HEALTH SCRUTINY COMMITTEE	AGENDA ITEM No. 6
6 NOVEMBER 2017	PUBLIC REPORT

Report of:	Cambridgeshire & Peterborough Sustainability and Transformation Partnership (STP)	
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CAMBRIDGESHIRE & PETERBOROUGH SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP (STP) UPDATE REPORT

R E C O M M E N D A T I O N S
It is recommended that the Health Scrutiny Committee note this update report.

1. PURPOSE AND REASON FOR REPORT

1.1 This report has been prepared at the request of the Health Scrutiny Committee in order to provide an update on STP implementation progress.

1.2 This report is for the Health Scrutiny Committee to consider under its Terms of Reference Part 3, Section 4 - Overview and Scrutiny Functions, paragraph No. 2.1 Functions determined by Council - Public Health and Scrutiny of the NHS and NHS providers.

2. BACKGROUND

2.1 The Cambridgeshire and Peterborough health system faces significant challenges due to:

- the health and care needs of our rapidly growing, increasingly elderly population;
- significant health inequalities, including the health and wellbeing challenges of diverse ethnic communities;
- workforce shortages including recruitment and retention in general practice;
- quality shortcomings and inconsistent operational performance; and
- financial challenges which exceed those of any other STP area in England.

2.2 In order to address these challenges, the NHS (including general practice) and local government came together in 2016 to develop a five-year Sustainability and Transformation Plan (STP) to improve the health and care of our local population and bring the system back into financial balance. The STP seeks to do the following:

- **deliver a shift from reactive to proactive care**, with a holistic approach to care planning, coordination, and delivery that empowers people to take as much control of their care as possible. This approach aims to manage the growth in demand for services through better prevention, self-management, re-enablement and intensive management of rising risk and high risk people;
- **deliver care pathway changes**, standardised care and reduced variation to maximise quality and minimise unit costs through, for example, improved clinical networks, reduced Length of Stay in hospital and staff skill mix;
- deliver **knowledge sharing**, breaking down organisational and setting boundaries;
- **close the under-funding gap** as quickly as possible and maximising income growth;

- **reduce overheads** within and across the health and care system by, for example, managing our Estate more effectively, maximising joint procurement across health and other public sector organisations, and integrating organisations and functions; and
- **use technology** to improve modes of interaction/intervention.

2.3 Health and local government partners agreed a unifying ambition for health and care in Cambridgeshire and Peterborough. This is to develop the beneficial behaviours of an 'Accountable Care System' by acting as one system, jointly accountable for improving our population's health and wellbeing, outcomes, and experience, within a defined financial envelope.

2.4 Through discussion with NHS staff, patients, carers, and partners, we articulated four priorities for change and we have also developed a 10-point plan to deliver these priorities, as set out below.

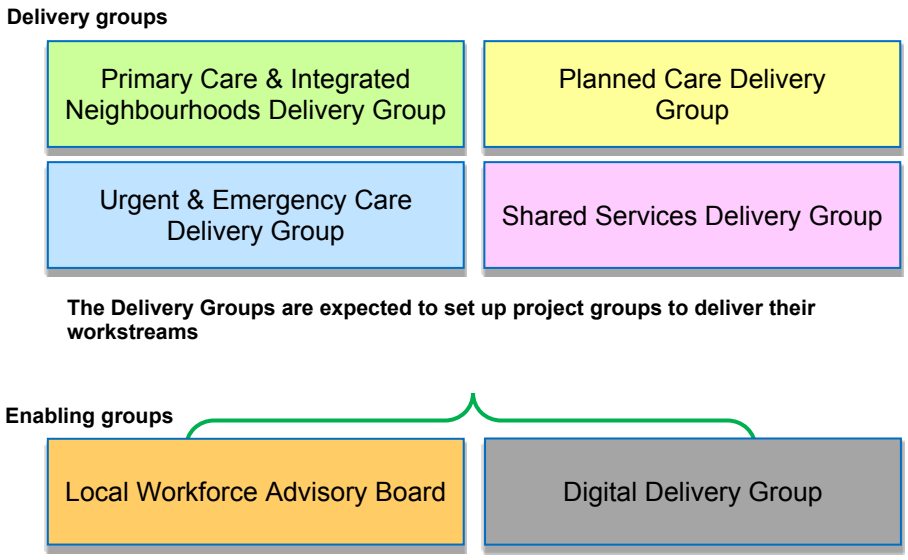
Priorities for change	10-point plan
At home is best	1. People powered health and wellbeing 2. Neighbourhood care hubs
Safe and effective hospital care, when needed	3. Responsive urgent and expert emergency care 4. Systematic and standardised care 5. Continued world-famous research and services
We're only sustainable together	6. Partnership working
Supported delivery	7. A culture of learning as a system 8. Workforce: growing our own 9. Using our land and buildings better 10. Using technology to modernise health

