**Agenda Item No:9**

# CAMBRIDGESHIRE AND PETERBOROUGH HEALTH AND CARE SYSTEM TRANSFORMATION PROGRAMME

To: Health and Wellbeing Board

Date: 2nd October 2014

From: Dr Neil Modha, Chief Clinical Officer (AccountableOfficer)
Cambridgeshire and Peterborough Clinical Commissioning Group

## 1.0 PURPOSE

1.1 This report gives an update on the ongoing development of the Cambridgeshire and Peterborough Health and Care System Transformation Programme.

## 2.0 BACKGROUND

### 2.1 The strategic planning process

Cambridgeshire and Peterborough Clinical Commissioning Group (CPCCG) has developed, in conjunction with providers, partners and patients, a 'system blueprint'to deliver sustainable health care now and in the future for the whole of the local health system.

There are four phases of plan development and implementation (see appendix 1). We are currently in Phase 2. This phase is likely to last until June 2015 and involves:

- Engagement with stakeholders and co-design of potential options
- Modelling the impact of these options
- Deciding on options for changing pathways and structures for delivery
- Preparing for public consultation for the chosen options

### 2.2 'Challenged Health Economy'

The Cambridgeshire and Peterborough system has been identified as one of 11 'challenged health economies' nationally. This reflects some of the challenges faced by both the CCG and our provider organisations. This has resulted in external advisors, PwC, providing support to the CCG from April to June 2014 and again in August 2014. Their work was sponsored and overseen by NHS England, Monitor and the Trust Development Authority (TDA).

PwC established a"care design group"process which considered elective and non-elective care. The CCG adopted a similar approach for other workstreams.

## 2.3 The System Transformation Board

The Health and Care System Transformation Programme Board met formally for the first time on 12th August 2014 and agreed:

1. That the workstreams that make up the programme would be as follows:

- Elective care
- Non elective care
- Children and maternity
- Mental health
- Older people and vulnerable adults
- Primary care
- System design

Appendix 2 sets out the high level detail of each workstream.

2. That 'prevention' would be integrated into each workstream
3. To add in a workstream on primary care.
4. To ensure strong patient representation in this programme by inviting Health Watch representatives to be members of the Programme Board
5. To hold a workshop to review the 5 year plans from each organisation with a view to aligning their delivery.

## 2.4 The lead role of the CCG and the System Transformation Team in the ongoing 5 Year Planning Work

The CCG is leading the System Transformation Programme. The CCG's Accountable Officer is the chair of the Programme Board. The CCG's Chief Strategy Officer is the System Transformation Executive Sponsor. The CCG is also hosting the Transformation Fund and System Transformation Team

The System Transformation Team has been staffed by internal secondments from the LCGs and CCG and secondments from other organisations across the health system.

Although the System Transformation Team is hosted by the CCG, it is explicitly working across the system and for the system and not for any one particular organisation in the system.

## 2.5 Engagement and communication work

An engagement and communications manager has been appointed and engagement work is already on going. Members of the System Transformation Team will be attending a Health and Wellbeing Board Development Session on Friday, 19th September 2014.

Clinical input and engagement to this process are fundamental. As the programme develops this need will increase. Experience in the CCG to date has shown the value of clinical leadership in change programmes. The CCG is currently recruiting for a clinical lead to support this work. This post will be focused on ensuring CCG clinical engagement in the process.

## 3.0 SUPPORTING PARAGRAPHS

### 3.1 System blueprint: final version

The final version of the system blueprint was submitted to NHS England on 20th June 2014 by the CCG. The blueprint and appendices are available on the CPCCG website:

http://www.cambridgeshireandpeterboroughccg.nhs.uk/five-year-plan.htm

### 3.2 Workstream content

The workstreams that make up the programme are in development. Detail about what each workstream is likely to entail is set out in appendix 2.

