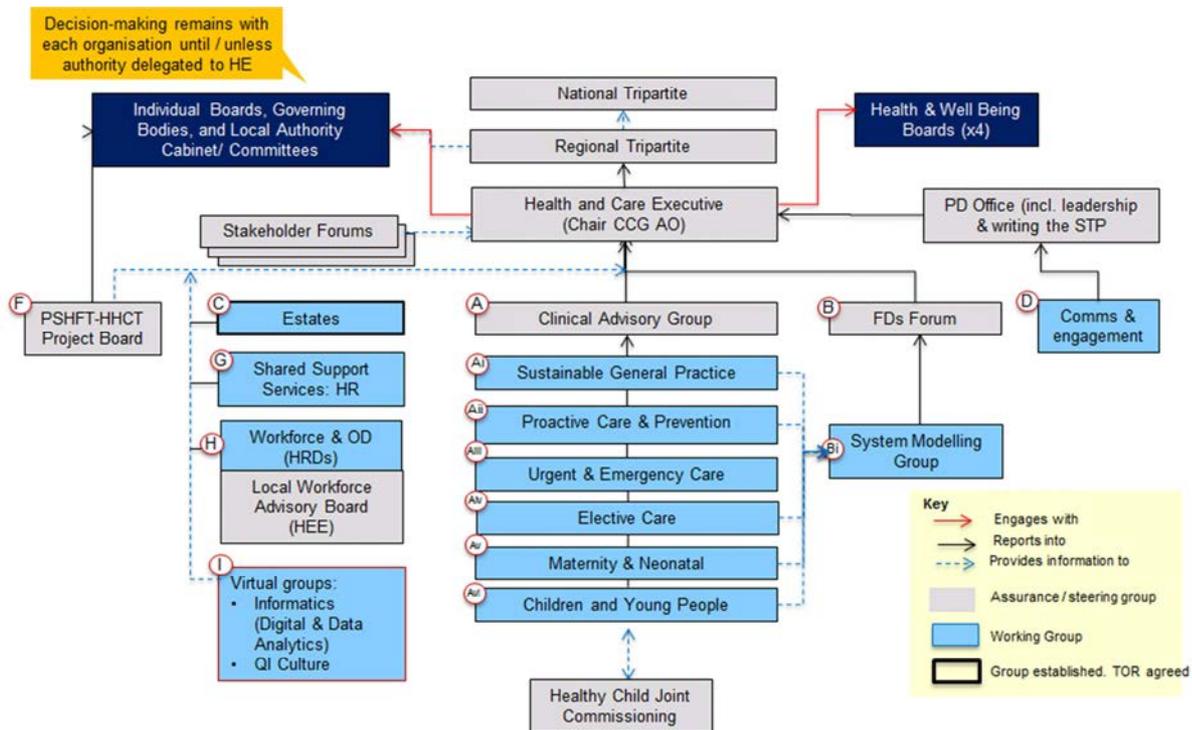
Appendix 3 - STP engagement

The STP Communications and Engagement Strategy aims to support the health economy through the period of STP submission, authorisation, and implementation planning.

The strategy is focused primarily on the following agreed as priority audiences to engage and support development and implementation of the STP:

• dialogue with residents and patients

• clinical and other staff working within the STP partnership

• key audiences external to the health care executive, including political opinion formers and partner agencies

• organisational representatives through participation in the programme.

Communications and engagement aims to:

• articulate the bold vision for health and care developed by the partnership, telling a compelling story which sets out the benefits for patients, staff, and local people

• help orientate the health economy and the HCE in the transformational changes required to achieve the STP's delivery models, primary and community hubs, ways of working, 'home is best', strategic direction, and organisation development/leadership

• support behavioural change among patients and residents

• continue to encourage and support participation in co-design/co-production of solutions and new ways of working

• engage with patients, public, and stakeholders on specific changes, such as patient choice hub, and provide opportunities for staff and local people to help shape proposals for wider transformation and service change and have a say in key decisions (including through consultation).

Publication of the Sustainability and Transformation Plan Summary

We published our draft Sustainability and Transformation Plan summary in July – 'How health and care services in Cambridgeshire and Peterborough are changing'. This 12-page document set out our 10-point plan, captured in an infographic.

The summary publication was co-ordinated with all NHS trusts, local authorities, and the Clinical Commissioning Group, and was issued to all staff, key stakeholders, and local media.

The summary is also available to the public on a new partnership website www.fitforfuture.org.uk, and was supported by a leaflet, Frequently Asked Questions (FAQs) document, and social media campaigns to raise and maintain awareness.

Patient and public influencing our plan

During 2015 we asked the public to consider the pressures and issues for health and care services over the next five years and, during a programme of Public Involvement Assemblies, we asked what services were important to them. This is captured in our Sustainability and Transformation Plan and summary.