3. STP PROGRAMME ARRANGEMENTS

3.1 In early 2017, we moved from the planning phase to the delivery phase of the STP. We put in place Fit for the Future (STP) programme arrangements, with a delivery governance structure to ensure effective implementation and this is illustrated at Annex 1.

3.2 The Committee is asked to note that the Programmes governance arrangements have undergone a recent review to ensure that they continue to be fit for purpose and a number of proposed changes are subject to agreement and implementation.

3.3 The programme has, at its core, six Delivery Groups, each one responsible to Accountable Officers who are Chief Executive Officers from across the health and social care system, as set out below.



3.4 The Delivery Groups cover clinical services, workforce and support services and are designed to encourage system-wide working and to allow for person-led care to be at the forefront of everything we do. Membership includes clinicians from organisations across the system as well as patient and public representation.

3.5 Improvement Project Groups have been established within each Delivery Group to take forward specific aspects of work and, again, these groups include clinical membership and patient and public representation.

3.6 **It is important to bear in mind that STP delivery will take place over several years and we are seeking to ensure a good balance of pace that will deliver real changes for people as quickly as possible but without overwhelming the health and care system's ability to process the changes.**

4. STP DELIVERY IN 2017/18

4.1 In Cambridgeshire & Peterborough, there are too many people ending up in hospital unnecessarily and/or spending too long in hospital unnecessarily. We have, therefore, focused much of our attention in 2017/18 on addressing this issue by creating more community based services and capacity to care for people in more appropriate settings. This work is being driven mainly through the Urgent & Emergency Care Delivery Group and the Primary Care & Integrated Neighbourhoods Delivery Group.

4.2 Urgent and Emergency Care

This Delivery Group is seeking to manage demand for urgent and emergency care services which have seen significant increases over recent years resulting in clinical and financial challenges for the system. The increase in demand in Cambridgeshire & Peterborough is driven mainly by population growth and, in particular, by growth in the older frail population, as well as a lack of community based services to support vulnerable people.

The key interventions this year are:

4.2.1 **Extending our Joint Emergency Team (JET)**:
This team intervenes to support vulnerable patients in their homes and/or the community and we are expanding and enhancing this service to enable it to care for more patients. We have invested £2m to expand this service with more than 70 additional staff and, as of the end of September, almost 50 job offers have been made with approximately 20 new staff in post.

Early outcomes are encouraging and include, as at the end of September:

- 169 referrals in the last week of September against an average of 148 referrals per week in the year to date;
- 80% of referrals result in a first contact with patient, based on the same time period data;
- % utilisation of JET capacity weekdays is 71% versus 57% reported at the end of July
- % utilisation of JET capacity weekends is 63% versus 28% reported at the end of July.
- % of referrals resolved without an Acute Hospital transfer = 89%.
- % first contact within 2 hours of referral date/time = 65%

4.2.2 **Stroke Early Supported Discharge (ESD):**
We are investing £0.7m to establish a service which will provide both intensive stroke discharge support and home based neuro rehabilitation. The operational model will result in therapy staff rotating between hospitals, the community based neuro rehabilitation teams and the stroke ESD team. This will result in an enhanced and multidisciplinary team with better joint working and communication across the patient pathway. We are currently recruiting to 35 additional posts to provide this service.