## 4.0 IMPLICATIONS

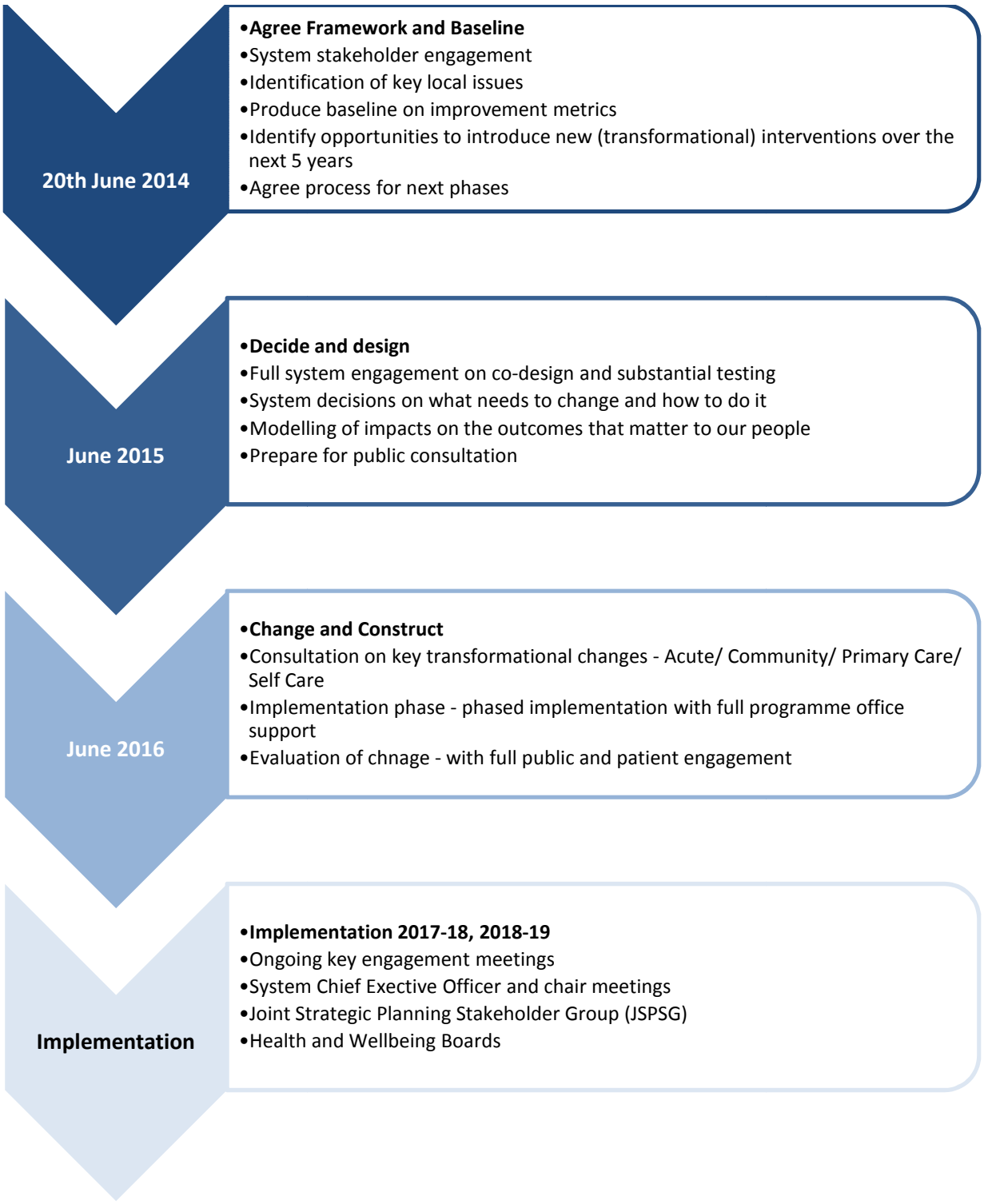
4.1 Phase 2 commenced on 1st July and will run until July 2015. This phase of work involves full engagement and co-design, system decisions on what needs to change and how to do this, modelling of the impacts on the outcomes that matter to our people and preparation for public consultation. It is during this phase that CPCCG intends to work closely with the four Health and Wellbeing Boards in the area it serves (Cambridgeshire, Peterborough, Northamptonshire and Hertfordshire).

## 5.0 RECOMMENDATION/DECISION REQUIRED

5.1 The purpose of the item is to provide information, and to raise awareness, to the Health and Wellbeing Board about the 5 Year Planning process. Health and Wellbeing Board members are asked to discuss the plan and to make comments.

| Source Documents | Location |
|---|---|
| • Cambridgeshire andPeterboroughhealth system Blueprint2014/15 to 2018/19: Main text | http://www.cambridgeshireandpeterboroughccg.nhs.uk/five-year-plan.htm |
| • Cambridgeshire andPeterboroughhealth system Blueprint2014/15 to 2018/19: Appendices | http://www.cambridgeshireandpeterboroughccg.nhs.uk/five-year-plan.htm |

