



How health and care services in Cambridgeshire and Peterborough are changing

This is an update to the Sustainability and Transformation Plan Interim Summary, published in July 2016

1 Why do we need to change?

Our health and care services face challenges

Ours 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.

The population of Cambridgeshire and Peterborough is growing rapidly. Our population is diverse, it is ageing, and it has significant inequalities. There are also more people with long term conditions, such as diabetes, and there are higher levels of obesity.

In addition, we are facing practical challenges:

- healthcare is not as good in some places as in others, and does not always meet the standards that it should
- recruiting and retaining staff is a challenge for all health and care services
- our health, local authority, and other care services are not always joined up. They do not always meet people's individual needs, and they do not always balance physical health with mental health and wellbeing
- local needs are growing and changing. Our average age and levels of sickness are all growing, and faster than in other parts of the country
- overall, we spend too much of our time and resources treating illnesses which can be prevented or kept under control in better ways
- The current health system is financially unsustainable. The local system has a total annual budget of more than £1.7billion for NHS services, but we spend about £160million more than that each year. We need to deliver our current plans and radically change the way we provide services. If we don't do both of these things the deficit is projected to increase to £500million by 2020/21.

The Sustainability and Transformation Plan (STP) proposes ways in which we can deliver the best possible care to keep our population fit for the future, and address our service and financial challenges.

What you've told us so far

During the last 18 months, we held listening events across our area to seek your views on the health and care system. We heard that:

- you want to be empowered to stay healthy
- you want easy access to information about health
- you want to understand how to use the right health and care service at the right time
- when you need care urgently, you would rather use a local service than be sent to A&E
- you want consistent access, such as opening hours for services
- you want care as close to home as possible
- children's services need to be co-ordinated better
- you would be happy to be sent home from hospital sooner if you had visits from a nurse to support you
- you do not want to be sent home too early with no support – you are concerned about needing to be readmitted
- you need better communication and planning before you leave hospital
- you want the people who provide health and care services to collaborate and work more closely together.



2 Our five-year plan to make Cambridgeshire and Peterborough Fit for the Future

This document tells you about our proposals, both to meet your ambitions for health and care and to make services financially and clinically sustainable.

The NHS and local government officers have come together to develop a major new proposed plan to keep Cambridgeshire and Peterborough Fit for the Future. We have also been asking you how you think we can manage our challenges. Our plan aims to:

- improve the quality of the services we provide
- encourage and support people to take action to maintain their own health and wellbeing
- ensure that our health and care services are financially sustainable and that we make best use of the money allocated to us
- align NHS and local authority plans.

It has been developed by our health and care organisations. We are working together and taking joint responsibility for improving our population's health and wellbeing, with effective treatments and consistently good experiences of care. The work is being led by local doctors and other medical professionals, supported by NHS England and NHS Improvement.

Fit for the Future sets out a single overall vision for health and care, including:

- supporting people to keep themselves healthy
- primary care (GP services)
- urgent and emergency care
- planned care for adults and children, including maternity services
- care and support for people with long term conditions or specialised needs, including mental ill health.

We are well placed to make the changes we need and have a lot to be proud of. Cambridgeshire and Peterborough has a committed and expert health and care workforce. We provide some excellent services to which people travel from other parts of the country. We host groundbreaking research and deliver excellent medical education and training. We have a resourceful voluntary sector, strong organisations, active local communities, and we work alongside research and technology industries which are world leaders in improving healthcare.

3 What are the priorities?

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

Fit for the Future programme

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

1 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 that people of all ages have good health, social, and mental wellbeing support.

Our first aim is to prevent illness and support people to take control of their own health and wellbeing. We will develop health services which work alongside patients and carers, social care, and housing providers, and which help to build strong communities.

We want patients to become equal partners with those caring for them, make more decisions about their own treatment and, with advice and support, become increasingly confident to manage their own conditions, supported by technology.

Summary of what we propose to deliver.



Housing and business - working in partnership with communities and businesses to provide employment, housing in new developments, and an environment to keep people healthy.

Where possible, we are influencing the design of new housing developments to reinforce active lifestyles and introduce smart technology that promotes independence for older people.



Prevention - helping people to keep healthy, dealing with problems earlier, and making sure people who are likely to fall ill are supported to keep well.

We will do this by implementing our Health System Prevention Strategy for Cambridgeshire and Peterborough. The strategy sets out practical steps to make this happen.