4.2.3 **Discharge to Assess**

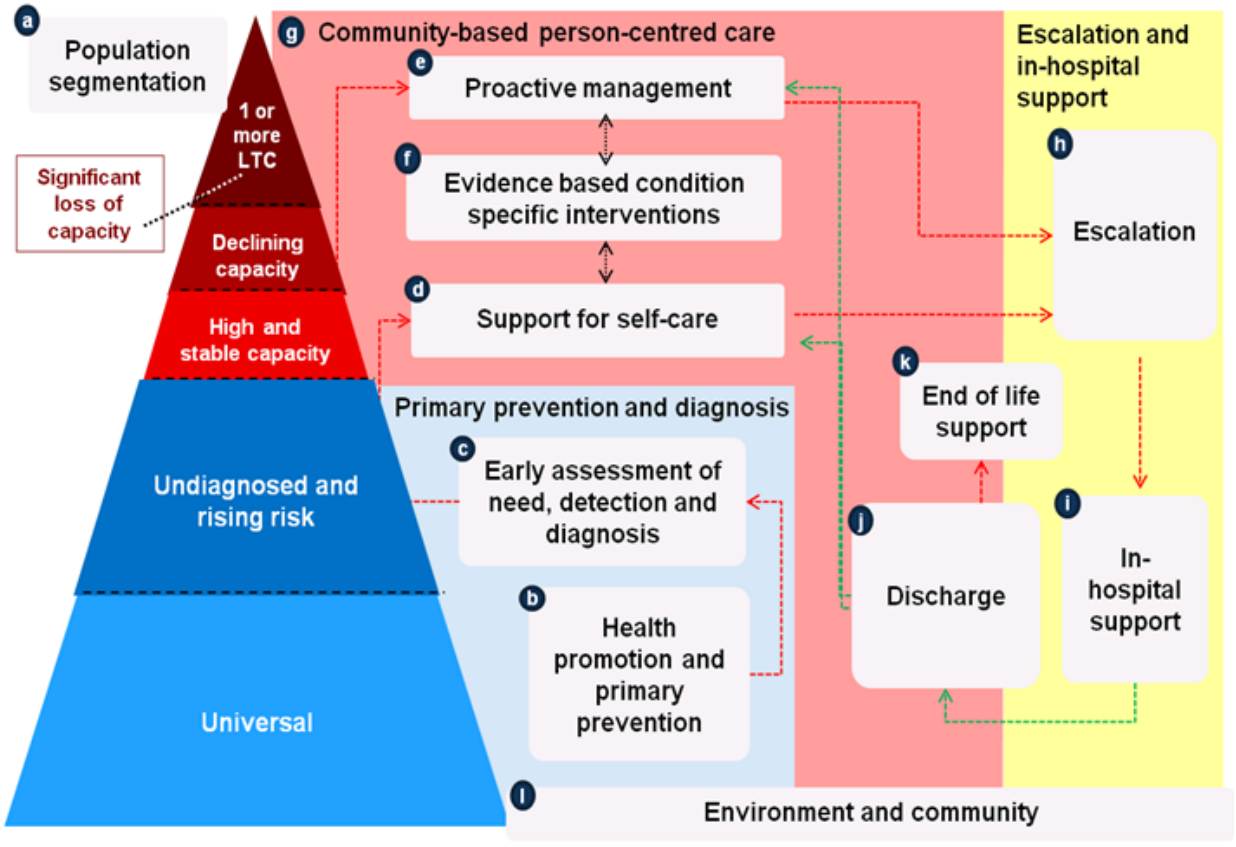
This service focusses on people in hospital who are at a point where care and assessment can safely be continued in a non-hospital setting and they do not require an acute hospital bed, but may still require care services. The principal is to provide short term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person. This approach can be otherwise known as, 'home first', 'safely home', 'step down'. This does not detract in any way from the need for agreed multi professional assessment or from the requirement to ensure safe discharge and it may work alongside time for recuperation and recovery, on-going rehabilitation or reablement.