Appendix 1: Phases of work



Appendix 2: Workstreams

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| Workstream | **Elective Care** |
| Main aim(s) | • To review expenditure on elective care (outpatients, day cases and elective inpatients)<br>• To determine short, medium and longer term QIPP schemes to deliver savings<br>• To provide the most productive quality service within the funding available. |
| Proposed lead | *Mark Avery* |
| Key areas of focus | • Benchmarking potential opportunities<br>• Referral & clinical thresholds<br>• Discharge planning<br>▪ Treatment in the 'right place'<br>▪ Use of single provider for specific elective work<br>▪ Jointly owned, risk shared "cold site" for elective work |
| Expected high level outcomes | • Fewer acute new/ follow-up outpatient attendances/ elective admissions per head of population<br>• Reduced overall cost of delivering acute elective activity across the system |
| Phases of work | 1. Phase 1 **(2014/15)**<br>• Ensure ongoing support and delivery of existing QIPP schemes across the system<br>• **Set out clear commissioning intentions for 15/16 (by 30 Sept 2014) – to include exploring mechanisms for capitated budget/ commissioning for outcomes for specific pathways**<br>• **Review referral / clinical thresholds and controls**<br>• **Review and implement improvements to the discharge planning processes**<br>2. Phase 2 **(2015/16)**<br>• Implement and test capitated budgets/ outcome based commissioning model for specific pathways<br>• Implement any changes to referral / clinical thresholds and controls<br>3. Phase 3 ***Link to workstream 7*** (longer term delivery – but worked up in parallel to phases 1 & 2)<br>• Explore the idea of a single provider for specific elective services<br>• Explore establishing a jointly owned, risk shared 'cold site' for elective work |
| Estimated savings | *To be confirmed* |

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| Workstream | **Mental Health** |
| Main aim(s) | • To develop an integrated physical/mental health approach to patient care which will focus on improved patient outcomes, experience and whole system savings<br>• To increase partnership working with local authority commissioners, housing providers, the voluntary sector, community services and primary care<br>• To continue to address the current health and access inequalities experienced by our patients |
| Proposed lead | *John Ellis* |
| Key areas of focus | • Data quality (cost of pathways)<br>• What can be learnt from cost effective models in use elsewhere<br>• Place of care (community vs inpatient)<br>• Opportunities for greater use of voluntary sector and community resources to support patients |
| Expected high level outcomes | • Delivery of a sustainable mental health service<br>• Delivery of savings<br>• Improved integration/ alignment between physical and mental health care and clinical outcomes<br>• Improved patient satisfaction of service delivery<br>• Equity of Access CCG-wide |
| Phases of work | 1. Planning and resourcing phase **(June – Sep 14)**<br>2. Agreement of project scope with Key Partners **(Oct 14)**<br>3. Development of Engagement Questions/ Engagement with key stakeholders **(Oct 14 – Mar 15)**<br>4. Service Design phase **(Dec 14 to May 15)**<br>5. Service Design to include "Closing the Gap" Guidance and "Crisis Care Concordat"<br>6. Consultation, review and service model finalisation **(May to Sep 15)**<br>7. Implementation **(Sept 15 to Mar 16)**<br>8. Service Launched **(Apr 16)** |
| Estimated savings | *To be confirmed* |

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| Workstream | **Non elective Care** |
| Main aim(s) | • To review expenditure on urgent care (A&E and non-elective admissions)<br>• To determine short, medium and longer term QIPP schemes to deliver savings<br>• To provide the most productive quality service within the funding available. |
| Proposed lead | *Mark Avery* |
| Key areas of focus | • Delayed transfers of care<br>• Front end A&E model<br>• Links between GPs & ambulance service<br>• Treatment in the 'right place'<br>• Urgent care service configuration<br>• Single points of access for patients and professionals |
| Expected high level outcomes | • Reduced delayed transfers of care<br>• Decrease in inappropriate use of A&E/ increase in number of patients treated in 'right' location<br>• Greater coordination between services |
| Phases of work | 1. Phase 1 **(2014/15)**<br>• Review outputs from Care Design Group process and prioritise proposals<br>• Ensure reduced delayed transfers of care **(before winter 2014/15)**<br>• **Set out clear commissioning intentions for 15/16 (by 30 Sept 2014) – to include exploring mechanisms for capitated budget/ commissioning for outcomes for specific pathways**<br>2. Phase 2 **(2015/16)**<br>• Review / monitor OPAC service integrator potential/initiatives to provide more care closer to home<br>• Adopt a consistent front-end A&E model across the local health economy<br>• Establish single points of access for patients and professionals<br>• Pilot links between primary care and the ambulance service<br>3. Phase 3 ***Link to workstream 7*** (longer term delivery – but worked up in parallel to phases 1 & 2)<br>• Review and reconfigure (if appropriate) urgent care services |
| Estimated savings | *To be confirmed* |

