NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

OPERATIONAL RESILIENCE AND CAPACITY PLAN

Financial Year 2015/16

Borderline and Peterborough -Peterborough and Stamford Hospital Foundation Trust

Version 12

Contents

1. The Peterborough Vision

The Peterborough and Stamford Hospital Foundation Trust system covers five Local Authority and three CCG areas. The largest volume of activity comes from Cambridgeshire and Peterborough CCG.

Cambridgeshire and Peterborough CCG is one of the eleven challenged health economies, and there is a System Transformation Programme to close a financial gap of £250m.

The Cambridgeshire and Peterborough CCG system was awarded the Urgent and Emergency Care Vanguard in September 2015. Our vision for implementing the UEC Review is to create an overarching clinically led strategic super-SRG, as part of the East of England Urgent and Emergency Care Network (population of approx. 6m), and to accelerate the pace of improvement we have started to deliver. We aim to achieve a model of best practice in line with the NHS England vision focussed on delivering:

- **Optimum delivery of urgent care in communities** and neighbourhoods for all age groups developing consistent fast and effective services across our rural, semi urban and urban areas.
- **Centres of emergency care excellence.** We currently have three A&E departments, with CUHFT as the specialist emergency care centre and trauma centre; PSHFT as a trauma unit and general emergency care unit; and HHT as a general emergency care unit. We will undertake a clinical and financial sustainability review including minor injury and illness units, to ensure that the model of emergency and urgent care best meets the need for local urgent care and consistent high quality and specialist emergency care.
- **Adoption of best practice in hospital pathways** as recommended by ECIST to sustainably deliver the 95% A&E standard towards which are starting to make good progress.
- **Development of our progressive and integrated model of Older Peoples commissioning**, supporting the new accountable provider, Uniting Care, to deliver improved outcomes for older people. This is an innovative model of commissioning which is **outcome based through a capitated budget**. The whole system (primary care, community, and mental health in the community) is integrating at the level of neighbourhood teams to enable Older People to live well in their communities, to receive urgent care in these communities and to return to them, living independently or with support, in their own homes as quickly as possible following a hospital admission.
- **Integration of the minor injury units in our communities with out-of-hours primary care**, which can be accessed by ambulatory patients, ambulances and community rapid response services to keep care as close to home whenever clinically safe to do so.
- High rates of access to all urgent and emergency care by **telephone first** so patients are clinically directed to the service that best meets their needs. We are currently procuring an **integrated Out of Hours GP and 111 service with a multi-disciplinary clinical hub** – this is a formal procurement which has completed public consultation, and is now in the final stages. It builds on our successful model of 'GP in 111' reducing A&E dispositions by 70%.
- **An ambulance service that thinks community first** –working with the Joint Emergency Teams (JET) in the community and primary care in and out of hours. A current CQUIN scheme to pilot GP triage of green ambulance calls in the control room is about to commence – stitching the ambulance service into our community services is as vital as their ability to respond to emergency calls within national response time standards.
- **A coordinated and integrated response for patients of any age with mental health urgent and emergency care needs**. We currently have a patchwork of services including crisis home

treatment, Section 136 suite, hospital based psychiatric liaison of varied hours and workforce in each of the three A&E departments - with little provision for Young People where growth in demand is not being met. We want to redesign these services so all patients can access appropriate urgent and emergency mental healthcare quickly, regardless of age and as close to home as possible.

- **Development of urgent primary care at scale** transformation programme. The Borderline and Peterborough (B-P) GPs were successful in their Prime Ministers Challenge Fund (PMCF) bid in 2015 resulting in the creation of evening and weekend primary care urgent care hubs in B-P LCGs. This 12 month pilot will be the precursor of developing extended primary care access across the CCG in order to support keeping people well in their communities.Primary Care to operate at scale to cover 250,000 pop in B-P.
- Practices will group into hubs serving 50,000 to 80,000 patients.
- 8.00am to 8.00 pm access on week days; direct booking to appointments via 111.
- At weekends 8-8 Primary Care delivered at Front Door ED

Promote 24 hour access to primary care through 'WebGP' with a one hour response to clinician if required. . The anticipated benefits will be

- A simpler system and extended access
- Reducing pressure on ED
- Continuity within larger primary care hubs
- Creating additional capacity for direct care
- Enhancing professional morale (sense of control and clarity on workload). Better able to serve the expectations of new staff; resilience and consistency of service
- Integrating care for older people
- Integrating pharmacy within the new approach
- Making better use of IT and comms technology