We are investing over £6m in 2017/18 to recruit 155 additional posts (mainly Integrated Care Workers).

Again, early outcomes are encouraging and, in the first week of September, we have supported 25% more patients to be successfully discharged across the system than normal weekly average, leading to a reduction in delayed transfer of care numbers at both North West Anglia Foundation Trust and Cambridge University Hospitals Foundation Trust. Many of these patients have very complex needs and had been awaiting discharge from hospital for over 20 days. By working across our system, these patients are now being supported in the community.

4.3 Primary Care and Integrated Neighbourhoods

4.3.1 The purpose of this Delivery Group is to implement integrated health and care neighbourhood teams providing proactive care stratified by different levels of need, as determined by peoples medical and psychosocial conditions, and as illustrated in the diagram below. We have brought together previously disparate work on healthy ageing, long-term conditions management, and mental health for the first time in this delivery programme.



4.3.2 Key 2017/18 Interventions:

- More specialist support for people with long term conditions such as **diabetes, lung problems and heart disease.**
- **Extra help for people who are at risk of falls** by strengthening existing services. This will mean more staff in the community to help to prevent falls and help people recover if they do get injured.
- More case managers to identify patients who need the most **support to remain at home** and to ensure they get the help they need (this will be piloted in four neighbourhoods in the first instance and then expanded to other areas on the basis of the evidence from these pilots).
- Improving the **prevention of stroke** by identifying more patients with atrial fibrillation, a heart problem which is a significant risk factor, by giving them medication that will help earlier
- More support for **people with dementia** at all stages of the disease.

4.3.3 Key Achievements in 2017/18 to date

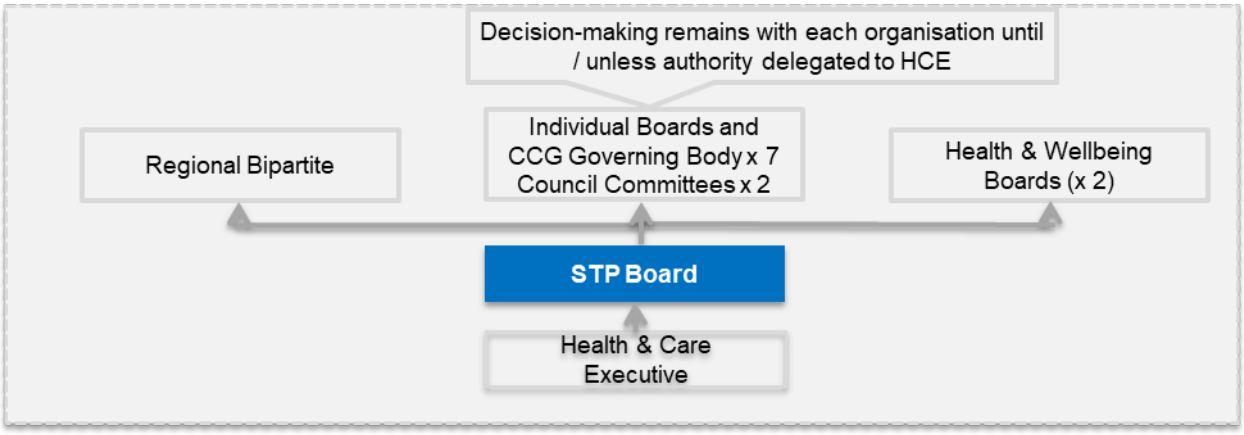
- £1m invested in respiratory, stroke prevention and falls prevention services
- £1.9m Diabetes funding awarded from national bid