We held further Public Involvement Assemblies in March 2016 to present the Evidence for Change and asked the questions on the work programme, design principles, and evaluation criteria. A 'You said, we did' document was produced to report on the meetings.

The clinical working groups have patient representatives on their groups, and representatives taking part in their workshops. The Clinical Advisory Group also has a patient representative.

Staff engagement and communications

Staff from across the organisations have been involved in the Clinical Working Groups – in the working groups and partaking in workshops.

Communications leads from all organisations meet regularly to discuss the Sustainability and Transformation Plan and communications and engagement with staff, as a 'Comms Cell'.

The Comms Cell developed and agreed a communications and engagement strategy, developed a Sustainability and Transformation Plan narrative, communications plans, and all STP materials.

Staff receive regular updates on the STP via their established communications channels, including email, intranets, briefings, and newsletters.

Union engagement

The Sustainability and Transformation Plan has been regularly discussed at the regional and local Social Partnership Forum, made up of representatives of all health and social care unions.

Meetings are held bi-monthly and the Sustainability and Transformation Plan has been a regular agenda item enabling the group to receive the latest updates on the plan and next steps.

Healthwatch and Health and Wellbeing Boards

Representatives from Healthwatch Cambridgeshire and Healthwatch Peterborough have been involved in the Clinical Working Groups, in the working groups, and taking part in workshops. Representatives are also a member of the Clinical Advisory Group.

Work is ongoing with Healthwatch Cambridgeshire to support patient representatives in taking part in the STP working groups.

The Sustainability and Transformation Plan has been a regular item on the Health and Wellbeing Boards in Cambridgeshire, Peterborough, Northamptonshire and Corby, and East Northamptonshire. The boards have received the latest updates on the plan and next steps in the programme.

The Sustainability and Transformation Plan team also held two workshops with both Cambridgeshire and Peterborough Health and Wellbeing Boards, discussing the issues for patients and services, and the direction of travel.

CCG Patient Reference Group

The CCG's Patient Reference Group received regular updates on the Sustainability and Transformation Plan and gave their experience and views on the issues for patients and services, and direction of travel.

An overview of the meetings and events at which the Sustainability and Transformation Plan is presented and discussed is shown below.

Public meetings on minor injury services

In August and September 2016, Cambridgeshire and Peterborough Clinical Commissioning Group began an intensive period of public and stakeholder engagement with regard to the future of the minor injury services in East Cambridgeshire and Fenland, specifically the Minor Injury Units at Doddington Hospital, North Cambs Hospital in Wisbech, and Princess of Wales Hospital in Ely.

The CCG held meetings with specific stakeholders, including local councillors and members of parliament, as well as a series of very well attended public meetings.

The public meetings were held in community venues, some of the first few of which proved to be so popular the venues were too small to cope with the numbers of people wishing to attend. Additional meetings were arranged in much larger venues.

Approximately 650 people attended the public meetings during this engagement exercise. People were happy that the CCG had given people a chance to have their say. People told us that we should run more public meetings. People asked whether this was a formal consultation and when the engagement period would come to an end.

Ongoing communications

The Sustainability and Transformation Plan communications and engagement plan is reviewed regularly to ensure we are getting the best benefit, including:

- checking stakeholders are identified and communications channels are established and used, using partner organisations to ensure widest reach
- continuing to use existing communications channels, including direct communications and meetings
- using the dedicated STP website, newsletter, and social media
- continuing to work as a communications network, through the regular meetings.

Ongoing engagement

Engagement in our plan is ongoing, including patient representative groups, Health Scrutiny/Health Committee and Health and Wellbeing Boards.

The Sustainability and Transformation Plan is covered regularly at standing meetings, and is presented to groups at regular intervals when requested.

An overview of the meetings and events that the Sustainability and Transformation Plan is presented and discussed is shown below.

Priority one - At home is best

Neighbourhood care hubs

More health and care services will be provided closer to people's homes and we will help people stay at home when they're unwell.

People powered health and wellbeing

We will help people to make healthy choices, keep their independence, and shape decisions about their health and care. We will work with community groups and businesses, so people of all ages have good health, social, and mental wellbeing support.

Priority two - Safe and effective hospital care, when needed

Responsive urgent and expert emergency care

We will offer a range of easily accessible support for care and treatment, from telephone advice for urgent problems to the very best hospital emergency services when the situation is life threatening.

Systematic and standardised care

Doctors, nurses and other health and care professionals will work together across Cambridgeshire and Peterborough to use the best treatments and technology available.

Continued world-famous research and services

We have world-class specialised care, but we are always looking for ways to be better. We will work together with our local research organisations and businesses to make this happen.

