Planning Landscape for the Financial Year 2016/17

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1. CONTEXT

1.1 This document sets out for discussion the planning landscape for the financial year 2016/17. Unlike in previous years which saw the publication of Commissioning Intentions to providers, we are adopting a different approach which emphasises joint working within the Cambridgeshire and Peterborough System (referred to as 'the System') and which sets the operational priorities for next year within the context of the strategic direction for the System. This document will therefore be used to represent commissioning intentions, should requests to see 'commissioning intentions' be received by NHS Cambridgeshire and Peterborough Clinical Commissioning Group.

1.2 The development of a strategic direction for Cambridgeshire and Peterborough is being taken forward through the System Transformation Programme. The ultimate goal is to achieve our vision of *One System, One Plan, One Budget,* which will take some years to realise.

1.3 As a health and social care system in Cambridgeshire and Peterborough, we will operate in an integrated way, putting patients' best interests at the heart of all decision-making to achieve the best care outcomes for patients, their carers and the population. By working together in an open and transparent way, we, as commissioners and providers of care, aim to maximise the wellbeing of the population and provide the safest, highest quality care outcomes for patients in our system. We aspire to commission and provide the safest, highest quality care and best patient experience within the resources available. We will seek to maximise the amount of care provided outside hospital as close to the patient's home as possible.

1.4 Effective joint working will be vital and we are committed to working with our Health and Wellbeing Boards through the Joint Health and Wellbeing Strategies, NHS England, service providers, patients and the public to ensure that our plans reflect within the resources available, known health need and comply with prevailing health policy and priorities.

1.5 Through the work of the System Transformation Programme, we have identified several reasons why the Cambridgeshire and Peterborough Health System must change now and in the longer term:

- If we do not change our health system substantially then we face a deficit of at least £250 million by 2018/19, making it harder to deliver good quality care
- At the moment our hospitals have significant deficits
- Demand for health services continues to increase
- Primary care is not sustainable in its current form
- We have a mismatch between capacity and demand, affecting all parts of the system and especially our hospitals
- There are gaps in some parts of the workforce across the Cambridgeshire and Peterborough health system
- We have service gaps in mental health and services for children

1.6 NHS Cambridgeshire and Peterborough CCG (the CCG) will retain overall responsibility for the 2016/17 operational planning process assisted by the System Transformation Board who will progress the development of the operational plan within the following timeframe:

1.7 For reference, the strategic framework and a detailed fact base have been encapsulated into a System Change Document: which can be found on: http://www.cambridgeshireandpeterboroughccg.nhs.uk/five-year-plan.htm

2. OVERVIEW OF THE PLANNING LANDSCAPE FOR 2016/17

2.1. During the past year in particular, we have seen several significant trends emerge as a result of national policy and due to the strategic development work undertaken in the Cambridgeshire and Peterborough System. These trends include:

- Increasing integration of services and partnership working across a wide range of organisations through 'vehicles' such as the Better Care Fund and the work of UnitingCare in relation to older people
- Emerging views that the grouping of services at scale would provide a sustainable service infrastructure which could better support the demands being placed upon it now and in the future
- Through the Vanguard Programme[1], an impetus to explore 'on the ground' a variety of innovative and radical service models.

2.2 As a first step to making the necessary strategic changes to the System, we will take forward in 2016/17 two transformational initiatives:

a) Developing plans to enable hospitals to work more closely together with increased sharing of medical expertise across sites through the establishment of accountable clinical networks

b) Radically transforming Urgent and Emergency Care through the creation of an overarching and strongly clinically led strategic System Resilience Group[2], whose aim is to accelerate the pace of improvement which the three System Resilience Groups have started to deliver in 2015/16

[1] NHS England and its national partners announced in 2015 a new programme to focus on the acceleration of the design and implementation of new models of care in the NHS to promote health and wellbeing and provide care that can then be replicated more easily in other parts of the system. Individual organisations and partnerships, including those with the voluntary sector, were invited to apply to be 'vanguard' sites and have the opportunity to work with national partners to co-design and establish new care models, tackling national challenges in the process. More information available at http://www.england.nhs.uk/ourwork/futurenhs/5yfv-ch3/new-care-models/

[2] A System Resilience Group (SRG) is the forum where all the partners across the health and social care system come together to undertake the regular planning of service delivery for elective and non-elective care. The group should plan for the capacity required to ensure delivery, and oversee the coordination and integration of services to support the delivery of effective, high quality accessible services which are good value for taxpayers. In Cambridgeshire and Peterborough there are three SRGs: Cambridge and Isle of Ely; Huntingdonshire; Borderline and Peterborough.

2.3 Also, several other developments started in 2015/16 will have a tangible longer-term impact:

a) The transformational changes in Primary Care such as the longer term impacts of the Prime Minister's Challenge Fund pilot in Borderline and Peterborough, the emerging direction of travel towards federation of practices and the development of co-commissioning and joint commissioning models
b) Through UnitingCare, the transformation of services for people who need adult community services and for older people aged 65 years and older
c) The transformational changes to Mental Health services arising from the new Adult Mental Health Commissioning Strategy which will be finalised in 2015/16
d) The continuing development of commissioning of children and young people services
e) Initiatives which have been identified by local health systems for implementation either arising from local health needs assessments or as a result of service reviews
f) Continuation of NHS and Local Authority partnership working, for example, the Better Care Fund.

2.4 One of the aims is to align operational (day to day running of services) and strategic (long term planning) work. For example, we have identified opportunities to build on existing work to improve musculoskeletal and orthopaedics services as part of the wider system transformation programme.