Psychological wellbeing - making support and treatment for people with mental ill health as available as it is for those with physical health conditions, mainstreaming mental health and prevention.

We will reduce stigma, support employers to have healthy workplaces, and reduce suicides.



Starting young - working together to ensure that there is support for children and young people with mental health and physical health problems, whatever their age.

We are joining up children's services across the NHS and local authorities, including Child and Adolescent Mental Health Services (CAMHS) and emotional health and wellbeing services, children's community health services, and local authority services for those aged 0-19 (which may include children's centres).



Reaching out - engaging those at high risk through the third sector and trusted networks.

Our neighbourhood teams, primary care, and social care will work with the voluntary and community sector to identify those at risk of poor or deteriorating health. Community-based workers will support those with a severe mental illness or dementia, migrant workers, travellers, and our wide range of diverse communities who may need help to access services in a different way.



Self-care - supporting patients to make decisions about their own treatment and become more confident to manage their own conditions.

Our GPs, consultants, and nurses will make it easier for people with long term conditions to manage their own care by adopting best practice for supporting self-care.



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.

We need to link up health and social care.

Peterborough
Public Workshop

2 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.

We aim to coordinate care better so that it meets the needs of the individual. We aim to pay close attention to the health and care services necessary to keep people living at home successfully, because we know this is the best way to keep people healthy and to maintain their independence.

When people become unwell, we will take every opportunity to spot warning signs and focus local support to help people live with long term health conditions.

We would like to see more joint working between local health and social care, with GPs playing a central role, supported by hospital clinical teams.

As much care as possible must be led by primary care (GPs). We are supporting our GPs to share best practice, work together, access advice from hospital consultants and to provide the enhanced primary and community care that our local people need.

Summary of what we propose to deliver.



Time to care - testbeds to support GPs.

Our 'Time to care' programme aims to support our 105 GP practices to manage increasing patient demand, help them to become more efficient, and to provide better quality of care to their patients. It also aims to improve the way in which GP practices work with local hospital, community, social care, and voluntary sector providers to provide proactive care close to the patients' home.



Neighbourhood teams - multi-disciplinary teams, led by GPs targeting those at risk (such as those with long term conditions, frail, elderly).

We aim to build on our neighbourhood teams which are staffed by district nurses, matrons, social workers, therapists, and pharmacists to provide integrated, proactive care for those with long term conditions, such as the dying, care home residents, and mental health service users.



Community experts - specialist clinicians will support neighbourhood teams.

To support the neighbourhood teams we need an integrated team of community-based experts to care for the more complex patients and provide advice and education. However, more needs to be done to ensure that access to the teams is fair, that the teams can access advice, and clinicians are able to review complex patients together to agree a management plan.



Sharing knowledge - this is a central role of the patient care plan, and electronic access to patient information across the system.

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.



Embedded mental health - ensure community mental health is within neighbourhood teams, and that there are links to liaison psychiatry and recovery.

Our neighbourhood teams already provide joined up community mental health services. We want to join up our community and mental health teams further to make sure the psychological needs of people with long term conditions and the physical health needs of patients with severe mental illness are met consistently.



Learning disabilities – implementing 'transforming lives'.

We have been working closely with the councils to implement 'transforming lives' for people with learning disabilities. The Collaboration for Leadership in Applied Health Research and Care (CLAHRC) is evaluating the use of integrated personal health and care budgets for people with learning disabilities.



Your own bed, not a hospital bed - for end of life and intermediate care.

We aim to provide more rehabilitation closer to, or at, home to retain a patient's independence, and provide more end of life care at home, rather than in hospital.

3 Responsive urgent and expert emergency care

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

This will be supported by better co-ordination, for example referral through NHS 111, close working with the ambulance service, and clear information provided to patients about which services are available - and how to reach them - when they have an urgent health need.

It is not good for patients to stay in hospital for longer than they need to be there, as it can have a negative impact on their recovery and ability to maintain independence. We must therefore make sure patients in hospital 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. As a result of this process, we have determined that it is in the best interests of our local population to maintain the current levels of provision, namely a specialist emergency centre at Addenbrooke's Hospital and an emergency department at Peterborough City Hospital. Hinchingsbrooke Hospital will retain its A&E department and will continue to be able to manage the current caseload of minor injury and major medical cases, with a physician-led service.

Since our three hospitals are already struggling to meet existing levels of emergency demand, and our volume of planned hospital procedures is significantly above that of similar health systems, 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.