Partnership working

Everyone who provides health, social and mental health care across Cambridgeshire and Peterborough will plan together and work together.

Priority three - We're only sustainable together

Workforce: growing our own

We have wonderful, talented people working in our health and care system. We aim to offer rewarding and fulfilling careers for our staff with opportunities for them to develop their skills and grow professionally. This way we can develop staff, including for those areas where we have some staff shortages.

Using our land and buildings better

We want to bring all our NHS and local government sites up to modern standards. We want to make better use of our out-of-hospital sites, which may mean selling some buildings to invest in other modern, local facilities.

A culture of learning as a system

We are committed to sharing knowledge across the whole health and care system, so the people working in our health and care organisations know they are part of the big picture.

Using technology to modernise health

Good information and advice helps people take control of their health. We will use apps and online tools to provide more rapid and reliable information.

Priority four - Supported delivery

Engagement activity

Activity	Approach, feedback, comments
Staff engagement through CCG, trusts' and councils' regular communications	Staff communications include intranet, staff newsletters, and staff briefings. Staff are also directed to the new Fit for the Future website. In August 2015, the STP team held a clinical roadshow and undertook iPad surveys and talked to clinicians, staff, and the public across the clinical and local authority buildings. 141 people were spoken to. Clinicians involved in the STP are piloting different ways to keep people updated on the programme. The Urgent and Emergency Care Clinical Working Group has a video blog: "Tell us what you think!" A summary of the Heath and Care Executive and Clinical Advisory Group meeting are produced and cascaded to staff.
Cam Health Patient Forum	Presentations made on request.
Cambridgeshire Health and Wellbeing Board	Regular discussions including specific topics, as requested, such as Wisbech and Doddington hospitals link to Queen Elizabeth Hospital, King's Lynn and closer working with local authority and health, as well as regular STP presentations. Workshops held on Sustainability and Transformation Plan.
Cambirdgeshire Health and Wellbeing Support Group	Regular discussions including specific topics, as requested, as well as standard presentations and updates on governance and plan development.
Cambridgeshire Health Committee/Healthwatch liaison meeting	Discussion was around the link between local authority and Health and Wellbeing Boards, to include patient experience in the design principles and to highlight why things will be better, to create a positive impact.
CATCH Patient Forum	The planned hospital care workstream presented its proposed 'elective care' pathway to gain feedback on its approach.
Fenland Health and Wellbeing Partnership	Sent link to Evidence for Change document.
Fulbourn Patient Participation Group	Standard presentation was made to the group.
GP Local Commissioning Group Board	Discussions covered role of CAG Chair, size of the financial gap, underfunding and transformation funding, role of provider boards, and impact and focus on what we will decommission.
Hinchingbrooke Hospital Patient Experience Group	Presentation on the Summary Sustainability and Transformation Plan and answer questions on the impact on Hinchingbrooke Hospital services and patients.
Huntingdonshire Patients Congress	Discussions covered the UnitingCare contract and the skills to take the STP forward, the need to have care homes and health joined up working/thinking, and to have conversations on fair use of the NHS. Regular discussions including specific topics, as requested, as well as standard presentations and updates on governance and plan development.
Huntingdonshire Strategic Partnership Health and Wellbeing Board	Discussions were around making sure that national initiatives link to local solutions. 'Generational solutions' in that young people do things differently and not forget the percentage of the population that will need face-to-face care. The group asked about risks and to make sure that public consultation is meaningful. Latest on PSHFT/HHCT merger. Regular discussions including specific topics, as requested, as well as standard presentations and updates on governance and plan development.