- **Develop a plan to implement the revised standards from RCPCH (Facing the Future) which are clear on the need for 24hr community nursing services for children** and the positive impact this has for admission and length of stay. This would be linked to the transformation of paediatric services across the patch. Addressing the needs of parents using 111 services is vital and will form part of the multidisciplinary clinical hub.
- **Development of a social network of support to enable people to live independently** and supported through the transitions of care by the local authorities, and by the voluntary sector who are increasingly a vital part of the urgent and emergency care system – working with Uniting Care as a significant partner, and helping people home from hospital. Development of Voluntary Sector Prescribing.
- **Working with the County Council and housing partners to develop a range of older people's short and long term accommodation** to reduce the need for acute hospital admission and to promote timely discharge. A Project Board, with system wide sign up has been established to take this work forward. The work includes partnership with the private sector and with Sheffield Hallam University. The focus is on both immediate needs (0-5 years) and longer term needs(5-25 years).
- **Develop practical options for data sharing** between key organisations. The initial phase is building on work led by Uniting Care to provide a Single view of key data. This work includes the use of the NHS number as the single patient identifier as part of the Better Care Fund Plan.
- Exploring opportunities to develop intelligence lead healthcare. This will involve sharing high level data and also triangulating it with the intelligence picked up by health and social care staff to prevent deterioration in our most vulnerable patients.

2. Current Position

2.1 What are the current challenges we are facing?

2.1.1 Population and Demography

Peterborough has a young population with a higher than average number of children and young people. It is also one of the fastest growing cities in the UK, with predicted population growth of 34.9% between the 21 years spanning 2010-2031. The city is ethnically diverse, with 29.1% of residents not self-identifying as White English/Welsh/Scottish/Northern Irish/British. The next most common ethnicities declared in the 2011 census were Asian/Asian British: Pakistani or British Pakistani (6.6%), White Polish (3.1%) and Asian/Asian British: Indian or British Indian (2.5%).
In 2014, economic migration was most common from Poland (1,100 migrant national insurance registrations), Republic of Lithuania (974), Portugal (504), Romania (427) and Latvia (397). There are socio-economic inequalities within the local authority area, with areas of significant deprivation close to central Peterborough.

Life expectancy at birth for females has risen in England from 79.1 years in 1991/93 to 83.1 years in 2011/13, an increase of 4.0 years or 5.1%. In Peterborough, the increase in life expectancy in this period has been slower than that observed nationally, from 79.2 to 82.6 years, an increase of 3.4 years or 4.3%. Evidently, the life expectancy in Peterborough has fallen from slightly above the England average to slightly below over this 20 year period.
For males, life expectancy at birth has risen more substantially but also at a slower rate than observed in England. Male life expectancy nationally has increased from 73.7 years in the 1991/93 time period to 79.4 years in 2011/13; an increase of 5.7 years, or 7.7%. However, life expectancy in Peterborough has increase more slowly, from 73.8 years in 1991/93 to 78.1 years in 2011/13. This represents an increase of 4.3 years or 5.8%.

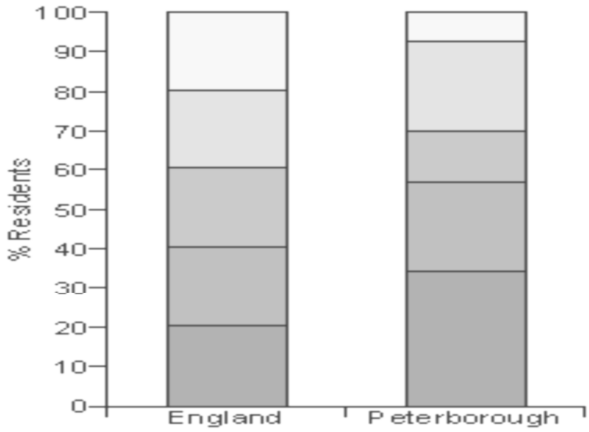
Children's health
Peterborough has a higher number of children than the national average living in poverty (27.2%) and a high level of diversity among the child population. The level of school readiness is at the national average and is better than average for children entitled to free school meals. However levels of educational attainment at GCSE vary significantly between electoral wards and poor attainment is closely associated with socio-economic deprivation. Childhood obesity is higher than the national average at 'reception' age, but lower than average amongst 10-11 year olds, although the proportion of underweight children is high at this age. The proportion of teenagers not in employment, education or training is higher than average, as are the numbers of teenage pregnancies. Hospital admissions for self-harm amongst children and young people, and admissions for injury amongst 15-24 year olds are also higher than average.

Adult health
A feature of adult health in Peterborough is a relatively high rate of premature death and disability, with life expectancy and healthy life expectancy being below national averages. Premature deaths from cardiovascular disease including in particular coronary heart disease, and from respiratory disease are higher than average – and these high rates of cardiovascular disease are focussed in electoral wards with the highest levels of socio-economic deprivation. Rates of premature death from cancer and liver disease are similar to the national average. Standardised hospital admission rates follow the pattern of premature mortality, with high admission rates for cardiovascular disease (and for all causes) from the more deprived wards.

