CAMBRIDGESHIRE AND PETERBOROUGH
SUSTAINABILITY AND TRANSFORMATION PROGRAMME

Cambridgeshire and Peterborough Clinical Commissioning Group NHS
Cambridge University Hospitals NHS Foundation Trust NHS
Cambridgeshire and Peterborough NHS Foundation Trust NHS
Cambridgeshire Community Services NHS Trust NHS
Hinchingbrooke Health Care NHS Trust NHS
Papworth Hospital NHS Foundation Trust NHS
Peterborough and Stamford Hospitals NHS Foundation Trust NHS
PETERBOROUGH CITY COUNCIL
Cambridgeshire County Council

MEMORANDUM OF UNDERSTANDING

CAMBRIDGESHIRE & PETERBOROUGH HEALTH AND CARE SYSTEM

Version Control

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Final sign off will be secured in public by statutory bodies (NHS Trust or Foundation Trust Boards, Governing Bodies). This will become a public document

Memorandum of Understanding: Cambridgeshire & Peterborough Health and Care System – a Partnership for implementing the Sustainability & Transformation Plan

Date effective: 1 October 2016 Signatories 'The partners', the CEOs/Accountable Officers & Chairs of:

1. Cambridgeshire & Peterborough CCG
2. Cambridge University Hospitals Foundation Trust
3. Peterborough & Stamford Hospitals Foundation Trust
4. Cambridgeshire & Peterborough Foundation Trust
5. Cambridgeshire Community Services NHS Trust
6. Hinchingbrooke Hospitals NHS Trust
7. Papworth Foundation Trust
8. NHS England Specialised Commissioning – tbc
9. Peterborough City Council: (CEO & HWB Chair) – Annex 1 only
10. Cambridgeshire County Council (CEO & HWB Chair) – Annex 1 only

In future others may wish to join or become more formally affiliated with the partnership embodied in this MOU, including East of England Ambulance Trust, CUHP, GP Federations, practices or third sector organisations.

Introduction

Purpose: The local health economy within Cambridgeshire & Peterborough CCG has agreed a single Sustainability and Transformation Plan (STP) for 2016 – 2021, which has been approved by NHSE and NHSI. The STP has been developed with front-line staff and patients, building from an evidence for change that had widespread public and patient involvement. The plan envisages widespread changes to how care is delivered to local people, with far greater emphasis on care being delivered in or close to home, and standardisation of necessary in-hospital care in line with best and most efficient practice. In the small number of instances where changes to the location of services are proposed, there will be formal consultation with the public, following close informal engagement.

In order to deliver this plan and return the system to financial balance, we must manage risk (financial, operational, quality and reputational) through a number of jointly agreed commitments (outlined below) to which the Partners have agreed. The most important of which relate to a new set of behaviours from the System Partners, in order to build long-standing trusting relationships that replicate those of an accountable care system.

Scope: Each of the respective partner organisations have clearly defined accountabilities and responsibilities in line with statute. This MOU describes principles of behaviour and action which pertain to the implementation of the Sustainability and Transformation Plan. Therefore, this MOU pertains only to those areas of work which have been agreed, by each individual partner organisation, as System improvement areas. The MOU does not relate to individual partners decisions but to any possible interactions those may have with other partner organisations. Active engagement between Partners will be the norm, with individual major decisions raised to the HCE's attention, to check for impact on others.

How this document relates to local authorities, their executive officers and members is described further in Appendix 1

Longevity: The term of the MOU is linked to the anticipated time required to implement the STP, therefore it is expected to expire on 31st March 2021, unless a decision is taken to extend it beyond this. If, during the intervening period, as confidence builds, System decisions are delegated to the HCE, this MOU and the associated Terms of Reference for all relevant System groups will be amended (current versions are appended). While, at no stage, can the powers of the HCE supersede those of statutory bodies, this MOU nevertheless reflects the minimum level of partnership required to implement the STP.

Commitment 1: One ambition: the STP sets out a five plus year plan to return C&P to financial, clinical and operational sustainability by developing the beneficial behaviours of an accountable care system, and thereby addressing the underlying drivers of the current system deficit. This means acting as a single executive leadership team, and operating under an aligned set of incentives to coordinate System improvements for the benefits of local residents and healthcare users by:

- Supporting local people to take an active and full role in their own health
- Preventing health deterioration and promoting independence
- Using the best, evidence-based, means to deliver on outcomes that matter
- Focussing on what adds value (and stopping what doesn't)

Such organisational altruism is fully congruent with Partners' duties to the public and is necessary to return each organisation individually to financial balance.