5. REVIEW OF STP GOVERNANCE AND LEADERSHIP

5.1 Establishing an STP Board

We have established an STP Board in order to improve accountability to partner organisations as well as to ensure better ownership of collective decisions as we move towards an accountable care system approach. Membership of the STP Board is currently as follows:

- Chair: Independent Chair
- Clinical Chair and Accountable Officer of the CCG
- Chairs and Chief Executives of all partner NHS organisations
- Local Authority Representation
- STP Executive Programme Director
- STP Care Advisory Group Chair



A process is underway to appoint an Independent Chair. The post holder is expected to be in post by the November meeting.

Key documentation, including the ToRs and the STP Governance Framework, is being revised to clarify the respective responsibilities of the STP Board and the HCE (see diagram above). Broadly, the HCE will be operationally focused while the STP Board will be responsible for setting medium and long term STP strategy; as follows:

Area	STP Board
Strategic decision making	• Responsible for **medium and long term STP strategy**, including ensuring the system has in place a process for working towards **Accountable Care**
Operational delivery	• **Holds to account HCE** for delivery of the STP, ensuring accountability and reporting arrangements are in place
Governance	• Ensures adherence to collective **governance** arrangements
Risk management	• Reviews/ addresses **strategic programme risks**
Engagement	• Ensures there is a process in place to understand how the system manages the expectations of **service users and the general public and members of the STP Stakeholder Group**
Accountability	• Receives brief update from the HCE regarding STP delivery. Chair attends Bipartite meetings.

5.2 STP Executive Leadership

Tracy Dowling, the current Accountable Officer for the STP, will continue in the role for the medium term. Catherine Pollard has been appointed as Executive Programme Director and has replaced Scott Haldane who has resumed his full-time responsibilities as Finance Director at CPFT