There are lifestyle and health behaviour issues with longer term implications for public health – adult smoking rates are above the national average at 21%, hospital admissions specific to alcohol use are higher than average, and about two thirds of adults are overweight or obese (similar to the national average). It is known that smoking, excess alcohol and obesity all cause long term medical conditions which require treatment and that high prevalence of these behaviours will result in additional demand on health and social care services.
Suicide rates in Peterborough are currently similar to the national average, but admissions to hospital for mental health causes are higher than average. The predicted increase in the number of older people in the population means that the numbers of people with dementia in Peterborough, as well as older people suffering from depression is forecast to increase significantly over the next ten years, which will increase demand on health and social care services.

2.1.3 Deprivation

- The overall level of economic deprivation is higher for Peterborough Unitary Authority (UA) than for that of England overall, with a higher percentage of residents than of England overall within the most deprived economic quintile and a lower percentage in the most affluent quintile.
- **Figure 5 - Peterborough vs England deprivation quintiles5**



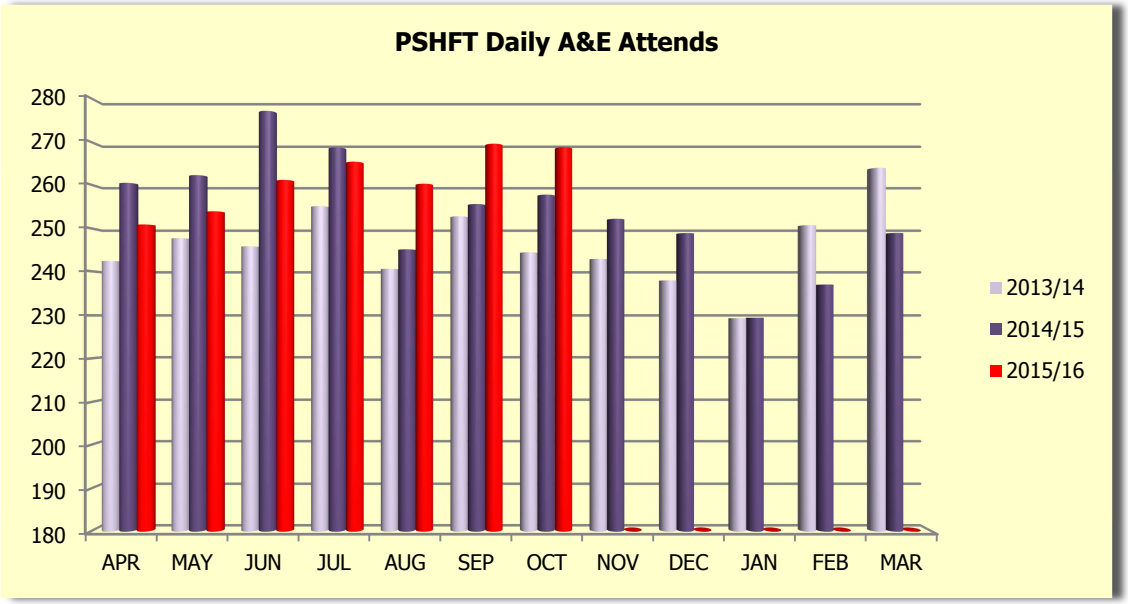
- Deprivation does, however, vary significantly throughout the UA – the below map illustrates that income deprivation prevalence is most apparent in wards near the centre of the UA, with the darkest shaded areas representing some of the most deprived wards in England. The percentage of residents living in income deprived households is highest in Dogsthorpe (28.0%), North (26.5%) and Central (25.5%).

2.2 What has changed?

In previous years there has been a distinction between winter and summer performance against the 95% standard. It has generally been accepted that there are seasonal fluctuations in activity and a recognised 'winter' pressure on the urgent care system. However, over the last couple of years there has been little differentiation or let up coming out of the winter months.

Cambridgeshire and Peterborough CCG have worked closely with South Lincolnshire CCG to build effective working relationships with providers to effectively manage patient flow. The two CCG's have worked collaboratively in aligning commissioning decisions and jointly commissioning services where it is in the best interest of patients.

Cambridgeshire and Peterborough CCG has led the development of an SRG that is collaborative in approach, with strong relationships that allows for robust challenge, and a collective understanding and agreement on the actions required to address continuous improvement.



2.2.1 Activity and performance at PSHFT level.

- The 4 hour standard has been met every month since May 2015, after a long period of not being met.
- Average monthly ED attendances have remained constant in 2015/16 compared with the same period in 2014/15. April-September 2014/15 7,973, 2015/16 7,933. Although there has been some variation in the peaks in activity compared with previous years
- EEAST ambulance conveyances have increased by 8% year to date in 2015/16 on 2014/15
- Ambulance handover standards are below target.
- Delayed Transfers of Care remain a system challenge

The system has made a number of significant improvements since winter 2014/15, these are set out in section 3.1

2.2.2 System Management and Escalation

The system has a robust system in place to manage delivery. There are real time updates throughout the day from the acute trust. In addition there are daily, weekly and monthly scorecards, and a community capacity scorecard has recently been added. Examples of these scorecards are in appendix 2.