3. PLANNING INTENTIONS FOR 2016/17

3.1 Developing Hospital Alliances and Accountable Clinical Networks

3.1.1 Aim(s)

Taking forward the development of hospital alliances and the supporting accountable clinical networks in 2016/17 will generate a shared focus to achieve:

- An effective network of general and specialist clinical services to meet people's needs delivered by our clinical workforce groups
- Sustainable timely access to quality healthcare, offering multi-site choice, information and support to patients across our single catchment area
- Effective research and teaching opportunities for tomorrow's patients and clinicians, supported by Cambridge University Health Partners and, in turn, the Eastern Academic Health Sciences Network.

3.1.2 Key Areas of Focus

Overall

The emphasis will be on collaborating in key areas of patient demand. Initially, the focus will be on four specialties comprising Orthopaedics, Ophthalmology, Ear Nose and Throat and Cardio-vascular disease whilst benefitting from a single Patient Choice Service that coordinates bookings from Choose and Book, identifies available capacity and supports discharges and repatriation to best meet patients' needs.

Specifically

a) For **Orthopaedics**, we will seek to benefit from the opportunity for senior clinicians to offer free peer-to-peer review of adult elective and spinal practice in other Trusts. As a result, we expect to reduce clinical variation and secure safe and affordable services across the System

b) For **Ophthalmology and Ear Nose and Throat**, we will seek to share expertise, resources and educational opportunities to optimise the use of hospital capacity to meet national performance targets, deliver seven day services and create a new focus for the overall development of the service. We will build on the existing ophthalmology network, extend this further and, where appropriate, apply this approach to other specialties including Ear Nose and Throat. This work will also be aligned to service transformation work already underway in the System to ensure that there is no duplication of effort or resources

c) For **Cardiovascular/cardiology services**, we will seek to develop an integrated care and contracting approach. These services will be clinically led, ensuring that improvements in patient care and outcomes are in accordance with good practice and national guidelines are achieved. This will require a review and potential change to contracting arrangements between Papworth, other Providers and commissioners for a range of services. The intention is that any potential changes are expected to take effect in part or in full from 1 April 2016.

   In addition, the system will take into account work underway with primary care and community services to ensure that appropriate care that can be safely provided in the community is provided as close to people's homes as possible.

3.1.3 Work planned for 2016/17 and beyond

2016/17 will be a year of preparation with the key activities comprising:

- Agreeing the principles of engagement across the providers
- Bringing together the relevant clinical teams to develop new models of working across providers
- Clinical governance teams working together to develop a single approach across all providers for the specialties.

New clinical pathways[3] for the four specialties above (Orthopaedics, Ophthalmology, Ear Nose and Throat, and Cardio-vascular disease) will be implemented in 2017/18 at the latest, with work planned to be underway during 2016/17. Additional networks in other areas will be developed such as Medicine for the Elderly, Cancer, Diabetes, Paediatrics and Gastro-enterology.

[3] Clinical pathways are described variously as integrated care pathways, clinical pathways, critical pathways, care maps, or anticipated recovery pathways. A clinical pathway is anticipated care placed in an appropriate time frame, written and agreed by a multidisciplinary team. It has locally agreed standards based on evidence where available to help a patient with a specific condition or diagnosis move progressively through the clinical experience. It forms part or all of the clinical record, documenting the care given.

3.1.4 Lead Organisation(s)

This is a joint initiative by Peterborough and Stamford Hospitals NHS Foundation Trust, Hinchingbrooke Health Care NHS Trust, Cambridgeshire and Peterborough NHS Foundation Trust, Papworth Hospital NHS Foundation Trust, Cambridgeshire Community Services NHS Trust and Cambridge University Hospitals NHS Foundation Trust. This work will be supported by the System Transformation Team.

3.2 Transforming Urgent and Emergency Care in Cambridgeshire and Peterborough (Vanguard Programme)

3.2.1 Aim(s)

Create an overarching and strongly clinically-led Strategic System Resilience Group, as part of the East of England Urgent and Emergency Care Network which will:

- Act as the 'vehicle' for leading and progressing all work relating to urgent and emergency care
- Accelerate the pace of improvement which the three System Resilience Groups have started to deliver this year
- Supported by the System Transformation Board, act as the governance vehicle designed to deliver this rapid improvement as part of the System Transformation Programme
- Achieve a model of best practice in line with the Keogh Review and the NHS England vision for urgent and emergency care.

3.2.2 Work planned for 2016/17

Building on the work underway within the three System Resilience Groups and on the joint work underway with Local Authorities on admission avoidance or new ways of working and pathways, we have set a range of objectives for achievement in 2016/17 including:

- Re-align the flows of activity and designation of emergency departments and urgent care centres
- Configure a network of community-based urgent care centres around primary care hubs, out of hours bases and Minor Injury Units
- Ensure that access to emergency care is primarily phone first via 111 or 999, and sign posting to services supported by multidisciplinary clinical hubs, seven days a week
- Reduce the admission rates of older people in line with plans for UnitingCare outcomes and a focus on prevention through a new third sector driven Well-Being Service
- Reduce significantly crisis mental health presentations to A&E, by improving early community based intervention models for all ages
- Expand GP services to cover 8am to 8pm midweek and 9am to 9pm weekends with GP services supporting the 'front door' of Emergency Departments
- Make significant progress in implementing 7 day working across all services with no deterioration in outcomes for patients admitted at weekends
- Provide specialty emergency services such as Ear Nose and Throat, ophthalmology and oral surgery through network models across providers whilst overcoming the emerging workforce limitations of small specialties
- Achieve sustained high performance and develop joint clinically-led planning and commissioning of urgent and emergency care through the Strategic System

Resilience Group with visible and strong clinical leadership of change across the CCG geography
- Align and commission voluntary sector services to support early intervention and post discharge pathways
- Work closely with Local Authority public health commissioned drug and alcohol services to support reduced demand on emergency services
- Minimise use of ambulatory care[4] pathways for conditions that do not require admission.