The Partners accept collective responsibility for delivering the plan in its totality. Together, we own the opening risk and agree that the plan, whilst challenging, is deliverable. However, in practice, the Partners recognise external influences and pressures each is subject to. We commit to honest, transparent, and mutual support of each other's position in circumstances where we may be able to help others and influence the view of regulators or external assurance bodies regarding the primacy of System sustainability entailed in this plan and the joint commitment to it.

Our immediate priorities will be agreed collectively and reflect local Health & Wellbeing strategies, together with addressing clinical and operational pressures. However given resources are scarce, priority will be accorded to projects with the greatest expected return on investment and/or fixing what is most broken – for example high levels of non-elective beddays per capita and high proportions of beds being occupied by patients whose discharge is delayed. The highest impact projects will be properly resourced with the Partners' best people. We will not try to do too many things at once, even though there are many aspects of our health and care system which need improving.

Commitment 2: One set of behaviours:

The Partners recognise the scale of change implied by this MOU and the STP. The partners agree that cultural change applies from HCE and Board level to front-line staff. By signing this MOU, all Partners agree explicitly to exhibit the beneficial behaviours of an accountable care system. In particular, Partner organisations collectively agree to:

- People first: solutions that best meet the needs of today and tomorrow's local residents and healthcare users must be the guiding principle on which decisions are made. This principle must over-ride individual or organisational self-interest. Embedding the voice and views of service users in service improvement will be key to ensuring this principle is not forgotten.

- Collective decision-making: Chairs, CEOs, SROs and clinical leads have dedicated time *face-to-face* to build trusting relationships, improve mutual understanding and to take shared strategic decisions together. As system leaders, Partners will work together with integrity and the highest standards of professionalism, for example by:
    - Not undermining each other
    - Speaking well of and respecting each other
    - Behaving well, especially when things go wrong
    - Keeping our promises – small and large
    - Speaking with candour and courage
    - Delivering on promises made
    - Seeing success as collective
    - Sticking to decisions once made.

- Common messaging: there is a consistent set of messages we tell our patients and our staff about why we need to work together, what benefits it will bring and how we are doing it, although how the story is told will be tailored to the audience. Each partner organisation will take full responsibility for making sure their staff are well briefed on system improvement work, drawing from system messages and materials.
- Open book: finance (cost and spend), activity and staffing data are shared between all parties transparently and in a timely manner. This data is held independently by the System Delivery Unit. On a monthly basis actual financial positions of each organisation will be shared with the HCE (and bi-partite, as required), with explicit transparency about performance against expected cost saving and demand management trajectories. The purpose of this sharing is to support collaborative problem-solving.

Commitment 3: One long-run plan: The Partners are committed to implementation at pace. By end of 2018/19, the Partners will have achieved the following:

- *Home is best:* fully staffed integrated Neighbourhood Teams will be operational across C&P, providing a proactive and seamless service. General practices will have received support from Partners to be sustainable. Social care will be functionally integrated. The first phase of the prevention strategy will have been implemented.
- *Safe & Effective hospital care*: hospital flow will be improved, with a reduction in annual growth rates in non-elective admissions, a fall in bed occupancy and Delayed Transfers of Care. Common pathway designs will be in place across all 3 general acute sites for frailty, stroke, ophthalmology, orthopaedics, ENT and cardiology. All acute services (including fragile ones such as emergency medicine, acute paediatrics, stroke, and others) will be clinically sustainable 7 days a week. People will receive consistent urgent and emergency care in the right place, as quickly as possible. More routine urgent and planned care will be managed, with support, within community and primary care, for example by being able to access consultants' opinions without referral.
- *Sustainable together:* We will exploit our collective buying power to get reduced prices, through a common approach to Procurement. The west Pathology Hub will be operational. The merger of PSHFT-HHC (subject to FBC) will be fully embedded, and the start of consideration of other organisational consolidation will have commenced. Papworth will have successfully moved onto the Cambridge Biomedical Campus.
- *Enablers:* There will be single 10 year plan for estates and workforce, a five year plan for the digital roadmap, and a quality improvement (learning) culture. Local

community estates are being modernised. Our workforce recruitment, retention and reported staff satisfaction will be improved. The first new roles will be in the training pipeline. Patient records securely accessible by any clinician anywhere, where appropriate and relevant to patient care, and a person level linked data set will form the foundation for population health improvement analytics. Staff will have been trained in a common C&P improvement methodology and will have been involved in a system wide improvement project.