Summary of what we propose to deliver.



Ambulance services - alternatives to hospital admission.

We are working with our ambulance teams to make sure 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 medical professionals, to decide whether options other than transfer to hospital are more appropriate.



Right call, first time - integrated urgent care and clinical hub.

From October 2016, if you call 111 and you need to speak to a clinician you will be able to do so. This service is provided by our expanded integrated urgent care service and clinical hub. The aim is to make sure that patients receive the most appropriate care that best meets their needs. This will ensure that our hospitals' emergency services are reserved for serious/life threatening injuries or illnesses.



Minor injury - walk-in minor injury services.

Following our review of the three Minor Injury 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 focus initially on integrating local primary, minor injury, and community services. This will move on to include development of point of care testing and consultant support, via telemedicine links. We intend to develop and test the first phase of new urgent primary care model over the next 12 months, which will inform further engagement and, potentially, consultation. We are also doing an analysis of all options put forward as part of our early engagement work.



Right call, first time for mental health concerns - dial 111 - press 2 if you have a mental health concern.

We are embedding mental health including community crisis services, liaison psychiatry, and Suicide Prevention Strategy. We are investing £2m of urgent and emergency care funding in an evidence-based, community first response service which provides urgent out of hours assessment and support to people in mental health crisis.



More support for people leaving hospital - we have a very high level of people staying in our hospitals for longer than they need to be.

We believe it is not good for any patient to stay in hospital for longer than medically necessary and we are putting in place processes to ensure that patients are discharged on time, including on-site social care staff to support discharge from hospital.



24/7 standards – in consultant-led services

Our three urgent and emergency care hospital departments will meet the government's seven-day service standards with early and daily consultant input to reduce the length of time people spend in hospital.

4 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.

Where it is important to provide services from several sites across the area, we believe we can use our skills and expertise collectively to achieve better results through doctors and nurses working across more than one hospital site and sharing their expertise.

We expect that maternity services will also remain at the Rosie Hospital in Cambridge, at Hinchingsbrooke Hospital, and at Peterborough City Hospital.

Evidence tells us that standardised care is often higher quality and lower cost. Networking between medical professionals will help us to deliver savings, as well as helping to ensure that the additional costs associated with increased clinical standards, especially seven day services, are minimised.

Summary of what we propose to deliver.



Networks of care - where services are provided from more than one site, we will use specialised skills and expertise collectively to raise quality everywhere.

Medical professionals at our hospitals are beginning to agree how to work as operational networks for planned, unplanned, routine, and specialised care. These networks will share information about appropriate patient referrals and the best treatment, and building workforce resilience through better career development and shared out of hours arrangements.



Patient choice hub - improving quality of referrals and align capacity and demand.

A new patient choice hub is being developed with the aim of improving quality of referrals, ensuring that clinical thresholds are adhered to, that capacity and demand are lined-up across available providers, and managing procedures across the health system rather than in organisations.



Centres of clinical excellence - clinical consistent pathways across all providers to improve outcomes and efficiency, with fewer, more specialist centres across our hospitals.

We need to create centres of clinical excellence that use consistent procedures and policies across all service providers. We have identified some quality and efficiency benefits from combining procedures.

- **Orthopaedics:** We are considering centralising specialised orthopaedic trauma services (such as fragility fractures from falls) at Peterborough City Hospital and Addenbrooke's Hospital, 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 Hinchingsbrooke Hospital (such as routine knee and hip replacements), to improve the quality and sustainability of services at all three hospitals. We expect to consult on these proposals in 2017.

- **Stroke:** National stroke indicators show that we perform below the national average on a number of stroke areas, including access to specialist rehab and early-supported discharge. In addition, inpatient and community bed-based stroke and neurological rehabilitation care is fragmented across multiple sites.

In order to improve the services offered to our patients we are considering providing all bed-based stroke and neurological rehabilitation on a single site and to establish an enhanced early-support discharge team, so many more patients can receive rehabilitation and support at home. We expect to consult on these proposals in 2017.

We have also considered whether we need one or two hyperacute stroke units (we have one in Cambridge and one in Peterborough), and have concluded that at present we should retain our two hyperacute stroke units.



Modern maternity - improving quality, choosing home births, standardisation and continuity.

For obstetric and neo-natal services we have considered the viability of our three obstetric (maternity) units, each with a co-located midwife-led unit, and concluded that all three should remain. However, we need to enhance networking between the three units to share knowledge and improve care for expectant mothers and women in labour.