NHS 111 / Out of Hours contracts will be extended beyond March 2016, in order to align with the revised procurement timetable for the integrated NHS 111/ Out of Hours service. All providers have agreed to extend up to 30 September 2016 if necessary and for the national inflation and efficiency rates to be applied in 2016/17. We are formally procuring an integrated Out of Hours GP and 111 service with a multi-disciplinary clinical hub which builds on the successful model of 'GP in 111'.

For 2016/17, we will consider expansion of the clinical triage scheme commissioned through the Commissioning for Quality and Innovation payments framework[5] in 2015/16 in order to reduce unnecessary conveyance of 999 ambulances and, in particular, Category Green 2 ambulances. In respect of growth, we need to consider and review the potential impact of the proposed media advertising in 2016 of the NHS 111 service.

We will expand clinical triage for primary and community clinicians to access specialist consultant advice and guidance.

3.2.3 Lead Organisation(s)

This initiative will be led by NHS Cambridgeshire and Peterborough Clinical Commissioning Group.

3.3 Planned Care, Long Term Conditions and Prevention

3.3.1 Aim(s)

- Under the leadership of a nominated Chief Executive Officer, ensure that there is a clear sense of direction for the development of elective care and that the appropriate planning infrastructure and processes are in place
- Support the development of work on-going to develop Primary Care at scale
- Ensure that care pathways are as efficient and effective as possible and in the most appropriate clinical setting to the benefit of the patient
- Proactively repatriate inappropriate outpatient follow ups to primary care
- Ensure that efficiencies are delivered across the system avoiding some of the historical work load shift unless this is appropriately commissioned. e.g. activity moving from secondary care to primary care

[4] Ambulatory care or outpatient care is medical care provided on an outpatient basis, including diagnosis, observation, consultation, treatment, intervention, and rehabilitation services. This care can include advanced medical technology and procedures even when provided outside of hospitals.

[5] The Commissioning for Quality and Innovation (**CQUINs**) payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare.

- Provide care in accordance with agreed clinical policies
- Explore further the opportunities to encourage prevention and reflect this in the commissioning and provision of services.

3.3.2 Work planned for 2016/17

County wide

- Adopt a collaborative approach to managing the demand for elective services across the System. Where relevant, this will include alignment with the preparatory work on creating a hospital alliance for implementation in 2017/18 (Musculoskeletal, Ophthalmology, Ear Nose and Throat and Cardio Vascular Disease)
- Review pathways and services to identify opportunities for improvement
- Ensure adherence to agreed clinical threshold policies and identify opportunities where care could be delivered more efficiently and cost effectively whilst remaining clinically safe
- Review and improve the clinical pathway for sleep apnoea
- Review diabetes services and identify the options for future service provision (also a local priority)
- Design and implement robust commissioning arrangements for Tuberculosis Services (led by Borderline and Peterborough System)
- Promote the benefits of self-care for long term conditions
- Continue to evolve the Musculoskeletal and Trauma and Orthopaedics services to move all possible work into the community where it is clinically safe and appropriate to do so (aligns with the hospital alliance development)
- Implement the new contract for the Non-Emergency Patient Transport Service from September 2016
- Conduct a deep dive into the impacts of obesity on health services and prepare plans for implementation to address the key issues identified as rapidly as possible
- Review diagnostic test requesting against clinical standards for effective use.

With a focus on Borderline and Peterborough

- Implement the procurement of Musculoskeletal services including Pain Management
- Review diabetes services and identify the options for future service provision
- Review ambulatory care pathways and explore the potential to develop additional pathways
- Ensure that Tier 3 obesity services[6] are jointly commissioned on a whole pathway of care approach.

In addition, through close joint working with the Peterborough Health and Well-being Board, a Cardio Vascular Disease programme steering group will be set up, drawing on membership of existing groups to improve the cardiovascular health of all in Peterborough. Expected outcomes include:

- Clarity around accountability through the Health and Wellbeing Board for taking the cardiovascular programme forward
- Setting clear trajectories and targets including the numbers of people who would benefit

[6] A Tier 3 obesity service is for individuals (usually with a body mass index ≥35 with co-morbidities or 40+ with or without co-morbidities) who have not responded to previous tier interventions. A tier 3 service comprises a multi-disciplinary team of specialists.

- Recognising the importance of individual behaviour change to tackle the preventable causes of cardiovascular disease
- A strong communications programme in place with clear simple messages for the public
- People able to access support on healthy lifestyles from GP surgeries, pharmacies or community venues easily
- Addressing the high rate of diabetes and coronary heart disease in South Asian communities and the need for culturally appropriate programmes for cardiovascular disease prevention
- Making best use of community assets and links with the voluntary sector, and specifically with Vivacity as local leisure provider
- Working together across organisation and avoiding duplication and wasted resources
- Undertaking specific clinical programmes.

With a focus on Cambridge

- Diabetic Pathway: work with UnitingCare to roll out to practices the community service model piloted by Cam Health Local Commissioning Group
- Review the pathways for diabetes and the prevention of coronary heart disease
- Review respiratory pathways for patients under 65 years of age
- Manage referral activity and service quality (referral pathway changes such as Advice and Guidance; one referral point/Clinical Assessment Service; virtual reviews: Neurology, Lipids, Gastroenterology and Hypertension)
- Review and improve the management of clinical thresholds including the Prior Approval process at Cambridge University Hospitals NHS Foundation Trust for a range of conditions
- Implement a planned clinical audit programme to provide an evidence base to inform current and future decision-making
- Embed the transformation work in Dermatology and Ear Nose and Throat community services
- Review the Sleep Apnoea and Pessary clinical pathways (both Local Enhanced Service /Primary Care driven) to ensure that they are as efficient as possible
- Implement Musculoskeletal Community provision (including pain management) and integrated pathways.