Taken together, the Partners believe that these actions give the system the best possible chance of returning to financial balance by 2021. However, capturing the savings opportunities identified will require certain assumptions to be true – for example achieving sustainable DTOC levels consistently below 2.5%. Addressing structural system deficits by securing additional system income by, for example, MFF recalculations and specific structural deficit funding (PFI support, CCG allocation increases, etc.) will also be key to system financial balance.

In many cases bringing about the changes envisaged by the STP can only be achieved with the support of local people and staff, including on occasion, through formal consultation. Therefore the exact shape of the solutions may change to reflect the feedback and views of local people and staff, the STP is a starting point not fixed destination.

Commitment 4: One programme of work: all System projects will be agreed by the HCE, and under the supervision of a CEO sponsored Delivery Group. HCE will agree what needs to be done to what end, by who, by when – be they projects done independently or as a System.

- The agreed Delivery Plan identifies the following work streams to be done as a System:
    i. Primary Care & Integrated Neighbourhoods: translating the proactive & preventative care schematic into operational practice, supporting sustainable general practice
    ii. Urgent & Emergency Care: achieving best practice non-elective bed-days per capita
    iii. Elective Care: standardising referral and treatment protocols in line with best practice
    iv. Women & Children: holistic, family-centred care, in line with iThrive, the maternity taskforce and peri-natal mental health
    v. Shared services (including estates): minimising the costs of over-heads
    vi. Digital: implementing the local Digital Roadmap, sharing data and information in a manner consistent with local and national policies and consent
    vii. Workforce & Culture: [leadership], [planning], [skills development], [recruitment & retention]
    viii. System Delivery: [system strategy], [system behaviour change / improvement culture], [supporting delivery to stay on track], [spread what works (locally & elsewhere)]
- The proposed split of work between System and organisational business will be agreed by the HCE, with new work not starting without HCE ratification.
- The proposed split of System work between what is undertaken once across Cambridgeshire & Peterborough, and what is undertaken on an area basis will be according to:
    - Phase of project life cycle: design projects must be done once across C&P
    - Locus of relationships: delivery projects should be local where vertical relationships dominate, and C&P wide where horizontal (across acutes) relationships dominate

    - Subsidiarity: change happens bottom up, and neighbourhoods across C&P differ significantly
- Each System project will have a CEO Sponsor and a named SRO (Exec level).
- Each System project will have a delivery objective – a savings, activity shift or quality improvement target (or a combination) and delivery date. Some System projects will have an agreed investment plan.
- The collective impact of System projects will be measured against an agreed definition of success (see Appendix II)

Commitment 5: One budget: in line with developing the positive behaviours of an accountable care system, and in recognition of the fact that one organisation's decisions about the level of service may impact another's costs, the Partners agree they will collectively focus on activities that take cost out, make agreed investments in order to save elsewhere, and move deficits to where they should most appropriately fall. System costs may be reduced by activity reductions and by unit cost reductions, and we recognise that all System Partners can influence both. Acting in this way requires:

- Financial incentive design: two year contracts for 2017/18 and 18/19 contracts will neutralise perverse financial incentives and aim to return the C&P System to financial balance. The Partners agree that the key aim of any incentives will be to focus on addressing the drivers of the system deficit. Financial incentive design options ***may***, therefore, include a combination of:
    - the inclusion of multilateral loss / gain sharing arrangements, for some aspects of C&P CCG commissioned activity;
    - a single System control total which has been negotiated with regulators;
    - alignment of all quality based payments to delivering System priorities (including CQUINs and following agreement with primary care, changes to local enhanced services and/or a local substitute for the QOF);
    - a suspension of non-value adding adjustments to basic cost & volume arrangements such as fines, marginal rates and 30 day readmissions rule (noting that some of these funds currently cover the costs of some community services, which would need alternative funding to be agreed if the services are to continue);
    - a cost plus based approach to local prices for service developments (eg ambulatory care)

  Within this framework and in recognition of the importance of gathering timely and accurate cost data, providers will be paid for the activity they under-take, against an agreed activity trajectory, and commissioners will be responsible for taking decisions about what services can be provided affordably, in line with their legal duties. Due to the lack of incentive to do more activity, even where this would be desirable as it would reduce overall system costs, block contracts should be avoided for all services.
- For the remainder of 2016/17, parties will exhibit win-win-win behaviours (for patients, providers and commissioners) – the financial recovery plan is a *System* financial recovery plan.
- Contract mechanics for 2017/18 and 18/19: the least required effort will be dedicated to contract negotiations, with early collective CEO engagement to agree key investment priorities and risk sharing parameters at the outset (rather than at the end). Contract management meetings will be replaced with place or care programme based financial assurance, performance and planning meetings.