Acute paediatrics - supported by strengthened community services.

Hospital stays for children and young people should be kept to a minimum. We will develop community care with enhanced community nursing, and with GPs and paediatricians working better together.

5 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.

We believe we can achieve consistently better results for people with more serious needs, such as for heart and lung services or complex surgery, in fewer, specialist units which make best use of the world-class expertise of our specialist consultants.

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

Summary of what we propose to deliver.



Cancer - improvements in waiting times and best practice services.

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.



Specialised mental health - We provide limited specialised mental health locally in a small number of low secure beds and Child and Adolescent Mental Health 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 across Cambridgeshire and Peterborough. Papworth Hospital which, following its move to the Cambridge Biomedical Campus next to Addenbrooke's Hospital, will lead the service across both organisations. Together with Peterborough and Stamford Hospitals NHS Foundation Trust, it will provide a vital role in supporting improved 24/7 access to cardiology opinion, as well as community-based services that focus on prevention.

How does the NHS support carers?

Cambridge Public Workshop

Ely Public Workshop

Most of us prefer to travel 100 miles for an operation for someone who's done it before.

Patient stories - how things could look in the future

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 advised 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, not better. Following the advice that GP Martin had given her earlier she took Olivia to the hospital. The specialist children's team could access 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.



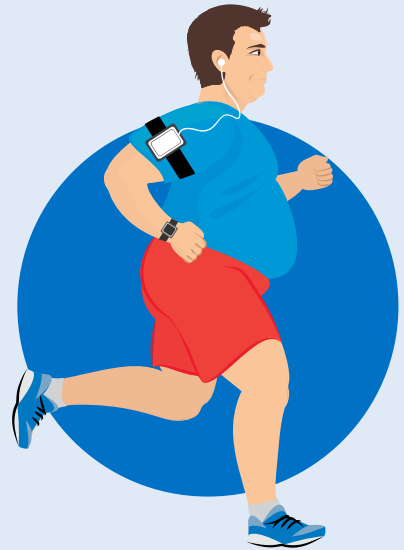
Looking forward – keeping active

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 suggesting 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 and 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, 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 the 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.



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.



Partnership working

Everyone who provides health and social care in Cambridgeshire and Peterborough will plan together and work together to improve the health and wellbeing of the community.

Priority three - We're on the move



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.

Priority four - We're on the move

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.

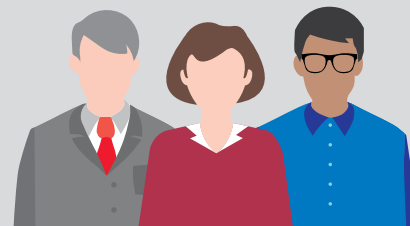
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A culture of learning as a system

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.

Supported delivery

6 Partnership working

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

We believe we must work across boundaries: between NHS and local authority social care; GPs and hospital care; and physical health and mental health.

None of our organisations can be sustainable acting alone; our financial challenge is too great. We need to work together in a way that we have never done before. In addition to new ways of working, and a new relationship between medical professional and patient, we can do more to collaborate in our non-patient facing services, including back office and clinical support services, and reduce duplication.

Collaboration between commissioners, including the Clinical Commissioning Group and local councils, NHS providers, and general practices, is crucial. There are examples in our system of where this is already happening and members of these organisations have already begun to work together as equal partners to a far greater extent than ever before.

Summary of what we propose to deliver.



Larger general practices - Many of our GP practices recognise the benefits for sustainability of working together as federations and larger primary care teams. We believe this will enable better access to resources through sharing and specialisation and closer working between GPs and their colleagues in hospitals. Development of the primary care workforce (GPs) is an important part of this.

We also recognise that people are supported by a network of formal and informal care, and aim to work in partnership with local organisations, such as faith groups and the voluntary sector.



Hospitals joining together - Hinchingsbrooke Hospital and Peterborough and Stamford Hospitals are looking at coming together to bring about financial efficiencies and also meet their clinical and workforce challenges. They will be making a decision in late November, and, if it is agreed, they will join together in April 2017.

Papworth Hospital is preparing to move onto the Cambridge Biomedical Campus in 2018. This will lead to further formal collaboration with Addenbrooke's Hospital in due course.



Back office - We have started to rationalise overheads and support services. We will establish a shared HR back office that includes healthy workforce. We will also 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 and transparency in tracking cost improvements and Quality, Innovation, Productivity, and Prevention (QIPP) delivery in 2016/17, we will look at ways to share risk and align financial incentives.