With a focus on Huntingdonshire

- Work with Hinchingbrooke Health Care NHS Trust and other providers to develop 'One-Stop Shop' Clinics, i.e. short, effective pathways
- Populate the DXS[7] Best Pathway (referral decision making tool) with a range of clinical pathways so that it is available for use by referring GPs
- Conduct a review of Cardiology services
- Assess the need and the business case for implementation of a Community Pain Pathway.
- Ensure that diagnostic tests are only undertaken in situations where the result would affect clinical decision-making. Ensure that tests are requested in accord with local and national policies

[7] DXS Point-of-Care™ is a clinical decision support system that enables recommended content such as care pathways, medicines, referrals, patient education and support groups to be filtered and presented to healthcare providers in their workflow, during a consultation and relevant to the patient's condition.

With a focus on Isle of Ely / Wisbech

- Isle of Ely: Integrate local elective outpatient and diagnostic services into contracts with one or more acute providers
- Isle of Ely: Act as a platform which could be used to test out elements of the hospital federation / accountable clinical networks strategic transformation initiative
- Wisbech: Building on the work undertaken in 2015/16, develop an all-in elective care contract which would include services delivered at North Cambridgeshire Hospital (links to the hospital alliance strategic work)
- Isle of Ely and Wisbech: Improve local end of life care services, gaining 'equity' as a result
- Isle of Ely and Wisbech: Review the increasing demand patterns for Dermatology and draw up plans to address them.

3.4. Maternity, Children and Young People

3.4.1 Aim(s)

- Consolidate the joint commissioning arrangements agreed in 2015/16
- Review non-elective admission rates for paediatrics as part of the development of effective pathways for urgent care
- Build on the benefits of joint working to ensure that services are available to meet the health needs of the population
- Integrate services where this is sensible with clear benefits to the care of children and young people.

3.4.2 Work planned for 2016/17

County-wide

- Consolidate and develop the work of the Joint Commissioning Unit in line with the "Future in Mind" guidance issued in 2015
- Implement the priorities identified through the current 'Transformation programme' in order to take forward a significant redesign of Children and Maternity services, including all elements of the healthy child programme
- Take forward with service providers the new specifications for Children Looked After health services (currently being re-designed)
- Implement the new Children and Adolescent Mental Health Services model, including strengthening Tier 2 services
- Develop an integrated service, particularly in response to the Special Education Needs and Disability[8] reforms
- Complete the re-commissioning of rapid response services
- De-commission Child Protection Medicals in Peterborough from Cambridgeshire and Peterborough NHS Foundation Trust and re-commission them from Peterborough and Stamford Hospitals NHS Foundation Trust:

[8] Children and young people with Special Educational Needs and Disability (SEND) may need extra help because of a range of needs, e.g. communicating and interacting, cognition and learning, social, emotional and mental health difficulties, sensory and/or physical needs. Some children and young people may have SEND that cover more than one of these areas.

i. Autistic Spectrum Disorder / Attention Deficit Hyperactive Disorder pathways will be integrated to include Cambridgeshire Community Services NHS Trust, Cambridgeshire and Peterborough NHS Foundation Trust and Local Authority services
ii. The review of 0-5 years services (Health Visiting and Family Nurse Practitioners) in line with the allocation reduction
iii. Review Section 256 agreements[9]

- Non elective paediatric pathway review: develop a paediatric Ambulatory Care Unit approach which links into the transformation work currently underway.

With a focus on Borderline and Peterborough

- Implement a new Children and Adolescent Mental Health Services model, including strengthening Tier 2[10] services
- Develop an integrated service, particularly in response to the Special Education Needs and Disability reforms.

With a focus on Cambridge

- Implement a new Children and Adolescent Mental Health Services model, including strengthening arrangements to improve urgent and emergency care and reduce attendance at A&E.

With a focus on Huntingdonshire

- Review the mental health support available for children and families
- Review the Emergency Department pathways for specialist / consultant review
- Greater joint working of services, e.g. Oak Tree Centre, Hinchingbrooke Health Care NHS Trust, Schools
- Balance the patient's desire for local service provision (for Maternity and Paediatrics) with the need to maintain safety and quality overall.

3.5 Primary Care

3.5.1 Aim(s)

- Achieve an improvement in patient experience, access to GP services, equity of access and reduced inequalities
- Achieve an improvement of outcomes, alignment of outcomes with other programmes of work, and the quality of general practice services
- Develop high quality, integrated out-of-hospital services, organised around the patient, closer to home
- Develop sustainable primary care organisations through developing options, piloting and implementing primary care provision models
- Consolidate the work underway with implementing 'primary care at scale' and the benefits of enhanced access to services in Borderline and Peterborough
- Progress the workforce development and the investment in resources required to deliver the Primary Care programme objectives

[9] NHS funding transferred to local authorities to support adult social care under Section 256 (5A)(5B) of the 2006 NHS Act.

[10] Practitioners at this level tend to be specialists working in community and primary care settings in a uni-disciplinary way.

- Increase the role in primary care commissioning leading to increased empowerment to improve primary care services.