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| Workstream | **Older People and Vulnerable Adults** |
| Main aim(s) | • To improve outcomes and patients' experiences of older people services<br>• For older people's services to be organised around the needs of the patient<br>• To make sure older patients have the right support to stay healthy, to maintain their independence and receive care in their home or local community whenever possible with hospitalisation as a last resort |
| Lead | *Arnold Fertig and Matthew Smith* |
| Key areas of focus | • Unplanned acute hospital care for older people<br>• Older People Mental Health Services<br>• Population & outcome based contract<br>• Lead provider (integrator approach)<br>• Community health services for older people & adults<br>• Enhanced primary care, voluntary sector input<br>• Alignment of pathway funding incentives<br>• Cultural, service and structural transformation |
| Expected high level outcomes | To drive improvement in quality and outcomes by:<br>• Ensuring people have an excellent & equitable experience of care and support, with care organised around the patient<br>• Treating and caring for people in safe environment and protecting them from avoidable harm<br>• Developing an organisational culture of joined-up working , patient-centred care, empowered staff and effective information sharing<br>• Early intervention to promote health, well-being and independence<br>• Treatment and / or support during an acute episode of ill health<br>• Long term recovery and sustainability of health<br>• Care and support for people at the end of their lives. |
| Phases of work | • Notification of preferred bidder **(Sept 2014)**<br>• Contract signature **(Oct 2014)**<br>• Mobilisation **(Oct 2014 – Mar 2015)**<br>• Service Commencement Date **(Apr 2015)**<br>• Transition and intensive transformation **(Apr 2015 – Sept 2016)** |
| Estimated savings | *To be confirmed in accordance with procurement process timelines* |

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| Workstream | **Children and maternity** |
| Main aim(s) | • To review and redesign children and maternity services across Cambridgeshire and Peterborough<br>• To develop a new service model<br>• To determine how to implement new services to fit the agreed model |
| Proposed lead | Lee Miller |
| Key areas of focus | • Maternity and newborn<br>• Acute care<br>• Long term conditions |
| Expected high level outcomes | • Increased integration with LA services<br>• Increased integration across the pathway (primary care to acute)<br>• Reduction in hospital attendances and admissions<br>• Increase in community based service delivery |
| Phases of work | Phase 1: Undertake a needs assessment/ review of current services **(July 2014 onwards)**<br>Phase 2: Develop a clear project plan<br>Phase 3: Examine the evidence, guidance and best practice models<br>Phase 4: Pre-consultation<br>Phase 5: Consultation **(from July 2015)**<br>Phase 6: Business case development **(for presentation in December 2015)**<br>Phase 7: Procurement **(between December 2015 and December 2016)**<br>Phase 8: Implementation of new contacts **(December 2016)** |
| Estimated savings | *To be confirmed* |

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| Workstream | **System design** |
| Main aim(s) | • To develop appraised options for the potential health system designs in the Cambridgeshire and Peterborough area<br>• To prepare pre-consultation business cases for the preferred options |
| Proposed lead | *Ian Weller* |
| Key areas of focus | • The current and potential future design of our system<br>• Identification of options for which services could be delivered from which sectors and which sites<br>• NB – detailed pathway redesign is NOT in scope |
| Expected high level outcomes | Proposed changes to the current system design that:<br>• Reduce system cost through more efficient use of available resources<br>• Improve patient outcomes through better use of resource - delivery care in the right place<br>• Ensure all services meet relevant best practice standards both now and in the future<br>• Accommodate the fixed points in the system including the PFI at Hinchingbrooke and the PSHFT CPT recommendations |
| Phases of work | 1. Set-up: establish project team, stakeholders and governance structure, develop communications strategy, define design parameters and finalise timescales **(Sept 2014)**<br>2. Baseline analysis and information gathering (health needs of population/ current activity) **(Nov 2014)**<br>3. Produce long-list of options based on what might be possible, interdependencies, availability of resource **(Nov/Oct 2014)**<br>4. Develop short list of agreed options (3-5?) to be modelled **(Dec 2014)**<br>5. Financial and activity modelling of short list options **(Jan/ Feb 2014)**<br>6. Pre-consultation business case **(March 15)** |
| Estimated savings | *To be confirmed/ costed based on proposed options* |