The system develops a weekend plan each week, with a system wide call with on-call managers each day to review delivery and address capacity issues. A copy of a weekend plan is at appendix 2.

The system has developed an escalation policy with clear triggers and actions for each levels of escalation, this is attached at appendix 3.

3. Continuous Improvement and Sustainable Performance Plan

3.1 Urgent and Emergency Care

The system has developed a 10 point improvement plan that sets out the actions the system has, is, and will be taking to improve urgent and emergency care. The work-streams are based on external reviews, national best practice, and the UEC Vanguard. The 10 point plan can be found at Appendix 1 . **The 10 point plan is the system's winter plan.** The document is a **live** document and is reviewed fortnightly at the SRG. The plan has had ongoing review by the tripartite and ECIST as part of the Monitoring process of PSHFT's recovery plan.

The winter plan can be found on tab 10 of the 10 point plan and is also included at appendix 1a.. The schemes on this plan are schemes funded to provided resilience to the system through a mixture of; additional capacity to existing services, continuation of schemes found to be beneficial in winter 2014/15, and new/redesigned services that are being piloted.

The system has been working to deliver the 8 high impact changes required by November 2015. The position of our delivery is set out below

Intervention	Is this intervention in place? Please answer 'Yes', 'No', or 'Partially'	Brief overview on how this intervention is covered in operational plans	Commentary on investment to support the intervention
1. No patient should have to attend A&E as a walk in because they have been unable to secure an urgent appointment with a GP. This means having robust services from GP surgeries in hours, in conjunction with comprehensive out of hours services.	Yes	• In hours. Prime Ministers Challenge Fund bid that will extend opening times 8-8 weekdays, and provide Primary Care at the front of ED at weekends and bank holidays with a phased go live from August. • OOH contract in place and being re-commissioned CCG wide. For Borderline and Peterborough SRG system co-location on the acute site will provide GP presence at ED. • MIIU open 8-8 7 days a week. GP led service. • Data is available from piloting a GP in ED model during the winter, and from audit work undertaken. GP working in ED Friday, Saturday, Sunday funded by PSHFT most weekends. • Patients contacting GP surgeries out of hours are directed to 111, who make a disposition to OOH GP and MIIU. • Data requested from NHS England on availability of appointments commissioned from Primary Care. • Need to triangulate appointment availability with number of patients presenting. Patients saying they can't get an appointment hasn't correlated with appointment availability in previous audits. • Choose well literature in practices, websites, radio adverts through CCG communications teams. Further work tailored to community groups needs to be reviewed.	• Prime Ministers Challenge fund £2.6 Million • OOH Contract – CCG wide £3.4m • 111 Contract – CCG wide £7.98m

2. Calls categorised as Green calls to the ambulance 999 service and NHS 111 should have the opportunity to undergo clinical triage before an ambulance or A&E disposition is made. A common clinical advice hub between NHS111, ambulance services and out-of-hours GPs should be considered.	Yes	• 111- GP in control room evenings and weekends. Shifts 8.00-22.00. There is a need to recruit more GPs to fill these shifts. • Evidence is good on reducing ambulance call out and conveyances • SRG have considered one clinical hub and concluded at this time with the current providers this would not be feasible and would be clinically risky. • A CQUIN with the ambulance trust – EOE ambulance is being developed for 2015/16 to review green ambulance conveyances. Start date expected Q2. • NHS 111 - clinical triage of Green Ambulance Dispositions : In April 2015, we commissioned our NHS 111 provider to clinically triage green ambulance dispositions returned by NHS Pathways at the following times : Monday to Friday 18.30 -22.00 Saturday and Sunday 8.00 - 22.00 The provider is due to complete technical testing in respect of this by w/b 11 May 2015 and based on results to date does not foresee any issues arising from a technical perspective that would prevent this triage from going ahead. The clinical capacity for this triage is to be provided by the GP's employed by the service to review ED dispositions. It is likely based on initial assessment of demand for green ambulance review, that this capacity will need to be increased. On this basis remote working facilities have been set up to expand the potential source of GP's beyond Peterborough where the service is based, into Cambridge. and the surrounding area. • EEAST 999 Urgent & Emergency Transport Service - Regional contract :We have proposed a regional CQUIN for the review of G2 ambulance dispositions returned by the above service. The consortium lead, Suffolk CCG are currently exploring this proposal with EEAST. The biggest risk to this proposal being implemented is the shortage of GP's or Enhanced Nurse Practitioners to do triage . service went live in Q2 New -UnitingCare OneCall service commenced 6th May -providing 24/7 co-ordination of clinical services -provide an alternative disposition for both 999/111 .This will co-ordinate the community OOHs services including rapid response and the new Joint Emergency Team, which will ramp up over Q1 to provide a 24/7 service by Q2.	The clinical triage in NHS 111 of green ambulance dispositions is to be pump primed in year 1 and funded out of savings generated thereafter. The review of G2's within 999 service is to be funded out of Regional CQUIN funding . Costs to be confirmed end of May 2015 - available funds approx. £900k across CCGs in consortia.