Activity	Approach, feedback, comments
Huntingdonshire Scrutiny Committee	Questions covered identifying risks, housing, palliative care, the benefit for Hinchingbrooke Hospital, how population growth and needs will be met, addressing workforce issues, attracting GPs, and the need to work together on information. Latest on PSHFT/HHCT merger. Regular discussions including specific topics, as requested, as well as standard presentations and updates on governance and plan development.
Jenner Health Centre Patient Participation Group	Standard presentation was made to the group.
Joint Cambridgeshire Health and Wellbeing Board, Scrutiny and Adults Committee seminar	The seminar received a presentation on the approach and emerging solutions. They also had discussion groups on ensuring the STP is a success, their support for plans to change the way the NHS organisations work and how local authorities play a greater role. They explored the implications for representative of local residents, how all can work together during the implementation phase, and how they can be kept up to date with progress.
Media	The Evidence for Change received wide coverage including BBC Radio Cambridgeshire, Fenland Citizen, Hunts Post, and Healthwatch Cambridgeshire newsletter. Summary plan provided and responses to questions and interviews given.
Newsletter	The monthly online newsletter was introduced in April 2016 and covers programme updates, working group activity, and vanguard news. It is issued to the CCG's and STP's stakeholder list, and to all staff via the communications leads.
Older Persons Lesbian, Gay, Bisexual, Transgender Network Meeting	Presentation on the scope of the 'Fit for the Future' programme, and ways in which this might address issues affecting older Lesbian, Gay, Bisexual, Transgender people.
Peterborough Health and Wellbeing Board	Discussions covered the need for council officers and members being more involved, joining up with Better Care Fund and the prevention strategy, and converting to delivery. Workshops held on Sustainability and Transformation Plan.
Peterborough Health and Wellbeing Board and Scrutiny briefings	The groups were supportive of the approach and didn't express concerns regarding the impact on local services. They asked if the NHS precept could raise the gap in funds and if we had considered NHS fraud in our calculations. They wanted to see better training of care home staff. The groups requested to be kept up to date with major changes. Subsequently undertaken regular discussions including specific topics, as requested, as well as standard presentations and updates on governance and plan development.
Healthwatch Peterborough Focus Group	The group was convened to give feedback on the Proactive Care and Prevention workstream. The group gave feedback on the language used on the pathways being developed. Attendees queried the meaning of the language and the aims of the approach. They also shared how the vision of the workstream related to their experiences.
Pharmacy Eastern Network	Presentation on the latest development with the Sustainability and Transformation Plan and answer questions on the impact for pharmacy colleagues.
Public Health Reference Group	Discussions covered Cambridgeshire Healthy Weight Strategy, improving physical activity levels, and on engagement and rate of plan formation.
Public Involvement Assemblies – July 2015	80 people attended the five locations to have an introduction to the System Transformation Programme, asking members of the public to work together and consider the pressures and issues that face health and related care services over the next five years. Information was shared with the assembly, and they were asked what services were important to them.

Activity	Approach, feedback, comments
Public Involvement Assemblies – March 2016: Cambridge, Ely, Huntingdon, Peterborough, and Wisbech	Around 90 people who attended the five assemblies commented on the Evidence for Change and gave feedback on the evaluation criteria and design principles. All comments were captured in an overall document and collated into clinical themes. These were shared with each clinical working group, to be discussed in their groups and workshops, and for consideration in their planning and redesign processes. A 'You said, We did' document reported how the comments and feedback was used and changes made as a result.
Public Service Board	The group was keen to know more of the detail so that impacts could be shared across the system and that shared opportunities are not missed. They were particularly interested in the role they can play jointly in the planning around mental health. They wanted to know what will change because of the size of the gap and they wanted to be involved earlier rather than later. They wanted to know the links with the county council's ambitious transformation programme. Regular discussions including specific topics, as requested, as well as standard presentations and updates on governance and plan development.
Saturday Cafes - June/July 2015	The Saturday Cafes were held across the area as drop-in interactive sessions to watch a presentation and have a conversation with a member of the STP team. Held in five locations in Cambridge, Ely, Wisbech, Huntingdon, and Peterborough.
Social media	Social media was used to promote the Evidence for Change and the Public Involvement Assemblies. 'Fit for the Future' has a Twitter and Facebook account, and the CCG's Instagram was also used. The latest social media campaign saw the number of times Twitter users saw our tweets grow by over 20,000. Social media used for publication of the summary document and a campaign in August and September kept the plan in the public eye.
St Ives Community Fair	The event was well attended and was a good opportunity to talk about STP. Some people had knowledge of the programme, some didn't, but general feedback was positive and keen to know more, with particular interest from community/volunteer groups.
Thorpe Road Practice Patient Group	Concerns were expressed around the ability to save money, especially the £250m. That it won't save money for the hospitals and need to get rid of both financial and commissioning barriers. Concerned about stroke services without neurosurgery.
Website	The CCG hosted previous STP web pages for the early Sustainability and Transformation Plan and Evidence for Change material. A new Sustainability and Transformation Plan partnership website has been set up – www.fitforfuture.org.uk. This hosts the Summary plan, leaflet, details of the working groups, and the latest news and events.

Appendix 4 - Shortlisting system solutions

The Clinical Working Groups (CWG) met a number of times to discuss all viable configuration options for their service area and undertook an indicative scoring exercise against the STP's evaluation criteria (see below). This scoring exercise enabled the CWGs to develop a long list of options viable for further analysis. The Clinical Advisory Group (CAG) considered the long list of configuration options from each CWG in order to identify interdependencies that would require further analysis and consideration at a CWG level. The CWGs then re-scored each configuration option. The difference with the previous scoring exercise was that further analysis was available to support the scoring exercise and the CWG scored the options against the evaluation sub-criteria.