3.5.2 Work planned for 2016/17

- Agree the vision for the range of services which could be commissioned from organisations offering primary care at scale
- Subject to support from practices and the Local Medical Committee and approval by the CCG and by NHS England, proceed to implement joint commissioning arrangements for Primary Care
- Together with Health Education England and others, continue to address the primary care workforce gaps and priorities, in order to secure longer term service sustainability
- Consolidate the implementation of the Primary Care at scale programme in Borderline and Peterborough (Prime Minister's Challenge Fund) focussing on:

  a) GP extended opening hours
  b) GP in front of house etc.
  c) Multi-skilled Workforce e.g. introduction of Pharmacists
- Explore the opportunities for streamlining the primary care processes for Direct Access Pathology and Radiology
- Explore options to enhance the benefits of having pharmacist resource and expertise within a primary care setting
- Work with System Resilience Groups to implement improved patient triage / treatment processes in Emergency Departments

3.6.1 Mental Health Services

Overall, 2016/17 will be primarily a year of consolidation of the service re-design initiatives which were planned and implemented during 2015/16. Through close joint working with Local Authority commissioners from Cambridgeshire County Council and Peterborough City Council, we have highlighted a consensus around a small number of key themes: equality of access, prompt access to effective help, the "recovery" model, prevention, personalisation, service user engagement and improved physical health.

We have also agreed areas where a jointly co-ordinated focus might accelerate the pace of progress. The areas of joint focus for working with Cambridgeshire and Peterborough NHS Foundation Trust for 2016/17 comprise (i) data quality, (ii) improving discharge planning and patient flow generally, and (iii) access issues for both health and social care. We will use our existing Cambridgeshire and Peterborough NHS Foundation Trust contracting forums to determine the best way to take forward an increased focus on each of these three areas.

In addition, the draft CCG Commissioning Strategy for 2016 to 2019 will align closely with Local Authority social care strategies for adult mental health and demonstrate clear links to the key themes that they have in common.

3.6.1 Aim(s)

- Consolidate the service re-design initiatives planned and implemented during 2015/16, using "Parity of Esteem" monies to create a more resilient local mental health system

- Together with local stakeholders, revise the Adult Mental Health Commissioning Strategy for 2016 to 2019 and ensure that the key priorities are reflected in planning intentions for 2016/17.

3.6.2 Work planned for 2016/17

County-wide

- Implement the outcomes of the review of the Advice and Referral Centre with the aim of developing local single points of access, closer links in each locality between primary care and local Cambridgeshire and Peterborough NHS Foundation Trust clinicians and increasing awareness and making more use of local community-based resources
- Embed the expanded and more equitable commissioning of third-sector mental health services undertaken during 2015/16, aligning NHS, social care and third sector pathways for service users and strengthening partnership working between those working in the NHS and third sector
- Roll-out the "Recovery Coaches" model including peer support workers who will support patients struggling with the next stage of their "recovery", enabling them to access effective support from NHS and non-NHS services
- Roll out the first phase of an Enhanced Community-Based Service to support primary care that is emerging from our current consultation process. This is likely to be closely aligned with the "Recovery Coaches" model described in the preceding paragraph, but with additional emphasis on improving the physical health of patients with mental health problems
- Physical health: ensure adequate provision of relevant physical health investigations and monitoring for patients in Cambridgeshire and Peterborough NHS Foundation Trust services (i.e. for all pathways)
- Continue to support local implementation of the Crisis Care Concordat[11], building on the significant investments already made for 2015/16. We anticipate that the Crisis Care Concordat Action Plan will include our emerging top priority which is improved access to crisis support including 24/7 telephone advice and additional crisis team capacity as part of a whole system approach to liaison psychiatry in local acute hospitals
- Fully implement self-referral to Improving Access to Psychological Therapies[12] services across all providers and further strengthen partnerships between Improving Access to Psychological Therapy compliant providers in each locality
- Re-design pathways for services where waiting times have become unacceptable with the aim of restoring a balance between capacity and demand within the resources available
- Review and address the transition of children with mental health issues into adulthood
- Review Attention Deficit Hyperactivity Disorder assessment and diagnosis in adults
- Maintain the improvements achieved to date in the quality of performance data being generated to inform contract/performance monitoring. This will include continued

[11] The Crisis Care Concordat describes how local commissioners, working with partners, can make sure that people experiencing a mental health crisis get as good a response from an emergency service as people in need of urgent and emergency care for physical health conditions.

[12] Improving Access to Psychological Therapies is an NHS programme rolling out services across England offering interventions approved by the National Institute of Health and Clinical Excellence for treating people with depression and anxiety disorders.

preparation for the implementation of Care Pathways and Pricing for mental health services. By the end of 2016/17, there will be sufficiently robust activity and financial information to enable each local system to understand what they currently receive for their money and what the outcomes of that investment are
- Take forward local data-sharing initiatives such as "One View" and the "Clinical Record Viewer" to enable information to be shared between service providers and enhance the help and support that they receive.

With a focus on Borderline and Peterborough

- Have in place a more responsive service to manage and direct patients who present in A&E but do not need physical help to an alternative service that can respond and manage the person's presenting needs and /or be a point of contact to avert a potential crisis
- Support the Severe Mental Illness work in primary care, acknowledging that there are limitations with GP recruitment issues; the model would need to be multi-disciplinary in nature.

With a focus on Cambridge

- Provide expert Improving Access to Psychological Therapies support for the management of long term conditions, depression, anxiety and pain control
- Implement a Frequent Attenders, Care Enhanced (FACE)[13] - type service for complex patients
- Seek the integration of primary mental health workers/dementia support with neighbourhood teams.

With a focus on Huntingdonshire

- Crisis/Timely Intervention: review the provision of psychiatric liaison services and consider joint working across Hinchingbrooke Healthcare NHS Trust and Peterborough and Stamford Hospitals NHS Foundation Trust. Up-skilling and training of A&E front line staff to be in place with advice and guidance support to primary care
- Hinchingbrooke Healthcare NHS Trust /Community Provision: improve the availability of mental health assessments prior to discharge. Consider step up "Recovery Coaches" to support the discharge planning process and complement the service redesign work relating to "Recovery Coaches" to support post-discharge
- Improving Access to Psychological Therapies: provide targeted support for those patients at severe end of pathway (Tier 3)
- Improving Access to Psychological Therapies /Long Term Conditions: ensure that services address chronic pain, diabetes and self-referral
- Review and address the transition of children with mental health issues into adulthood
- Review Attention Deficit Hyperactivity Disorder assessment and diagnosis in adults.