- Commissioning intentions will be based on a clinically led, evidence-based and person-focussed appraisal of how best to meet local people's need. Once developed, Partners will discuss openly within HCE any new service developments, closures or relocations prior to public and staff engagement and consultation as required. The HCE and the System Delivery Groups will be the fora for agreeing commissioning intentions, including those of the Joint Commissioning Unit.
- Financial and operational plans will be aligned across health and social care: the Partners agree to plan finances and operational capacity together, neutralising any inclination to cost shift or not invest in one part of the system to save elsewhere. This will involve working from common assumptions, producing plans for regulators that are not works of fiction and doing our best to ensure there are no in-year surprises. Where appropriate, this will also include greater use of pooled budgets between NHS and council commissioners, which will be determined on a case by case basis.
- Savings: Savings will be calculated on the basis of resource utilisation across the entire patient pathway, including all points of care and Partner organisations – thereby capturing direct and indirect savings. Delivery Groups will track savings against pre-determined trajectories in a robust and timely manner, with the Programme Director's guidance and SDU support. A named AO Sponsor for each project is responsible for making sure savings trajectories are met and / or securing recovery proposals where implementation is not on track.
- Investment: an agreed 'pot' for System wide investments will be agreed up front. In 2017/18 it is likely that this will require a System bid to NHS England, due to cash constraints. Decisions on how to spend this System wide investment and re-investment pot will be taken collectively. Analysis will be under-taken first to ensure existing resources cannot be safely redeployed /or productively improved before investment can be made. The investment pot will come from any STF funds, recycled savings and the CCGs 1% hold-back. Before funding is agreed, everyone will be completely clear on recurrent vs non-recurrent investment requirements.

Commitment 6: One set of governance arrangements: the HCE and the groups reporting to it (Area Executive Boards, the Care Advisory Group (and strategic sub-committees), the FD Forum and the eight Delivery Groups), will be the vehicle through which System business is conducted. All existing arrangements will either be dissolved (eg SRGs) or aligned. The Area Executive Boards will offer the two Health & Wellbeing Boards a delivery vehicle for local health and well-being strategies.

As much business as possible that pertains to the system will be conducted via the system governance described in Appendices 3-7. However it is recognised and accepted that some decisions will need to be referred back to Partners' Boards / Governing Bodies for ratification. Given this may add time before implementation can commence, the limits to the HCE's powers must be anticipated, and accommodated in planning.

Commitment 7: One delivery team: resources are in place to deliver the STP. This means:

- System Delivery Unit: A new SDU led by an Independent Chair and Programme Director will be created from October 2016. The Independent Chair and Programme Director will be invited to attend Partners' Boards regularly to provide updates on the STP. The SDU will have a budget agreed by HCE to employ staff, funded jointly by NHS Partners (see Appendix). The SDU will be responsible for:
    - Finance, Evaluation & Analytics

- System Strategy, Planning and Development

The System Delivery Unit is primarily envisaged as adding much needed analytics, project management, quality improvement and problem solving capacity to the system. However, it will be responsible for giving assurance to the HCE that the STP plan and its future modifications is being appropriately delivered, on budget and to planned timelines.