Health and social care

The Clinical Commissioning Group and local authorities are collaborating with the aim of aligning commissioning arrangements for mental health and healthy child services.



Working with the voluntary and community sector, and support for carers - Key to reduction of hospital admissions is coordinating support for people. Many relevant services and interventions are provided by voluntary and community sector organisations. All commissioners are seeking to work more closely with the voluntary and community sector.

Case Study: Peterborough is leading the way

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

To enable the required change, improvements, and efficiencies in this plan to be delivered we have identified four key things that will need to happen to underpin our work across the system.



7 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.

We want to develop a culture of learning. This means our staff developing a shared understanding of our services, priorities, and challenges, a common approach to analysing opportunities and problems, and finding solutions together.

We believe we can share knowledge and expertise from the specialist services in Cambridgeshire and Peterborough, making the most of our world-class medical and healthcare education and training, and using research to drive improvement.

We know we must invest in system-wide quality improvements. To be successful, our system must develop a shared understanding of all the interrelated issues and must 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.

We are developing a system-wide quality improvement and organisational development plan which will focus on 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.

We need to build on our research heritage and be at the forefront of adopting new therapies and delivery models for the patients of tomorrow.



8 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.

We want staff to choose to work here and to see themselves as part of the whole health and care service in Cambridgeshire and Peterborough - this will help us where we have services that have staffing shortages.

Workforce data and intelligence from other parts of the country has provided us with the building blocks to design a workforce and transformation strategy.

In the short-term we have developed a whole systems approach to 'grow your own' and 'earn as you learn'. We are building on existing programmes 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.

Over the longer term our system needs to work differently to ensure our staff are supported appropriately and retained. We need to ensure that the contribution of our mature workforce is retained and that they help us to develop competence and confidence in newer members of the workforce.

Many of the emerging new models of care, including our aspiration to operate in networks of care, require both the current and future workforce to work more flexibly across locations, in line with the demand for our services. Our human resources model will need to become more flexible and, where possible, we will do things in common to enable staff to move between organisations more easily.

Case Study: Skills for people-powered care

We have made progress towards training and developing our staff to deliver new roles:

- Funding from Health Education England supports training and research on integrated working in Neighbourhood Teams.
- Cambridgeshire County Council's Early Help Team helps individuals at an early stage, in the community.
- Cambridgeshire Better Care Fund's care home educators are learning from a local pilot and the Care Home Vanguard.



9 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.

We want to explore how we can work together to get more value from our land and buildings, and bring all our sites up to modern standards.

There is a great deal of building development in Cambridgeshire and Peterborough so we see opportunities for new strategic partnerships, such as the planned Hinchingsbrook Health Campus.

We have many community estates, some of which are poorly used, which provides us with the opportunity to reduce the number of buildings used and potentially develop new primary and community care facilities on the larger sites.

We want to 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.

We want 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 side by side with community and social care staff, have direct access to diagnostics and specialist advice, and are enabled to diagnose and care for more patients without the need to refer to hospital. Over time we expect these hubs to replace much of outpatient care.

Local authority plans to bring NHS and local health and care resources together under one social/community/mental health/primary care roof, will go a long way to providing proactive care, rather than reactive care in hospital.

Similar changes are possible as back office services begin to collaborate more. The sites at Princess of Wales Hospital in Ely and North Cambridgeshire Hospital in Wisbech could be 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 two sites.



10 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.

Shared information will help medical professionals in hospitals, GP practices, community teams, and social care to work together more effectively.

Technology will also help us to provide more reliable information for patients more quickly, and our clinicians will make sure technology is built in to new services.

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:

- Data and information sharing
- Health apps
- Telehealth/remote monitoring
- Access
- Real-time information
- Health analytics

Staff stories – how things could look in the future

Making the right call

Joanne supports several people with long term health conditions, enabling them to continue to live independently at home. She has built up a lot of knowledge about signs to look out for and urgent care options, and has always felt that she has valuable insight into how the emergency admission process works and whether it could provide a better experience for patients and carers.

Now working within a larger, multi-disciplinary team she can play a greater role. For example, she has received coaching from a local hospital consultant from whom she can also access immediate support and advice. This includes examples of symptoms which should raise concerns, so Joanne has the reassurance that she knows when it is right to call an ambulance and how she can help to prevent emergencies.