[13] A small, but increasing group of service users have a disproportionate impact on emergency services across the country. This cohort frequently uses Emergency Services (ambulance, A&E, police, fire and out-of-hours GP) with the service unable to provide the care that the service users require. A FACE team was designed in line with evidence from pilots in Edinburgh Royal Infirmary, St Thomas Hospital London and the Kings Fund recommendations, to meet with frequent attenders referred to the team by the various emergency services, and facilitate their engagement with existing services over the course of an 8 week pathway.

With a focus on Isle of Ely / Wisbech

- Establish a locally-sensitive Advice and Referral Centre single-point-of-access to improve communications with local GPs, and implement single assessments to avoid re-referrals either to other pathways within Cambridgeshire and Peterborough NHS Foundation Trust or to other local service providers to whom the referral could have been passed directly
- Improve liaison between the A&E department at the Queen Elizabeth Hospital in Kings Lynn and local Cambridgeshire and Peterborough NHS Foundation Trust mental health services, again avoiding the need for referral via local GPs of patients presenting in crisis who require transfer to the care of Cambridgeshire and Peterborough NHS Foundation Trust services
- Revise the service model for adults with Attention Deficit Hyperactivity Disorder to eliminate current access issues
- Use the resource allocated for "enhanced primary care" to establish a "one-stop shop" resource centre in Wisbech to provide multi-agency patient help and support both as an alternative to secondary care services and post-discharge from these services.

3.7 Learning Disability

3.7.1 Context

Local specialist services for people with learning disability are commissioned in Cambridgeshire by Cambridgeshire County Council, acting as lead commissioner on behalf of both the CCG and the Local Authority. There is a pooled budget in place. In Peterborough, the commissioning of in-patient services is now carried out by the CCG with the commissioning of community-based specialist services undertaken by the City Council. The budget for the health component of these services is transferred to the City Council for this purpose.

The two Learning Disability Partnership Boards provide the governance of these arrangements. Cambridgeshire and Peterborough NHS Foundation Trust provides most in-patient services for people with a learning disability; community services are commissioned from a range of providers; and the Learning Disability Partnerships themselves directly provide some services.

3.7.2 Aim(s)

- Achieve excellent joint working between Health and Local Authorities with the patient foremost in mind
- Ensure that services are accessible and available in the community as required
- Provide easy to read and understand information for patients
- Continue to progress the Assuring Transformation / Winterbourne View Plans
- People with a learning disability are able to live within local communities
- Uptake of health checks in primary care is supported.

3.7.3 Work planned for 2016/17

- Support the local implementation of the Assuring Transformation / Winterbourne View Plans for Cambridgeshire and Peterborough
- Review local in-patient requirements in the light of the requirement - that post-Winterbourne View, all people with a learning disability should be supported to live within local communities. We will continue to work with Local Authority colleagues to expedite the progress of the current in-patient review

- Support the uptake and delivery of primary care Learning Disability health checks and the primary care Learning Disability Local Enhanced Service (e.g. by offering practice-based training, promoting health check awareness etc.)
- Support the achievement of the new national accessible information standards by all commissioned providers (e.g. by the provision of easy read materials).

3.8 Medicines Management

3.8.1 Aim(s)

Maintain a clear focus on:

- Safe, appropriate and cost-effective prescribing
- Supporting key clinical pathway change programmes to ensure that the prescribing elements are addressed
- Clear and consistent communications to improve understanding and to encourage greater co-operation
- Promoting the Self-Care Agenda, empowering patients to treat themselves (with advice from community pharmacy) for self-limiting conditions
- Ensuring that best use is made of the Information Technology infrastructure and systems and, in particular, the use of use of electronic repeat prescription and maintenance of prescribing decision software.

3.8.2 Work planned for 2016/17

- Review the external monitoring requirements of pharmacy repeat prescribing systems
- Antibiotics: Reduce overall use and ensure formulary compliance due to concern about increased resistance and causal link with Clostridium Difficile
- Work with project leads to ensure that the prescribing elements for diabetes, respiratory, Tuberculosis services and stroke care pathways are identified and addressed. For Tuberculosis, work with services to explore the potential for Directly Observed Therapy to increase compliance
- Explore with UnitingCare the possibility of procurement or central supply
- Continence**:** evaluate the outcomes of the pilot undertaken in Borderline and Peterborough
- Wound care: explore with Cambridge University Hospitals NHS Foundation Trust the potential to use VAC pumps
- Centralise Insulin pump provision
- Review the arrangements for patients who inadvertently become addicted to medication
- High cost drug validation processes: to continue to review and develop processes
- Infliximab 15 minutes infusion: will change from a day case to outpatient procedure
- Implement a communication programme to encourage a reduction in medication waste and in unnecessary prescriptions requests
- Managed Repeats**:** increase the use of Electronic Prescription Service and continue to encourage patients to take responsibility for their own prescriptions
- Ensure safe monitoring of patients within shared care, with specialist back up available
- Work with the Primary Care Federation to evaluate the role of Pharmacists in General Practice in order to help with workforce issues.

3.9 Health & Wellbeing, Integration and the Better Care Fund

Context

Cambridgeshire and Peterborough's Health and Wellbeing Strategies were informed by national and local evidence of health needs as measured, analysed and reported in the Joint Strategic Needs Assessments, existing local strategies and plans, consultation with the public and key stakeholders and Community Impact Assessment.