3. The local Directory of Services supporting NHS 111 and ambulance services should be complete, accurate and continuously updated so that a wider range of agreed dispositions can be made.	Yes	• The DOS is reviewed on an ongoing basis in response to any reported issues in NHS 111 and/or as part of themed reviews to address service areas which could be improved (e.g. dental). • The DOS is a standing item on the monthly NHS 111 Clinical Governance Board agenda. • DOS changes as a result of the last version of pathways (version 9) were implemented in November 2014. • The services profiled on the DOS are primarily those taking referrals from NHS 111. The z code profiling exercise currently underway will expand this to include partner more services, especially in the area of mental health. • Reporting is in place to monitor journeys to A&E where alternatives are not available. UnitingCare OneCall service using the DoS and is an output for the DoS	

4. SRGs should ensure that the use of See and Treat in local ambulance services is maximised. This will require better access to clinical decision support and responsive community services.	Yes	• Ambulances have access to GP in 111, OOH doctors, Intermediate Care pathways, Ambulatory Care in PSHFT • Currently no ECPs within ambulance service • Ambulances can contact GP practices in hours • Halo service will be funded for 2015/16 1) Commissioners are monitoring Red and Green call non- conveyed rates to A&E by hospital site and are tracking trends and will require EEAST to produce remedial plans if rates increase. 2) Specific CQUIN will be in place for Q2 to support ambulance crews on the ground to help with conveying decisions - this follows successful Pilot run in Norfolk and also learning from similar support schemes in 111. 3) EEAST current position is an average of 42% non conveyed which is about 5% higher than national average. As 2014.15 saw significant acuity rises in red calls (which were up 17% on prior year) the commissioners have set a 'maintain' target for 2015/16 - longer term commissioners expect a stretch target on this as EEAST continues progress in recovering their core Red response standards. 4) Clinical capacity is being built up by EEAST as the core aim of the recent Transformation Programme and the increase in paramedic capacity towards a 70% skill mix ratio of qualified/non qualified front line staff will be monitored by commissioners. 5) Ambulance crews cannot directly refer to Out of Hours to book appointments at present, owing to the mix of providers running these services in the region however SRGs will be looking at how this barrier can be addressed. 6) Some hospitals run rapid access clinics and SRGs are reviewing their DoS entries to ensure these services are up to date and ambulance crews know how to refer into these services 7) Development work continues on regional DoS and this is work in partnership with EEAST and community providers locally to ensure that DoS is up to date. Through UnitingCare there is currently a care home educator within the Peterborough locality ,will review benefits and possibility of increasing service	Commissioners are targeting CQUIN funding of around £4.7m to make this happen for two schemes - first is to support EEAST in training the second year student paramedics to maximise capacity and skill mix of crews and second scheme is around enhancing clinical support for crews in Emergency Operations Centres to help with conveyancing decisions.

5. Around 20-30% of ambulance calls are due to falls in the elderly, many of which occur in care homes. Each care home should have arrangements with primary care, pharmacy and falls services for prevention and response training, to support management falls without conveyance to hospital where appropriate.	Yes	• Primary Care are aligned to each Care Home with a LES in place for undertaking ward rounds in the home and providing care to patients • Care Homes have access to GP in 111 • Pharmacy team working with care homes to undertake medicine reviews and training. Over 12 months the medicines of 1954 care home residents have been reviewed by the team. In the same period 2822 interventions were made, with 1964 being recorded as a quality or safety intervention. The associated cost saving was £252,259 • Care Home educator providing training to all care homes in Borderline and Peterborough. • Data capture of care home admissions monitored on a daily basis, and reported monthly • Ambulance can make referral to the community falls service • South Lincolnshire CCG have commissioned EMAS to deliver a falls car enabling patient triage once an ambulance is called. If the triage suggests that the patient could be seen by the falls car, the car will be sent. A full patient assessment is made and treatment offered on site if not life threatening. If the patient can be treated they will be and transported home or to an appropriate safe place (e.g. to a family member). Referrals to voluntary organisations are made by EMAS where appropriate. If the patient is assessed and needs urgent attention they are conveyed to hospital. The pilot is operational 7 days a week. The pilot started in November 2014 and so far has been successful with latest data evidencing a non conveyance rate (i.e. admission avoidance) of 37.5% from 24th November 2014 to 31st March 2015 . Monthly data is submitted to the CCG's performance team for analysis. The pilot will be evaluated and if successful a business case will be written to fund for the year ahead. • The CCG has also commissioned LCHS to provide a care home educator role to work with care homes across south Lincolnshire and educate staff on several key areas. Several topics will be focused on this year including pressure ulcers, end of life and UTI's. If a high proportion of falls are identified within one particular care home the care home educator will deliver training within the care home and educate staff on falls prevention and what action to take if a patient does fall. The care home educator is part of the Neighbourhood Team in Long Sutton and picks up any care homes with high admissions. This approach will be rolled out to the remaining Neighbourhood Teams across the south of Lincolnshire once implemented - anticipated by end September 2015.	Care home Pharmacy team costs £156k. The care Home Educator is funded by through Uniting Care.