The outcome of the CWG scoring exercises was reviewed by the CAG. The CAG then considered combinations of viable configuration options, taking into account interdependencies between the proposals from individual working groups, and recommended a preferred configuration of services to the HCE. In all cases further discussion and work with the Clinical Senate needed to follow.

Design principles

In developing the vision for sustainable care the CWGs took into account the following design principles.

Principle	Definition
High quality care	• Solutions should deliver safe, effective care for all when needed. • Services should provide a positive experience for patients and carers.
Integrated care	• Services should be delivered through joined up health and social care that treats the 'whole person' and delivers a seamless service with minimal duplication of processes. • This will require joined-up working across different groups of care givers from the different health and care organisations, as well as full involvement of patients, carers and, where appropriate, the voluntary sector.
Right care, right time, right place, right people	• Solutions should enable patients to receive health and social care appropriate to their particular needs. • This means providing proactive, timely care that takes into account patients' particular circumstances. • Care should be provided in the most appropriate place. Where possible care should be provided locally (close to home and/or in the community). • Some more specialised services may need to be centralised in order to provide safe services, with safe staffing levels. • Care should be provided by the most appropriate care giver.
Minimise inequality	• Services should be designed to improve the health outcomes for all and minimise health inequalities. • Solutions should not have a disproportionately adverse impact on any specific patient groups.
Maximising value for the public	• Solutions should deliver efficient and cost effective care, by reducing the system-wide costs to deliver services. • Solutions should make the best use of existing buildings and equipment, where possible.

Evaluation criteria

The CAG and HCE agreed a set of evaluation criteria to assess the configuration options. The evaluation criteria and sub-criteria were weighted, taking into account the views of the CAG, Finance Directors Forum, and Healthwatch Cambridgeshire and Healthwatch Peterborough. The weighted evaluation criteria are set out below:

Sub criteria	Criteria weighting % (A)	Sub-criteria weighting % (B)	Total score % (A*B)
Quality	**30.0**		
Alignment to national best practice guidelines including clinical standards		19.1	5.7
Impact on patient safety and population health outcomes		26.2	7.9
Impact on patient experience		18.7	5.6
Impact on health inequalities		21.3	6.4
Impact on patients' ability to access services (journey times)		14.7	4.4
Subtotal		100.0	30.0
Affordability	**25.0**		
Options deliver a sustainable income and expenditure position		69.8	17.5
Transition costs including capital expenditure		30.2	7.6
Subtotal		100.0	25.0
Sustainability	**22.4**		
Ability to recruit and retain sufficient staff with appropriate skills and expertise		54.5	12.2
Extent to which the model meets future demand for service provision		45.5	10.2
Subtotal		100.0	22.4
Deliverability	**22.6**		
Stakeholder support		38.2	8.6
Ease and speed of implementation		32.2	7.5
Alignment to local and/or national policies or strategies		28.7	6.5
Subtotal		100.0	22.6
TOTAL	**100.0**		**100.0**

Assuring our proposals

We will seek appropriate assurance on our proposals for changing the way that we deliver care, as set out in the STP. This will include seeking assurance from the Clinical Senate for our proposed model of care and assurance from NHSE on the patient, clinical, financial, and strategic case prior to consulting with the public on our recommendations.

We have already presented our proposals for the following service changes to the East of England Clinical Senate for a "Stage 1 Review":

- Relocating the Minor Illness and Injury Unit (MIIU) from Peterborough City Care Centre to the PSHFT site
- Providing urgent care services in Wisbech, Ely, and Doddington including the future vision for the Minor Injury Units (MIU)
- Enhancing stroke rehabilitation services and the centralisation of stroke rehabilitation beds and neurology rehabilitation beds
- Enhancing community rehabilitation services by increased provision in a home setting and the potential reduction of the use of community beds for rehabilitation.

The Clinical Senate approves of our proposals in principle and supports the STP in taking further steps to develop them. When our proposals are more advanced we will seek further approval from the Clinical Senate at a "stage 2 review". This will take place during summer 2017. Following the stage 2 review we will present the proposals to NHSE and, where applicable, undertake public consultation.