- Alignment of resources: We recognise the scale of change required to deliver the STP, and all Partners commit to align our staff and, by prior HCE agreement, funds to deliver these changes. This may include prioritising the availability of staff for STP planning and implementation, the voluntary secondment/loan of staff and other such pragmatic arrangements – in recognition that delivering the STP is essential to each organisation's individual sustainability strategy. Through the delivery planning process, each prioritised project will be allocated staff, from across Partners. These, 'aligned' staff will be expected to dedicate the bulk of their time to the system work – with up front negotiations about what may need to be stopped as a result. SROs and if necessary CEO sponsors will be expected to escalate to the employer if they feel staff are not being released as agreed. The employing Partner will be expected to rectify the situation within [2 weeks]. The SDU will make transparent the relevant wte contributions (clinical and managerial) from each Partner organisation, to ensure the burden of effort is fairly shared.
- Assets: in addition to Partners' employees we agree there are other assets which can help deliver the STP, including local communities and Health and Wellbeing Boards. Partners will explore how existing relationships with the Universities, Charitable trusts, local business, informal carers and other public services (like the Fire Service) can be exploited for the benefit of the System. All Partners will highlight opportunities for leveraging these assets for the benefit of the System and will represent the System's interests as well as their own.
- Skills development: where our staff don't have the required skills and expertise to deliver the scale and nature of the change required, we will recognise and address this. It's important that our people are in the right roles.

Commitment 8: One assurance and risk management framework.

- Crucial to strengthening trust and creating a sense of shared accountability, will be evolving the HCE from a forum for making strategic decisions, to one where Partners can be assured of the delivery of System wide improvements. The System Delivery Unit is responsible for monitoring implementation of the STP plan and giving such assurance to the HCE about delivery of the plan. The SDU will provide timely, and regular reporting to the Delivery Groups, Area Executive Boards, the CAG, the FD Forum and the HCE to give mutual assurance that the Delivery plan is on track. A small number of new monitoring dashboards will be developed by the SDU for this purpose, subject to the agreement of the HCE and/or relevant CEO sponsor. In exceptional circumstances new data items may be collected, but the default presumption is that existing data items will be used (even if these are not normally shared beyond organisations). Once the data collection is agreed, accurate data will be supplied on time.
- Inevitably, things will not go as planned, and there are already many risks that planned impacts will not be realised. Some of these risks will be best managed individually, but many can only be effectively managed by the Partners together. The Partners therefore agree that mitigations will be more effective if they are done together. Transparency around risk / risk mitigation is non-negotiable. Whilst it is difficult to specify in advance the actions that may be required to address risks to delivering the STP, we agree about the process:

    - A HCE Risk Register maintains emerging risks to both the agreed delivery plan and agreed mitigations;
    - System Delivery Groups, Area Executive Boards, the CAG and the FD Forum may raise with the Programme Director an emerging risk and a written Requirement for Risk Mitigation by the HCE. This requirement will reflect a perceived risk that the Sponsor CEO considers he/she are unable to mitigate within the Group.
    - Project SROs are expected to deliver all actions to the pre-agreed time-table of milestones – repeated risks and issues regarding process delays due to poor project management and oversight, which are within the control of the SRO will be escalated by the Programme Director to the employing CEO.
- For the purposes of this agreement, risk is not narrowly defined; examples include reputational, clinical, governance, performance against targets and financial risks.
- Select risks will be reviewed by Boards each month, as determined by the Programme Director and Independent Chair.

Annexes

I. Local Authorities and the C&P Sustainability & Transformation Plan.
II. Delivery plan October 2016 – March 2019
III. STP Measures (One year health check, Quarterly performance tracking)
IV. ToR for HCE, including
    a. Delegation of decision-making – for example relating to contract design, (dis) investments, STP implementation risks & mitigations, activity assumptions, service developments/ reductions/ significant changes
    b. Relationship to Partners' Boards – including which decisions rest with Boards, which must have Board support pre-HCE agreement and which Boards can be informed about after the event
    c. How decisions are made – for example, voting, whether decisions are binding, limits of deputies, withholding of consent, etc
    d. Stakeholder engagement approach
    e. Bipartite reporting
V. ToR for Delivery Groups, including:
    a. Chairing: a CEO
    b. Membership: a clinical lead, an FD, an HRD + SROs
    c. Meeting frequency
    d. Escalation either to PD, another CEO or the HCE
VI. ToR for Area Executive Boards, which will also encompass the national responsibilities for A&E Delivery, for:
    a. Greater Cambridge & Ely (Papworth to be included)
    b. Huntington & Fens (Papworth to be included)
    c. Greater Peterborough
VII. ToR for Care Advisory Group, and Strategic sub-committees for:
    a. Frailty/ Ageing / BCF
    b. Mental Health
    c. Sustainable General Practice
VIII. ToR for Financial Performance & Planning Group (formerly the FD Forum)
IX. SDU Financing: Funding split (%); Initial budget for the SDU; legally binding arrangements for sharing SDU costs (expected and unexpected)