		• South Lincolnshire CCG have asked PSHFT to identify care homes with high numbers of admissions. The CCG and Care Home Educator will address if analysis shows any admissions into hospital which could have been prevented.	
6. Rapid Assessment and Treatment should be in place, to support patients in A&E and Acute Medical Units to receive safer and more appropriate care as they are reviewed by senior doctors early on.	Partially	• Pilot commencing 7th May for a consultant to RAT patients coming into majors, wont be 24/7 or 7 days a week as there is currently not the consultant cover to ensure this can be rostered effectively. Consultant recruitment is taking place with new consultant to start in ACU in September. • Ambulatory Care Unit taking patients 8-6 Monday to Friday, 8-4 Saturday and Sunday. Medical Assessment Unit opens 7/5/15	

7. Daily review of in-patients through morning ward or board rounds, led by a consultant / senior doctor, should take place 7 days a week so that hospital discharges at the weekend are at least 80% of the weekday rate and at least 35% of discharges are achieved by midday throughout the week. This will support patient flow throughout the week and prevent A&E performance deteriorating on Monday as a result of insufficient discharges over the weekend.	Yes	• System has agreed a target of 40% of discharges by 1pm • Consultant led ward rounds 7 days per week – this will be happening on MAU from 7th May, but there will not be standard full ward rounds 7 days per week on the other wards. There are Board rounds happening every day on each ward and these are being rolled out to all wards at weekends • Weekend plans identify patients to be discharged. Plans don't currently reflect the post take discharges. • Discharge planning team is now in place 7 days a week. Staff consultation is in process to amalgamate the discharge planning teams to provide a full 7 day service. • The Transfer of Care Team (PCC) have implemented 6 day working for Adult Social Care to support weekend discharges including support in the E.D. and MAU. Access to the reablement service is 7 days per week. However, consistently low numbers of referrals. including completion of assessment and support planning Social care assessments are available for some areas 6 days a week and not yet robustly, but not for all LA areas. • Care home contracts are being amended to reflect the need for patients to be accepted 7 days a week. PCC have commissioned an additional 185 reablement hours to support discharge planning and avoidable admissions • Ongoing Review of all community beds to look at effective working across 7 days • SRG has responsibility for the BCF 7 day work stream	

8. Many hospital beds are occupied by patients who could be safely cared for in other settings or could be discharged. SRGs will need to ensure that sufficient discharge management and alternative capacity such as discharge-to-assess models are in place to reduce the DTOC rate to 2.5%. This will form a stretch target beyond the 3.5% standard set in the planning guidance.	Partially	• Integration of discharge teams into one service. Discharge team now present in the trust 7 days a week • D2A beds and interim beds are in place for Borderline and Peterborough patients. Issue of capacity for other areas • Metrics are in place for assessment times • Medically fit patients are identified on a daily basis for discharge • Task and finish group established to deliver stretch target – focus on training, implementing best practice else where, alternative capacity for some areas with limited bed availability • System management in place to escalate DTOCS – Daily calls and when needed twice daily calls to expedite discharges. • 'Red/Green days' introduced 15/7/15 to manage action is taken for every patient every day. • South Lincolnshire CCG have also continued to commission the AIR's team who focus on DTOC's and ensuring that these are kept to a minimum for South Lincolnshire Patients. The team also assist the Trusts discharge with CHC assessments when required to ease the pressure of the urgent care system. This service currently operates Monday to Friday 8.30am until 4.30pm. The CCG have recently approved additional funding to expand the team from 2 whole time equivalent nurses to 3 whole time equivalent nurses and 25 hours of administration support to move to a proactive planning for discharge from point of admission model of care which will: improve patient experience, prevent DTOC's and improve capacity and flow throughout the Trust. • Lincs: increased community capacity in place, further review of community capacity (homecare and beds under way). Work underway on agreed LoS reduction in community beds and agreed admission criteria and discharge plan. • Additional capacity for step up/step down reablement flats commissioned from operational resilience from July 2015. • Online training module developed for Wards staff in the acute trust. • Capacity and pathway review of community services to be completed by end of August. • Red Cross service has been recommissioned from operational resilience fund to commence 1st September	Interim beds are funded through the Uniting Care contract. Discharge to assess beds - the SRG has committed £552k for beds in 2015/16. Further work to undertake a procurement exercise is planned to ensure value for money

3.2 Elective Care

The sections below are based on the '12 principles of good practice' for elective pathways building on the key target areas set out in 2014/15:

For Elective Care, our aim is to continually improve access to services for patients and their carers both directly through meeting the NHS constitution operating standards and through the re-design of pathways and services. We continually monitor measure and report on our performance against local and national targets to ensure that the services we commission on behalf of patients meet their needs based on Clinical Threshold (CT) policies.