Hospital care at home

Maqsood leads a newly-established team in St Neots. It helps to keep people living independently by providing intensive nursing input at home - so avoiding hospital admission or enabling earlier discharge.

Maqsood knows that the research evidence is clear. Too often, on admission to hospital the care and support networks on which older people depend fall away and with them their ability to live independently. He helped to co-design the service and has worked hard to develop his team, which brings together professionals across several organisations and focuses on each individual patient's needs.

For example, Mrs Barlow was one of the team's first patients, after she was discharged from hospital much sooner than she would have been before it was in place. She was able to recover at home, at first with high-level healthcare and daily contact with support workers, which then stepping down to every other day contact with a nurse. She even received home visits from the pharmacist to make sure her medication was correct.

To stop people going to A&E you must provide alternatives.

Huntingdon
Public Workshop

Wisbech Public
Workshop

People would be happy to be treated at home if they could get good support.

Peterborough Public Workshop

Ensure health staff on the ground are involved.

Mental Health is a key element to all patient pathways.

Wisbech Public Workshop

Staff stories – how things could look in the future

Joining up physical and mental health

Greg leads part of the liaison psychiatry service, which joins up mental health and physical health care when people need hospital treatment or urgent care. His team works in hospitals across Cambridgeshire and Peterborough.

As well as helping to make sure that the NHS meets its commitment to give mental health the same priority as physical health, Greg believes that his service is based on principles which are fundamental to transforming care services.

When people are admitted to hospital, the liaison psychiatry service focuses on helping them to recover and how they can be supported to return home. This requires a holistic approach - working across mental health and different hospital specialties, in partnership with the patient, and alongside carers, advocates, and social care providers - because keeping people well requires a team effort.

As a clinician, Greg wants to help shape new ways of working and sees his role as a great opportunity – both to help bring about better outcomes for patients, and to develop his own professional skills.



World-class hospital care – delivered closer to home

Visha, a Geriatrician, has always strived to provide the very best care available anywhere and, although they handle an enormous number of patients, she is proud of the outstanding results achieved by her hospital-based team.

Visha was recruited onto the transition team which managed the set up of a new service running satellite clinics. Working with Paul, one of the GP leads, she realised that this challenging change could mean even better treatment and an improved experience for patients. By setting up a buddying system, Visha's specialist expertise and Paul's broader experience were combined and Paul was supported to take on monitoring and care which would previously have required a hospital visit. Visha's team is now on rota to advise local GPs 24/7 via a hotline, so reducing the number of patients reaching them through A&E.

The practice at which Paul is based proved an ideal location for outpatient clinics. As a community 'hub', it is well-equipped and a new IT system enables Visha to access patient records and communicate with specialist colleagues - whether she is in the practice or on her ward.



What these changes mean for our finances

We have reviewed our finances thoroughly, including making comparisons with national figures and looking for opportunities to make savings and organise services more efficiently.

As reported in the summer, by 2020/21 we predict a system-wide £250m financial deficit. This is in addition to £250m of savings and efficiency plans individual trusts and the Clinical Commissioning Group (CCG) need to deliver over the same period. This makes a total system-wide financial challenge of £500m over the next four years.

If the trusts and Clinical Commissioning Group meet their plans, and all aspects of the Sustainability and Transformation Plan are delivered, this will achieve the savings and efficiency target of £500m and will actually produce a small NHS surplus of £1.3m (by 2020/21).

To enable all the proposed service improvements and developments within the STP to be delivered it will require an estimated additional investment of £43m. If this investment is to be locally funded it will need to be paid back, and therefore would increase the total system-wide financial challenge from £500m to £543m.

We believe that success lies in reducing demand, 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 reducing our overhead costs.

We are confident that there is significant scope to both improve the efficiency of patients being admitted and discharged from hospital by reducing the differences in the care provided and to deliver care more effectively outside of hospitals.

We feel that there is also opportunity to reduce clinical support services costs, through sharing back office costs and organisational mergers, where beneficial.

There are a number of areas that we believe should produce additional benefits, including growing income from commercial opportunities, and by reducing the cost of debt repayments.

Our approach to implementation

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, to fully understand the root causes of this, and to use this information to identify solutions and build commitment for implementation and 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.

System leadership, system working

We recognise the importance of partnership working in order to implement the changes described in our Sustainability and Transformation Plan. This includes partnership working across our organisations as we move towards greater joint health and social care commissioning and services.