Appendix 5 - Implementation plan

Fit for the Future — Working together to keep people well

Timeline columns: 16/17 | 17/18 | 18/19 | 19/20 | 20/21 | Expected impact

1. At home is best

16/17:
- Time to Care tests beds programme for GPs
- Optimise existing NEL community services e.g. JET, trailblazer NTs.
- Specify new community capacity
- Plan MIUs and design extended GP scope

17/18 – 18/19:
- Enhance and embed community services (w/ formative evaluation)
- Integrate GP capacity and embed MH service with neighbourhood teams
- Implement people-powered health & care strategy (includes prevention, self-care, iThrive & primary care, mental health and wellbeing)
- Consolidate rehab beds at HHCT (stroke & community) → Launch HHCT campus
- Launch locality IC teams
- Launch integrated children's community services
- Redesign MIUs w/ GP led urgent care, 7 days a week
- New primary and community health hubs in Wisbech and Ely
- Plan and secure resources for impact evaluation
- Evaluate impact of integrated care model

19/20 – 20/21:
- Transition to formally GP led diagnosis & care planning (e.g. Primary Care Home)
- Refine & standardise care models

Expected impact:
- Growing demand will be absorbed through true functional integration between NTs, local authority services, and primary care
- Better proactive targeting of tailored, evidence-based care packages supports better LTC care
- Patients receive more effective out of hospital care and can be discharged from hospital sooner
- Robust primary care model of delivery results in a more stable service model will lead to improved staff satisfaction and improved staff retention
- Standardisation of urgent care results in equitable and holistic care for patients
- Patients receive urgent care closer to home

2. Safe & effective hospital care, when needed

16/17:
- Prepare for networking – ophthalmology prototype
- Invest in MH Crisis teams & RAID
- Implement new 111 (foundation for integrated urgent care hub)
- Specify and test patient choice hub

17/18 – 18/19:
- Go live with networking wave 1 (starting with ENT, maternity, then cardiology, paeds)
- Orthopedic redistribution (EL, rehab, DGH trauma)
- Bring services in line with Keogh & 7DS standards
- Frailty pathway improvements
- Scale patient choice hub
- Review of "quick win" pathway changes – scale what works, discard what doesn't
- PAU at CUHFT
- Stroke pathway improvements

19/20 – 20/21:
- Networking wave 2
- Case for Movement centre @CUHFT
- Embedded feedback loops for continuous quality improvement and standardisation

Expected impact:
- Common care protocols, standardised inputs (drugs, devices) & set up (diagnostics, theatres)
- Rota gaps filled, through optimised staffing mix
- Patient escalations handled smoothly, w/ access to care records & 'right first time' outcomes
- Reduced demand for outpatient activity & where procedures needed, waiting times are reduced
- Consistent quality of care for patients across the country through standardisation of care pathways
- Standardisation of frailty and stroke care results in equitable and holistic care for patients

3. We're only sustainable together

16/17:
- HHCT-PSHFT business cases (OBC, FBC)
- Agree principles for incentives, governance
- Shared back office: HR (inc healthy workforce)

17/18 – 18/19:
- HHCT-PSHFT merger
- Papworth move to Cambridge Biomedical Campus; consolidation of cardiology services in Cambridge. Further collaboration bet Papworth & CUHFT explored
- Align finances to system, including for GPs & gradually transition to system decision-making
- Provider procurement alignment
- Pathology/ TPP
- Single back office
- Delegated commissioning
- GP @ scale (phase 1 early adopters)
- Align VCS and district council resources
- Co-location of children's services
- CCG/Council back office synergies

19/20 – 20/21:
- GP @ scale (phase 2)
- Consider formalized integrated commissioning

Expected impact:
- Minimal overheads with common back office
- Move knowledge and not people as far as possible
- Make best use of all local public and community assets, bringing together local authority and NHS services (in line with devolution agenda)
- Binding commitment to not letting financial incentives get in the way, including for GPs
- System governance increasingly takes on more delegated decision-making responsibility

4. Supporting delivery

16/17:
- Develop estates plan and sign off SEP (HHCT)
- Develop system workforce plan
- Secure tech funding for identified digital solutions
- Staff, patient and population buy-in to STP

17/18 – 18/19:
- Estates sales & reinvestment (community)
- Estates sales (Papworth)
- Workforce tbc
- Shared care records roll out, increased digital usage
- PSHFT-HHCT EPR
- Digital tools for patients
- Health analytics hub established
- Patient level costing roll out and improvement
- Quarterly system performance tracking and formative evaluation of projects
- System wide culture change programme – embedding Quality Improvement skills and mindsets

19/20 – 20/21:
- The Forum
- Paper-free NHS

Expected impact:
- All staff have required skills collaborative mind-sets to deliver new models of integrated care
- Enhanced career offer through new roles and rotations, reduced stress improves satisfaction
- Rationalisation of estate brings teams together and fosters integrated care delivery
- Technology embedded to support self-care, remote care, improved clinical communications
- Feels like 'one system'

