



## How health and care services in Cambridgeshire and Peterborough are changing

## 1 Why do we need to change?

### Our health and care services face challenges

The population of Cambridgeshire and Peterborough is growing rapidly. People are generally living longer, so we have an aging population, and more people have long term conditions or 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, not always designed to meet people's individual needs, and do not always balance physical health with mental health and wellbeing
- overall, we spend too much of our time and resources treating illnesses which can be prevented or kept under control in better ways.

In Cambridgeshire and Peterborough we have a total budget of more than £1.7billion for NHS services, but we spend about £150million each year more than that. By 2021, this overspend is set to grow to about £250million if nothing changes.

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

### What you've told us so far

During 2015, we held listening events across Cambridgeshire and Peterborough 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 use Google and pharmacies)
- 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 (e.g. opening hours for services) across Cambridgeshire and Peterborough
- you want care as close to home as possible
- children's services need to be co-ordinated better (they are currently too fragmented)
- 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

The NHS and local government officers have come together to develop a major new plan to keep Cambridgeshire and Peterborough Fit for the Future. 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.

Local doctors and other clinicians are leading this work, supported by NHS England and NHS Improvement, the organisations that oversee our local NHS - ensuring that the views of patients and local people shape key decisions.

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 know that we need to develop improved communication and stronger working relationships across our organisations. We also need a shared culture that means we can learn and make improvements together. We are committed to delivering the healthcare you need - working together as one system with one budget.

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 developed a 10-point plan to deliver these priorities.

Fit for the Future programme	
<b>At home is best</b>	<ol style="list-style-type: none"> <li>1. People powered health and wellbeing</li> <li>2. Neighbourhood care hubs</li> </ol>
<b>Safe and effective hospital care, when needed</b>	<ol style="list-style-type: none"> <li>3. Responsive urgent and expert emergency care</li> <li>4. Systematic and standardised care</li> <li>5. Continued world-famous research and services</li> </ol>
<b>We're only sustainable together</b>	<ol style="list-style-type: none"> <li>6. Partnership working</li> </ol>
<b>Supported delivery</b>	<ol style="list-style-type: none"> <li>7. A culture of learning as a system</li> <li>8. Workforce: growing our own</li> <li>9. Using our land and buildings better</li> <li>10. Using technology to modernise health</li> </ol>

## Priority one – At home is best

### 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 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 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.

### 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 it is tailored to the needs of the individual, paying 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, for example during regular health checks and visits to urgent care services, 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.

## Patient story - future scenario

### 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.



## Priority two – Safe and effective hospital care, when needed

### 3 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.

This will be supported by better coordination, 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.

We have made a commitment that all urgent and emergency care services must meet the recently revised national standards.

We expect that 24/7 urgent care services will remain on our main three sites: Addenbrooke's Hospital, Hinchingbrooke Hospital, and Peterborough City Hospital.

### 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.

### 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.

We aim to make better use of research evidence – drawn from Cambridgeshire and Peterborough and beyond – to help us to use care and treatments systematically which are proven to be the most effective.

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, Hinchingbrooke Hospital, and Peterborough City Hospital.

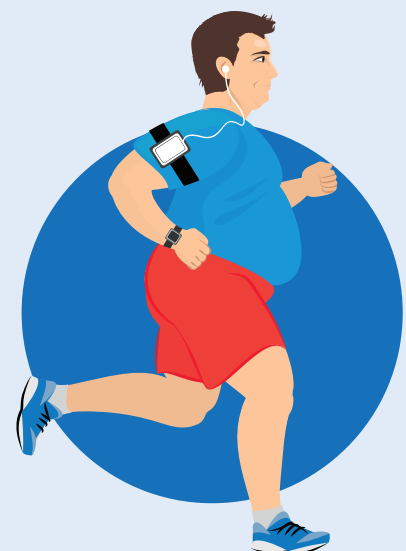
## Patient story - future scenario

### 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.



## Priority three – We're only sustainable together

### 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.

In addition, we aim to support our GPs to collaborate more, and work with them to develop sustainable services. 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 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.

## Patient stories – future scenarios

### 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 four – Supported delivery

### 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.

### 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 Hinchingsbrooke Health Campus.

### 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 – not just the organisation which employs them, or their own clinical or professional groups. This will help us where we have services that have staffing shortages.

### 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 hospital clinicians, GP practices, community teams, and social care to work together more effectively.

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

## Staff story – future scenario

### 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.



## Staff stories – future scenarios

### 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, and is managed jointly by Cambridgeshire and Peterborough NHS Foundation Trust and Peterborough and Stamford Hospitals NHS Foundation Trust.

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 in Cambridgeshire and Peterborough.

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 better outcomes for patients, and to develop his own professional skills.



### 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 it their ability to live independently. He helped to co-design the service as part of the Fit for the Future programme 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, 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.



### 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.





## 4 What these changes mean for our finances

We have thoroughly reviewed our finances, including making comparisons with national figures, looking for opportunities to secure savings and ways to organise services more efficiently. We continue to look at the demands on services and our costs.

So far, if we deliver all the changes we have described our plan turns the currently projected £250million financial gap in to a small NHS system surplus by 2020/21.

**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.**

## 5 How you can get involved

There will be more opportunities for patients, carers, and local people to be involved about 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 also need a shared understanding about how best to use your valuable health and care services, and your priorities.

When we make changes, we aim to involve patients as early as possible - working alongside clinicians to help design services, as well as giving feedback.

You will be able to have a say in key decisions, including formal consultation.

And we want to help you look after yourself and take control of your own health and care.

## Fit for the Future

Working together to keep people well

We will hold engagement events in the coming months and you can find the details on our website [www.fitforfuture.org.uk](http://www.fitforfuture.org.uk)

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](mailto:contact@fitforfuture.org.uk)

You can also register on our website [www.fitforfuture.org.uk](http://www.fitforfuture.org.uk)

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