We have made the public commitment to return the health and care system to a sustainable position, and improve care for local residents and healthcare users – through a Memorandum of Understanding. The Memorandum of Understanding (MoU) states:

- **One ambition:** to return Cambridgeshire and Peterborough to financial, clinical and operational sustainability by acting as a single leadership team, with mutual understanding, aligned incentives and coordinated action with external parties (e.g. regulators).

- **One set of behaviours:** all partners agree to exhibit the beneficial behaviours of a single leadership team.
- **One long-term plan:** we are collectively responsible for delivering the plan that will achieve our long-term ambition, including capturing the savings opportunities identified that will enable us collectively and individually to return to financial sustainability.
- **One programme of work:** all system projects will be aligned to the Sustainability and Transformation Plan and under supervision of a Chief Executive Officer-sponsored delivery or design group.
- **One budget:** within NHS contracting, a number of financial incentive options will be considered.
- **One set of governance arrangements:** the Chief Executive leadership group, and the groups reporting to it, will be the vehicle through which system business is conducted.
- **One delivery team:** we have ensured that resources are in place to deliver our system's plan.
- **One assurance and risk management framework:** Strengthening trust and creating a sense of shared accountability.

What these changes mean for local people

We have considered the impact that the changes outlined in our Sustainability and Transformation Plan will have on the different groups within our local population. In particular, we have considered the impact 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, patients, and carers when thinking about solutions to the problems we face, and worked with them to come up with proposals that are beneficial to our population. This is the beginning of our engagement and we want to do more to involve local people and staff in developing and delivering our plans.

We published our interim Sustainability and Transformation Plan summary in July, 'How health and care services in Cambridgeshire and Peterborough are changing', which was provided to staff, stakeholders, and the public.

Our forthcoming engagement with the public has three key aims:

- 1. Publicising our plan:** We will continue to tell people about our vision for health and care, describing what it means for patients in more detail.
- 2. Co-designing care models:** We will continue to work with patients and the public to ensure that the care we design has the patient at its heart and promotes independence. We will need to engage fully with the public about service redesign that will change how and where they access services.
- 3. Supporting behavioural change among patients and the public:** We will work with the public to promote healthy behaviours and taking individual responsibility for health and wellbeing, stressing to our population the importance of leading healthy lives. We will provide education around appropriate and effective ways of using services including self-care, urgent care, and A&E.

Regional centres make sense, seeing a specialist who does it often.

Huntingdon Public Workshop

What do the changes mean for our staff?

We have worked through our solutions as a single leadership team. The staff we have involved in developing solutions have been tasked with putting patients first, over and above organisational or professional interests. With the Sustainability and Transformation Plan 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. The proposals have been developed by approximately 200 frontline staff and we have already started to plan how we will engage with staff more widely. 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 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 together 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. We need to make the best use of our most expensive, and often scarce, consultant workforce by sharing posts where appropriate.

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.

Our move towards working as one network will see significantly greater collaboration between organisations. This may mean that we ask staff to work in different locations or with different working patterns. We will work with staff to alleviate any concerns they might have around this and we will ensure that the benefits of this new approach are made clear.

Fit for the Future

Working together to keep people well

How you can get involved

There will be more opportunities for patients, carers, and local people to be involved with the specific improvements we would like to make, and we will provide opportunities for staff and local people to help shape proposals for service change.

We are committed to being as inclusive and open as possible. We will listen to all contributions and use these contributions to influence the decisions we make. You will be able to have a say in key decisions, including formal consultation.

If you want to be part of the discussion and work with us to develop solutions, please contact us via email on **contact@fitforfuture.org.uk**

You can also register on our website **www.fitforfuture.org.uk**

Follow us on Twitter and Facebook for the latest news and developments.

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 **01223 725 304**

Can we do more
in the community?

**Ely Public
Workshop**

There should be
an intermediate
facility to go to,
from hospital,
before home.

**Cambridge Public
Workshop**

Our Partners

Cambridgeshire Community Services 
NHS Trust

Cambridgeshire and Peterborough 
NHS Foundation Trust

Peterborough and Stamford Hospitals 
NHS Foundation Trust

Cambridge University Hospitals 
NHS Foundation Trust

Hinchingbrooke Health Care 
NHS Trust

Papworth Hospital 
NHS Foundation Trust


**Cambridgeshire and Peterborough
Clinical Commissioning Group**



Fit for the Future

Working together to keep people well