Appendix 6 - System Delivery Unit

Appendix 7 - Draft balanced scorecard

Indicator	Provider	Target / Threshold	Previous 6 months						Latest month	c/w same month last year	same month last year	YTD	c/w YTD last year	YTD last year	Latest month is:
YTD % variance to system control total (allowable deficit)	STP (7 orgs)	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a		n/a	0	⬇		Jul-16
Emergency hospital admissions for falls in persons aged 65+ annual DASR per 100,000 population	CCG	n/a	1988.7	2018.3	2015.6	1968.7	1907.8	1832	1735.0	⬇	1969.1	1735	⬇	1969.1	Jul-16
A&E waits % in 4 hours	CCG	95%	83.5%	85.7%	81.8%	81.0%	80.9%	87.7%	80.4%	⬇	94.7%	82.9%	⬇	92.0%	Sep-16
DToC attributable to the NHS and Social Care crude monthly rate per 100,000 population	Pboro	0	374	250	366	417	349	298	297	⬇	303	1361	⬆	1052	Jul-16
DToC attributable to the NHS and Social Care crude monthly rate per 100,000 population	Cambs	0	448	433	370	425	468	501	466	⬆	428	1860	⬆	1671	Jul-16
Non-elective admissions for respiratory conditions for people aged 18 years & over	CCG	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a		n/a	0	➡	0	Jul-16
Non-elective admissions for respiratory conditions for people aged under 18 years	CCG	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a		n/a	0	➡	0	Jul-16
Total bed day crude monthly rate per 100,000 registered population	CCG	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a		n/a	0	➡	0	Mar-16
Emergency admissions crude monthly rate per 100,000 registered population	CCG	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a		n/a	0	➡	0	Mar-16
RTT % in 18 weeks	CCG	92%	92.7%	92.6%	92.8%	93.8%	93.7%	93.5%	92.8%	⬇	93.7%	93.3%	⬇	94.0%	Aug-16
Non elective admissions variance to plan	Pboro	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a		n/a	0	➡	0	Mar-16
Non elective admissions variance to plan	Cambs	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a		n/a	0	➡	0	Mar-16
Overall patient experience of GP services - % very good or fairly good	CCG	n/a	86.5%	n/a	86.0%	n/a	86.2%	n/a	86.4%	⬆	86.0%	86.4%	⬆	86.0%	15/16 Q4
Extended access to GP services on a weekend and evening.	CCG	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		n/a	n/a		n/a	16/17 Q1
Time to third next available appointment	CCG		n/a	n/a	n/a	n/a	n/a	n/a	n/a		n/a	n/a		n/a	16/17 Q1
Patient satisfaction with opening times	CCG		n/a	n/a	n/a	n/a	n/a	n/a	n/a		n/a	n/a		n/a	16/17 Q1
Staff Sickness Absence Rate	STP (7 orgs)	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a		n/a		➡		Mar-16
MH - completed therapy and are moving to recovery	CCG	50%	51.4%	52.1%	42.8%	46.2%	47.5%	46.2%	48.0%	⬆	42.2%	45.5%	⬆	42.0%	Aug-16
People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral	CCG	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		n/a	n/a		n/a	16/17 Q1
Out of area placements for acute mental health inpatient care - transformation	CCG	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		n/a	n/a		n/a	16/17 Q1
Reduction in the inequality between mortality in the areas of poorest CHD health c/w area of best CHD health	CCG	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a			n/a			
Staff Satisfaction / Workforce Survey	STP (7 orgs)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a			n/a			

Appendix 8 - Local savings opportunities to close the gap by 2020/21

We have developed £548m worth of savings opportunities to close the collective NHS system deficit by 20/21. A summary of these is set out below:

Bucket	Opportunity	Gross opportunity by 2020/21 (£m)	Comment	Source(s)
Income growth	Increase private patient volumes	4.4	Local system analysis	Provider figures / NHSI projections based on current values
	Repatriation from private sector	2.0	Local system analysis	Provider input / NHSI estimate
	Increase commercial income	9.0	Local system analysis	Provider FTC plans (scaled for 5 years)
	CUH external opportunities	5.0	Local system analysis	Provider input
	TOTAL	20.3		
Demand management	Elective demand in line with peers	11.2	National opportunities based on local circumstances	Right Care
	Non Elective demand in line with peers	21.0	National opportunities based on local circumstances	Right Care
	Continuing healthcare improvements	5.8	Local system analysis	C&P CCG QIPP plans
	NHS England Specialised Commissioning QIPP	21.6	Assumptions applied to local figures	Midlands and East Local Area Team
	Increasing clinical thresholds	5.6	Proportionate opportunities from Success Regime areas	NHSI analysis of local outpatients activity; Success Regime benchmarking
	Use of patient aids to support decision making	3.0	Local system analysis	C&P CCG input
	A&E Activity Shift	3.1	Local system analysis	C&P CCG input
	TOTAL	71.2		
Reducing Variation	Primary care prescribing in line with peers	16.8	National opportunities analysis	Right Care
	Reducing readmissions to align with peers	15.6	National opportunities based on local circumstances	Better Care, Better Value
	Reducing acute hospital drug costs	7.1	National opportunities based on local circumstances	Carter
	Froniter shift in reducing acute variation	17.2	Local system analysis	Provider input
	Extend GP practices to 7 day opening	1.6	Local system analysis	Provider input
	TOTAL	58.2		
Shift care to lower cost setting	Pathway changes including reducing outpatient appointments	43.6	Assumptions applied to local figures	NHSI outpatient analysis
	Reconfiguration (MIUs, community beds, stroke, and DGH trauma)	2.0	Local system analysis	NHSI local system reconfiguration modelling
	TOTAL	45.6		
Reduce unit of care cost in existing settings	Reducing procurement costs to align with peers	21.9	National opportunities based on local circumstances	Carter
	Workforce: reduced agency, sickness, and turnover	38.9	National opportunities analysis	Provider agency spend improvement assumptions; NHSI workforce
	Digital innovation	8.3	National opportunities analysis	NHSI analysis
	Reducing LOS (acute 2.5% pa, plus MH)	30.0	National opportunities based on local circumstances	NHSI local LOS analysis
	Improving theatre efficiency	6.0	Local system analysis	Provider input
	Further procurement savings	32.0	Local system analysis	Carter Model Hospital data pack shared with providers
	TOTAL	137.0		
Reduce system support costs	Clinical support service efficiences	7.5	Assumptions applied to local figures	Provider input
	Reduce CCG running costs	1.3	Assumptions applied to local figures	C&P CCG input
	Horizontal integration - back office savings	12.0	Assumptions applied to local figures	Provider input, Monitor C&P SOC 2015
	Closer working with council social services	2.5	Assumptions applied to local figures	Local system input
	TOTAL	23.3		
Estates	Estates strategic management	15.0	Local system analysis	Provider input
	TOTAL	15.0		
S&T Funding	Sustainability and Transformation funding	55.0	Local system analysis	Advised share of national S&T funding
	TOTAL	55.0		
External funding	PFI support	15.0	National funding	PSHFT total £25m opportunity, £10m already in basecase.
	Achieve CCG Distance From Target	6.7	National funding	NHSE allocations published January 2016
	CCG additional income from population growth	10.3	National funding	Estimate of opportunities
	CUH Market Forces Factor	12.2	Provider opportunities	Provider input
	CUH structural deficit	26.1	Local system analysis	Provider input
	Papworth Market Forces Factor	2.1	Provider opportunities	Provider input
	TOTAL	72.4		
East of England Ambulance Service	East of England Ambulance Service solutions	14.2	Provider opportunities	Estimate of opportunities
	TOTAL	14.2		
Avoided debt costs	Avoided cost of financing debt	35.9	Local system analysis	Provider input
	TOTAL	35.9		
	GRAND TOTAL	548.2		

*Note that net opportunities are realised after investment.

Appendix 9 - Investment requirements

Investment	2017/18	2018/19	2019/20	2020/21	Total
		(£000)			
Non-recurrent revenue investment for national priorities					
Seven day services roll out	1,603	188			**1,790**
Taking forward the programmes set out in the GP Forward View and delivering extended GP access	1,411	1,411	393	393	**3,608**
Increasing capacity of CAMHS and implementing access and wait targets for eating disorders services					
Implementing the recommendations of the Mental Health Taskforce					
Cancer Taskforce Strategy					
National Maternity Review					
Investment in prevention, tackling childhood obesity, and improving diabetes diagnosis and care	250	28	28	28	**333**
Local Digital Roadmaps supporting paper free at the point of care and electronic health records	9,068	12,425	9,815	1,440	**32,748**
Recurrent revenue investment for national priorities					
Seven day services roll out	5,910	8,285	10,740	10,926	**35,860**
Taking forward the programmes set out in the GP Forward View and delivering extended GP access	8,120	8,120	8,120	9,961	**34,321**
Increasing capacity of CAMHS and implementing access and wait targets for eating disorders services	298	724	1,008	1,562	**3,593**
Implementing the recommendations of the Mental Health Taskforce	3,864	3,864	5,796	7,728	**21,252**
Cancer Taskforce Strategy	1,045	1,045	1,045	1,045	**4,180**
National Maternity Review	-	-	-	-	**-**
Investment in prevention, tackling childhood obesity, and improving diabetes diagnosis and care	5,090	5,113	5,113	5,113	**20,430**
Local Digital Roadmaps supporting paper free at the point of care and electronic health records					
Recurrent revenue investment for STP outside national priorities					
QI			1,500		1,500
Elective			800	800	1,600
Total revenue investment (recurrent and one-off)	**36,659**	**41,203**	**44,358**	**38,996**	**161,215**