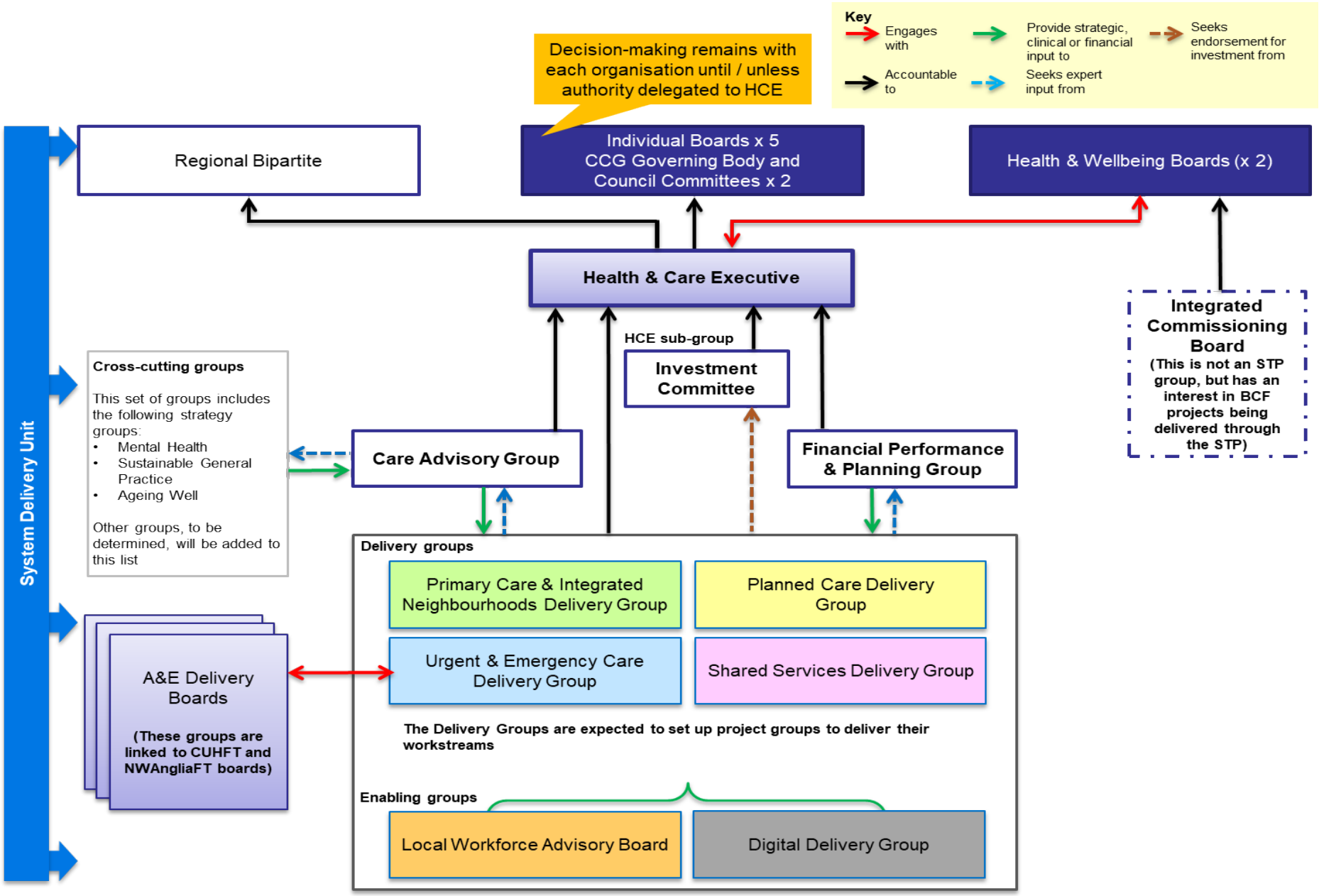
6. KEY STP RISKS

6.1 We have included, at Annex 2, the key strategic risks to the effective delivery of the STP, as well as a summary of the interventions and mitigations to these risks.

7. APPENDICES

7.1 Annex 1 - Fit for the Future Delivery Governance Structure
Annex 2 - STP Strategic Risks

ANNEX 1: *Fit for the Future* Delivery Governance Structure



ANNEX 2: ***STP Strategic Risks (page 1 of 2)***

Ref No.	Risks/Issue Description	Risk Score	Mitigating/resolution/ Actions	Post Risk Score
R-06	There is a risk that deterioration of our core financial position may lead to failure to access additional monies such as sustainability funds.	**20**	CCG Financial turnaround plan aligned to STP delivery plan. CUHFT and NWAngliaFT financial recovery plans and operational Plan assumptions aligned to STP. Delivery of QIPP and CIP.	**16**
R-08	There is a risk that, if we do not effectively engage with patients, members of the public and other stakeholders, STP implementation may be compromised due to lack of support.	**20**	Communication & Engagement Strategy in place and to be routinely refreshed. Training & guidance in how to effectively engagement with stakeholders provided to all STP staff and clinicians. Active patient involvement in STP Delivery Groups and Improvement Areas. Routine stakeholder communication via, for example, STP Website, newsletter, social media and proposed Stakeholder Group.	**12**
R-15	There is a risk that Clinicians will not engage with STP implementation if they believe that clinical conclusions and agreed care models will not be implemented.	**20**	Clinical Engagement Strategy that 1) establishes Strategic Clinical Networks to lead clinical planning and proposed care models in areas such as Cardiovascular and Stroke 2) ensures clinical leaders are in place for every significant implementation area 3) puts in place Evaluation Task & Finish Groups and 4) strengthens, in collaboration with communication colleagues, engagement with specific clinical groups e.g. GPs.	**12**
R-16	There is a risk that proposed solutions are not supported by MPs, councillors and other elected representatives.	**25**	Engagement with councillors via Health Committee, Health & Wellbeing Board and processes, specific meetings and fora to ensure two-way dialogue that informs elected representatives of the case for change and ensures that there is an opportunity for councillors to influence solutions. Routine meetings with MPs, individually and collectively, to brief on issues.	**20**
R-17	There is risk that Primary Care as providers are not engaged or included in system wide leadership conversations.	**25**	Sustainable General Practice strategy group to provide assurance over implementation of GP Forward View. CCG investment in GP time to support GPs to be involved in redesign work. Communications Cell to devise system-wide GP engagement strategy.	**20**
R-20	There is a risk the system will not have the ability to capture sufficient savings opportunities in 2017/18 due to the lack of dedicated delivery resources.	**16**	Prioritise where to focus effort and response for 2017/18. CCG have realigned staff to priority projects. Focussed oversight of delivery by SDU.	**12**
R-25	There is a risk that negotiations with national bodies (Department of Health, Treasury) are un-coordinated among system partners, reducing negotiating leverage and likelihood of getting desired changes (e.g. to Market Forces Factor, for estates / infrastructure investment)	**20**	Application of MOU behaviours regarding sharing intelligence about strategic intent, via updates to HCE and/or FPPG. CEO commitment to speaking as a system, with one voice when negotiating with national bodies. HCE & CPSB meeting quarterly with shared agenda priorities agreed.	**16**