Our plan for elective care also has several components which are described in this section.

3.2.2 RTT Staff Training Programme	There is an ongoing process for ensuring Trust staff are compliant with RTT policies. Additional resource has been put into Administrative teams.
3.2.3 Annual Analysis of Capacity and Demand	RTT capacity was part of a major review in 2014. As part of the review areas where further capacity was required were identified and delivered through central RTT funding. The 2015/16 contract planning round included analysis of waiting times and demand and sufficient capacity to deliver aggregate RTT activity has been built into the Indicative Activity Plan. .
3.2.4 Making Capacity Mapping business as usual	This is embedded into the annual, 2 year and 5 year planning processes.
3.2.5 Elective Pathways for common Referral / Treatment Plans	. The 2015/16 QIPP planning process has identified the following elective areas for development: Community ENT service – commenced 01/04/15 Ophthalmology triage Integrated MSK rheumatology and pain service across community and acute providers.
3.2.7 Review of Local Application of RTT Rules	Local Application of RTT rules will continue to be reviewed. The Trust will undertake a rolling validation process of all pathways.

3.2.8 Data Validation and Quality Improvement	We will continue to work closely with our analysts across the system to ensure the accuracy of the data that we supply and that it is used to support the commissioning of services within the urgent care system.
3.2.9 Performance Management Framework	We will performance manage our providers using the mechanisms we have in place via the contracting teams within the Cambridgeshire and Peterborough Clinical Commissioning Group. The NHS Standard Contract contains specific measures in relation to Elective Care. These are set out in Schedule 4. Quality Requirements part A. Operational Standards. A Contract Query and Remedial Action Plan is in place
3.2.10 KPIs well established	Trust set of metrics are in place.
3.2.11 Promoting good Practice in Referral Management	The LCG's have an electronic referral management system in place:- Pathfinder. This will be further enhanced by the move to a new system from January 2016
3.2.12 Promoting Choice of Provider	We continue to promote Choose and Book and other mechanisms that facilitate choice for the patient. Choose and Book is a CCG requirements.
3.2.13 Board Assurance on Implementation	Governance arrangements for the Peterborough Resilience Group are set out in the current Terms of Reference. The System Resilience Group is not a decision making body, but is responsible for making recommendations to the Cambridgeshire and Peterborough CCG Senior Management Team and to the CCG Governing Body for approval and final decision making. Members of the System Resilience Group will also report to their individual Boards within their respective bodies.

