Agenda Item No. 9

SUSTAINABILITY AND TRANSFORMATION PLAN (STP)

To: Health and Wellbeing Board

Date: 19 January 2017

From: Jessica Bawden, Director of Corporate Affairs, Cambridgeshire and Peterborough CCG

1.0 PURPOSE

1.1 The purpose of this report is to update the Health and Wellbeing Board on the latest Sustainability and Transformation Plan (STP), published by the Sustainability and Transformation Programme team on 21 November 2016.

2.0 BACKGROUND

2.1 Cambridgeshire and Peterborough's latest five-year Sustainability and Transformation Plan (STP) to improve local health and wellbeing was published on 21 November 2016.

2.2 Led by local clinicians, the STP has been developed by all local NHS organisations and local government officers, and through discussion with our staff and patients. It aims to provide solutions to the county's challenges to deliver the best possible care to keep the population fit for the future and take joint responsibility for improving health and wellbeing.

2.3 The plan addresses the issues highlighted in our Evidence for Change (March 2016) and the main reasons why changes are needed in the local health and care system. It details how we propose we could improve services and become clinically and financially sustainable for the future.

2.4 Following on from the interim STP summary published in July where we forecasted that as a system we will have a £250m financial deficit by 2020/21, the STP outlines that 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. It also estimates the need to invest £43m to improve services over these four years, which increases the total system-wide financial challenge from £500m to £543m.

2.5 The scale of the changes required is significant and we all recognise the delivery will be challenging.

3.0 KEY ISSUES

3.1 Through discussion with our staff, patients, carers, and partners we have identified four priorities for change as part of the Fit for the Future programme, and developed a 10-point plan to deliver these priorities:

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

3.2 **We have translated the STP into a programme of improvement projects, each of which reports to a delivery group**

Our priorities will be delivered through eight delivery groups, responsible to Accountable Officers who are Chief Executive Officers from across the health and social care system.

The groups cover clinical services, workforce and support services. The clinical delivery groups include public health and care services and are designed to encourage system-wide working and to allow for patient-led care to be at the forefront of everything we do.

Delivery Groups

Urgent and Emergency Care Accountable Officer: Roland Sinker, CUH	**Women & Children** Accountable Officers: Matthew Winn, CCS & Wendi Ogle-Welbourn, CCC & PCC	**Elective** Accountable Officer: Tracy Dowling, C&PCCG	**Primary Care & Integrated Neighbourhoods** Accountable Officer: Aidan Thomas, CPFT
Shared Services Accountable officer: Stephen Graves, PSHFT	**Digital Delivery** Accountable Officer: Stephen Posey, PHT	**Workforce & Organisational Development** Accountable Officer: Matthew Winn, CCS	**System Delivery Unit** Accountable Officer: Lance McCarthy, HHCT

Improvement projects

Service area	Improvement projects
Urgent and emergency care	Reduce demand for hospital care through: • Integrated NHS 111 and out of hours with clinical hub • Develop and deliver a mental health first response service to enable 24/7 access to mental health

	• Re-design the clinical model for intermediate care (community beds, re-ablement and therapy) • Ambulances: dispatch on disposition, hear and treat, divert to community services • Reduce re-admission rates through supported discharge • Extent and enhance ambulatory care services as alternatives to admissions • Develop primary and urgent care hubs in rural communities • Reduce length of stay in hospital
Women and children	• Introducing a 7-day-a-week paediatric community nursing (for children who would otherwise require emergency/urgent care in the hospital setting) • Maternity developments such as the 'saving babies lives' care bundle • Improving the care models for children with asthma and children's continence services • Developing an integrated children and family health and wellbeing service for 0-19 year olds (universal services) • Improve the mental health support for children and young people
Elective care	• Achieve shorter, faster, more effective treatment pathways • Models of care to enable GPs and consultants to share decision making • Develop GP referral support to address unwarranted variation in referral practice • Maximise clinical thresholds for effective services • Standardise high volume elective treatment pathways (hip, knee, arthroscopy, cataract, glaucoma, cardiac, ENT) • Reduce outpatient follow-up activity through virtual clinics, technology for results • Deliver productivity gains in provider trusts
Primary care and integrated neighbourhood teams	• CVD and stroke prevention • Improve identification and management of patients with hypertension and atrial fibrillation • Improve uptake of NHS Health Checks • Improve uptake and completion of cardiac rehabilitation • Mental Health • Implement enhanced primary mental health care (PRISM) • Ensure mental health service model matches capacity and demand • Implement mental health strategy across the system • Diabetes • Support self-care, provide enhanced patient education and virtual patient reviews • Develop a proactive integrated model of care for people with long term conditions • Design and implement the 8 diabetes NICE care processes • Respiratory • Improve respiratory patient identification • Develop specialist community expertise • BLF 'Love your lungs' and spirometry testing

	• Implement new medicines management and prescribing practices including minimise triple therapy for COPD
Shared services	• Merger of HHT and PSHFT to enable shared service savings • Explore back office consolidation across primary care at scale • Implement a single approach to procurement across C&P • Develop and sign off strategic estate plans, (including potential for primary care co-location, including other public services like Citizens Advice)
Digital delivery	• Digital opportunities: tele-medicine, tele-monitoring, GS1, remote monitoring, internet of things • Shared Wi-Fi, infrastructure for professional and citizen – all health and care locations • Paper free care delivery
Workforce & Organisational Development	• Develop a system wide Workforce Investment Plan, in which all providers commit to investment priorities in relation to Apprenticeships (via LEVY), Pre Registration, CPD and wider workforce transformation • Link to supply improvement programme and design a tailored programme for primary care, linking to case load management trailblazers

3.3 All of the leaders across the system are being asked to sign a Memorandum of Understanding (MoU) as a demonstration of their commitment to work together, share budgets, deliver agreed clinical services and ensure that together we provide health and care services that are clinically and financially sustainable.

3.4 Eleven delivery groups have been set up to deliver the 'Fit for the Future' 10-point plan – led by chief executives officers from across the system. The 11 groups have identified 53 improvement areas which are being scoped and measures for success developed, including quality key performance indicators and targets, and key milestones.

3.5 If patients and carers want to be part of the discussion and work with us to develop solutions, they can contact the team on contact@fitforfuture.org.uk

4.0 IMPLICATIONS

4.1 If the Trusts and CCG meet their savings and efficiency plans, and all aspects of the STP are delivered, this will achieve the savings and efficiency target (of £500m) and produce a small NHS surplus of £1.3m (by 2020/21).

4.2 Due to the high levels of acute hospital activity, and resulting deteriorating financial position in our system, we are looking at ways to accelerate the pace of change and focus early investment on the areas that will have greatest impact on reducing hospital activity levels.

4.3 Our priorities are to increase the amount of care delivered closer to home and to keep people well in their communities.

4.4 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 and to be involved with any formal consultation process. Any changes to services will also be open to scrutiny by the County Council's Health Committee.

4.5 The proposals will be further developed over the next few months. If anyone wants to be part of the discussion please contact the team via email: contact@fitforfuture.org.uk

5.0 RECOMMENDATION/DECISION REQUIRED

5.1 The Health and Wellbeing Board are required to comment upon and note the STP.

6.0 SOURCE DOCUMENTS

Source Documents	Location
• Cambridgeshire and Peterborough Sustainability and Transformation Plan – October 2016 • Sustainability and Transformation Plan summary document – updated, November 2016 (also attached as a PDF) • Frequently Asked Questions – Third edition, November 2016	All available at www.fitforfuture.org.uk/what-were-doing/publications/