ANNEX 2: *STP Strategic Risks (page 2 of 2)*

Ref No.	Risks/Issue Description	Risk Score	Mitigating/resolution/ Actions	Post Risk Score
R-26	There is a risk that ineffective STP Governance may lead to failure to deliver on agreed actions.	**20**	Revision of Governance Framework underway and seeks to strengthen accountability and decision making.	**16**
R-27	There is a risk of delivery of STP wide projects due to capacity of teams and SROs alongside business as usual pressures.	**20**	Accountable Officer to actively monitor delivery of STP objectives, seek to resolve any delivery issues and escalate unresolved issues to HCE.	**12**
R-29	There is a risk that competing pressures placed on the CCG and Providers from National Bodies to deliver short term turnaround could be at the detriment of longer turn sustainability and deliverability of the STP.	**20**	HCE to monitor delivery of programme and to raise concerns honestly and openly in the HCE meetings in the first instance and escalate any unresolved issues to Bi-partite meeting with NHS England and NHS Improvement.	**12**
R-30	There is a risk that the system will be unable to secure external funding required to support delivery and this will result in the programme failing to achieve its objectives.	**25**	Deploy appropriate resource to ensure bids for national monies are completed to a high standard to maximise opportunity to be awarded funds. Utilise the virtual task and finish group to support the process. Seek other funding sources. If funding is not granted reassess STP objectives and identify other opportunities to deliver savings and objectives. Engaging with local MPs.	**20**
R-31	There is a risk that if a number of business cases all rely on recruiting new staff it may be difficult to recruit to all positions and if they are recruited from within the system this may cause problems for existing services	**25**	Delivery Groups to work closely with their Workforce lead to develop an appropriate recruitment strategy. Workforce leads to liaise to maintain an overview of Workforce requirements to ensure the needs of all business cases do not conflict and to ensure that the impact of large scale recruitment may have on other parts of the system is understood.	**20**
R-32	There is a risk that current transformation staff within all organisations aren't fully aligned to the STP and could result in the programme failing to achieve its objectives.	**25**	Accountable Officers to actively monitor delivery of STP objectives, seek to resolve and any unresolved issues to be escalated to HCE. Review engagement and communication strategy within organisations to ensure understanding and awareness of the STP.	**20**
R-33	The is a risk that as a consequence of being drawn into the Capped Expenditure Process (CEP) the system will be required to focus on short term actions and/or restrict the systems ability to focus on delivery of the STP programme of work.	**20**	Accountable Officers to continue to engage national bodies to understand and, where possible, influence the CEP.	**12**

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