The Health and Wellbeing Strategies have informed the development of our aligned Cambridgeshire and Peterborough Better Care Fund plans. There have been longstanding plans to more closely integrate health, social care and housing in Cambridgeshire and Peterborough. This will be through a shift of resources to invest in joined-up services that are focused on preventing deterioration and which support people to be independent, healthy and well in all aspects of their lives and the Better Care Fund provides one vehicle for achieving this.

Focusing on preventative community support where possible means a shift away from acute health services, typically provided in hospital, that often requires on-going social care support. This shift cannot be achieved immediately; acute services are usually funded on a demand-led basis and provided as needed, in order to avoid people being left untreated or unsupported when they have had a crisis. Therefore, reducing spend is only possible if fewer people have crises. Being able to achieve a shift from hospital to community has proved challenging in the past but this is required if services are to be sustainable in the medium and long term.

In support of this direction of travel the Older Peoples and Adult Community Services contract, delivered through UnitingCare will establish more integrated community services between different parts of the health system and between health, social care and other Local Authority and voluntary sector services.

This forms the context for the development of our two Better Care Funds in each of Cambridgeshire and Peterborough Local Authorities.

3.9.1 Better Care Fund Aims

- Move to an operating model for the health and social care system that helps people to help themselves, where the majority of people's needs are met appropriately through family and community support
- Maintain the focus on returning people to independence where possible
- Ensure that more intensive and longer term support is available to those that need it
- Realise the benefits of the contract with UnitingCare as one of the key delivery vehicles.

3.9.2 Work planned for 2016/17

With a Joint Focus across Peterborough and Cambridgeshire

Both Cambridgeshire and Peterborough Better Care Funds are aligned as far as possible resulting in five joint projects across the CCG. In addition there are individual plans within each system to ensure local needs are met. The joint projects are as follows:

Person Centred System

The intention is for:

- Development of a Neighbourhood Team / Multi-Disciplinary Team approach
- Development of a shared assessment process for health, social care and other partners
- Development of a risk stratification process and shared risk tool.

Data Sharing

The intention is for:

- Sharing data between UnitingCare and Peterborough City Council / Cambridgeshire County Council for frontline staff - phase 1
- Development of a 1 - 5 year plan
- Standardisation of data sharing, Information Technology systems and processes across Cambridgeshire and Peterborough
- Data sharing for risk stratification, early intervention and links to other Better Care Fund programmes
- Standardised use of the NHS Number
- Development of patient access and portals
- Evaluations of the impact of data sharing.

7 Day Working

7 day working is already present within some community-based health and social care services. The new agreed approach will look to expand a range of services involved in the hospital discharge process including health, voluntary sector, housing, social care and the domiciliary, residential and nursing home sector. It will directly contribute to the admission avoidance agenda whilst aligning to a significant number of the CCG Older People's and Adult Community Services outcomes.

The services provided will be based on need and not availability and a redesign of services will create capacity within the system. This does not mean that all services will operate 24 hours a day, 7 days a week – it is about ensuring that across the system, whatever time of day, there are appropriate services available. To ensure patients are discharged from hospital based on their needs and not that of the organisation. 7 Day working will be co-ordinated by each System Resilience Group to ensure relevant plans are made within each part of the health system. The Peterborough System Resilience Group has already conducted its 7 day working workshop, thus actions have been agreed. Similar workshops are to be held with the Cambridgeshire System Resilience Groups this Autumn.

Information and Communication

The intention is to:

- <u>Define a joint charter, agree shared language and understanding</u>

  This workstream will capture, define and agree joint terminology (glossary of terms) to be used within the scheme across all partner organisations.

- Understand the options for an Information Hub

  This workstream will develop the requirement specification for the information hub. This will set out what is and what is not possible, the data standards required, what behaviour change is required and the information sharing requirements to ensure a shared model of information and advice. There will also be work to consider the value of and what would be required to deliver an eMarketplace.

- Develop a single consistent approach to provision of 'front door' services

  Firstly there is a need to understand the current state of all the partner organisations' information about their front door models and their future plans. A paper will be developed setting out the requirements and a way forward for a joint information strategy around front door services.

- Change Management and communication

  Establish a whole system approach to communication and develop a joint marketing strategy for system communication. Consider both workforce development and an external facing marketing plan.

Healthy Ageing

The Healthy Ageing project is aiming to develop preventative community based services and capacity. This is to support and enable older people to enjoy long and healthy lives, to feel safe within their home and as part of their community, to promote independence and reduce the number of people requiring long-term health and social care services. The ultimate aim is to deliver better outcomes for older people.

The intention is for:

- Public Health delivering a series of planned evidence based health programmes to prevent falls, promote physical activity and promote mental health and emotional wellbeing and improve health outcomes
- Strong and supportive communities: co-ordination of public sector activity to prevent or reduce isolation and loneliness; support to ensure people are living in appropriate housing; provision of accessible services within communities
- Planning for growth: links with existing projects and services that deliver new communities to ensure factors that contribute to *'ageing healthily'* are considered in the planning of new estates, villages and towns
- A recognised set of triggers of vulnerability which generate a planned response across the system
- Older people remain living at home and in their own communities for as long as possible into later life and are supported to retain or regain the skills and confidence to look after themselves into older age
  Increased uptake of outreach programmes which will ensure services reach the most vulnerable communities who may be less willing or able to access services.