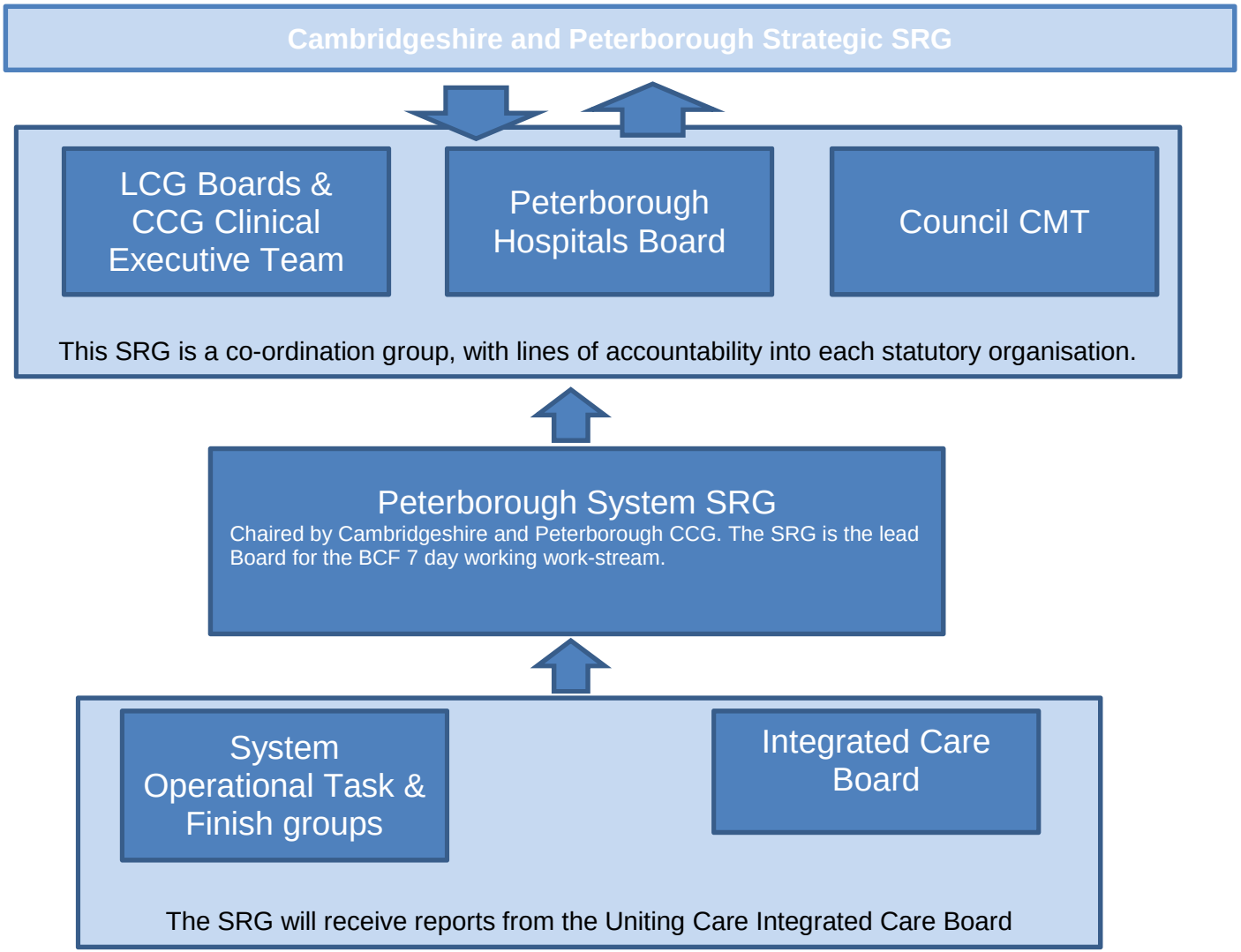
4. Governance and Risk Management

4.1 System Resilience Group Governance

The Peterborough System Resilience Group (SRG) is a multi-stakeholder group responsible for overseeing and driving the development of urgent and elective care services. There is a robust structure for the SRG to report into the CCG and system partners.

The Peterborough system structure is shown in the diagram below.
Each of local area SRG's may utilise elective and urgent care operational sub groups. The SRG's links into the UEC Vanguard, and LCG and CCG boards through to the CCG governing body

Peterborough SRG Governance:



4.2 Top Level Risks

Operational resilience risks are reported, reviewed, and actioned within the SRG as part of the continuous review of the system 10 point plan

We have identified several top level risks that are set out below.

Risk Register for "Top Level" Operational Resilience in Peterborough.

No	Risk	Mitigation	Risk Owner
1	Bed occupancy unable to be maintained between 90-93% due to surges of emergency activity.	Full implementation of 10 point plan, with 100% delivery supported by community and statutory partners; Roll out of System Resilience Operational Plan 2015/16; 75% uptake staff 'flu vaccinations	N.Dovert y
2	Recruitment and retention of staff, and ongoing reliance on agency/locums. System-wide developments, including 7 day services all pulling from same pools of staff	Adoption of good practice in nursing recruitment to medical staff recruitment; monthly Recruitment & Retention Strategy Group refocused to identify key new actions	I.Crich
3	Appetite for significant organisational change over short timeframe and impact on staff	Staff engagement and robust communications across whole system. Continue with system-wide workshops to maintain face to face comms	I.Crich/C . Mitchell
4	Shortage of step up and step down facilities leading to longer length of stay	Additional beds already purchased, but now focus needs to be on non-bed based models	S. Myers/ C.Hall
5	Ability to reduce DTOCS to 2.5% OBD and maintain lower levels throughout winter period	system management and escalation in place. Understanding capacity demands, and during service reconfiguration having alternative pathways in place	SRG
6	Demand during winter is greater than expected across winter 15/16	Daily and weekly review of trends. Resilience funding has been reserved to purchase additional capacity of required	SRG
7	Inadequate discharges and times of discharges will impact the ability of MAU to operate successfully.	Increase discharges using discharge lounge, and promotion of PDDs when medically fit to ensure adequate discharges during day. Improved weekend discharges	N. Doverty
8	Consultations for neighbourhood teams and integrated teams having a negative impact on staff - potential for increased sickness +/- losing staff to other organisations	Neighbourhood teams have been implemented and staff inducted into new roles. Overall staff are positive about changes	S. Myers

Appendices

Document title	Supporting File
Appendix 1 Peterborough 10 Point plan	
Appendix 1a Operational schemes for winter 2015	Winter plan summary templateFINAL 3010.
Appendix 2system management scorecards	SRG Weekly Scorecard 20151018. SRG Monthly Scorecard 20150309. System Resilience Group Weekend Plan SRG Daily Dashboard 20151027.xlsx
Appendix 3 Escalation policy – A CCG wide policy is being finalised and will supersede this policy shortly	escalation policy August 15.docx

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