With a focus on Cambridgeshire

- In light of the overall strategic direction for use of the Fund, maintain a focus on reducing over-reliance on long-term and acute care in favour of shorter term services that are focused on maintaining or returning people to independence. Partners will continue to work towards the '10 aspects of integrated practice'
- Wherever possible, continue to seek to align projects between Cambridgeshire and Peterborough, whilst recognising that in some parts of the system the two areas may have different priorities
- Continue to allocate a similar proportion of the fund to the Older People's and Adult Community Services contract held by the CCG with Uniting Care to ensure that agreed service development and delivery are maintained. Including this within the Better Care Fund will continue to provide an impetus for inclusion of social care and wider system colleagues in the planning and delivery of community health
- Reserve a similar proportion of the Fund for the protection of social care, the continuation of previous Section 256 investment and for delivery of new responsibilities under the Care Act
- Continue to reserve similar funding for the virtual joint integration team which works across Cambridgeshire and Peterborough, with Peterborough-specific posts funded from the Peterborough Better Care Fund. Projects established under the Better Care Fund in Year 1 are intended as medium term projects and so are expected to continue. Budgets for the projects may vary but should be from within a similar total amount. Cambridgeshire remains committed to a goal of a jointly employed team working on behalf of the whole system
- Review the progress made in working towards the 10 aspects of integrated practice and its project funding to ensure that partners are able to make swifter progress towards achieving them
- Continue to ring-fence the Disabled Facilities Grant and pass it direct to Districts. Allied to this, initiative a wider discussion amongst partners about housing-related support in general and determine whether there is scope to improve the use of related revenue and capital funding streams in future years
- Continue to seek new ways of integrating services; and our approach will continue to focus on functional integration, rather than emphasising the creation of single organisational structures or one single pooled budget. A key organising principle will be the need to develop our system in a way that is based upon the real experiences and needs of vulnerable people and their families and carers, rather than on organisational arrangements.

With a focus on Peterborough

Community Connectors:

A new service focussing on harnessing community capacity and facilitating positive change in communities by:

a) Identifying contacts within targeted community groups, establishing engagement networks and developing a closer understanding of the social and Health issues faced by the community
b) Identifying and developing projects which can be delivered in close partnership with communities to address identified needs
c) Facilitating activities to bring communities together, to enhance community cohesion and improve linkages between the targeted community, wider communities, the Council/ CCG and our partners

d) Strengthen community support and a community spirit that helps people take responsibility for their future health outcomes and for their wider community; and
e) Help prevent situations in families who are experiencing difficulties getting worse by securing early help.

7 Day Working:

The approach will build upon and/or expand these services by means of the following phases:

- **Phase 1**: formal expansion of the existing 7 day working in Peterborough (re-ablement, intermediate care, district nursing, voluntary sector, housing and commissioned home care services) by means of aligning and integrating the Local Authority discharge planning teams (includes social workers and discharge planning nurses) accordingly
- **Phase 2**: focus on the Local Authority discharge planning teams working alongside independent providers to enable commissioned residential and nursing services plus re-ablement flats to assess and receive residents at weekends
- **Phase 3**: will the focus upon expansion of the broader services required to enable successful 7 day working across the whole system including health and housing providers.

  As a result, focus will centre upon:

- Service redesign to support an integrated approach for health and social care to avoid unnecessary admissions to hospital and reduce the number of excess bed days and delayed transfers of care. Patients will leave acute hospital as soon as clinically fit and safe to do so; and that complex assessment will be undertaken at home or within interim provision such as a nursing home
- Re-shaping the housing market - minor and major adaptations – responsive equipment and adaptations offer supporting people to be discharged from hospital and enabling people to maintain their independence will be provided. This will offer people more control of their life and support them to remain at home for longer
- Re-shaping the 24 hour bed-based care market - residential care, nursing care, re-ablement/rehabilitation bed based. An integrated health and social response for people in ambulatory care or on the frailty unit will be provided to return home. Better capacity is established to enable 'step up' and 'step down' options and better alignment and agreed pathways for re-ablement and intermediate care services. This will reduce the number of excess bed days through enhanced re-ablement or the urgent community response service
- Implementation of Tele-care, Tele-health, and/or Assistive Technology[14] - Extra Care, Residential and Nursing homes are supported through appropriate channels to avoid unnecessary admission to hospital through direct links with primary care and/or secondary care (e.g. Skype).

[14] An umbrella term that includes assistive, adaptive, and rehabilitative devices for people with disabilities and also includes the process used in selecting, locating, and using them. Assistive technology promotes greater independence by enabling people to perform tasks that they were formerly unable to accomplish, or had great difficulty accomplishing, by providing enhancements to, or changing methods of interacting with, the technology needed to accomplish such tasks.

Develop the Housing-related Support:

Under the Better Care Fund Programme, we will look to re-shape the housing market (through the development of minor and major adaptations) and re-shape the 24 hour bed-based care market (in particular, with regards to residential care, nursing care, re-ablement/rehabilitation bed based). As a result, focus will centre upon:

a) Re-ablement

- Putting more resources into re-ablement services for those people who become ill or have a fall to enable them to regain their previously levels of independence as quickly as possible and to reduce their need for longer-term care
- Integrating the enhanced re-ablement/rehabilitation pathway, aligning to the Intermediate Care pathway to avoid duplication - 7 day working, strong alignment to multi-disciplinary teams and accountable lead professional/coordinator named; and
- Developing the re-ablement offer for both Learning Disabilities and Mental Health to reduce the need for long term care and support and proactively support individuals experience improved mental health and wellbeing.

b) Accommodation

- Expanding the take-up of extra care housing and reposition the market to take a higher dependency client and thus reduce demand for other more costly forms of residential placements and which might not be the most appropriate option for people with long term care and support needs
- Increasing funding for Home adaptations
- Improving provision and quality of sheltered accommodation
- Developing and implementing a new service specification/contract to deliver improved provision and quality of residential and nursing care;
- Developing and implementing a new service specification/contract to deliver bed based re-ablement/rehabilitation at Friary Court.

Assistive Technology:

Intermediate care services, crisis response and Local Authority re-ablement and emergency home care services will be reconfigured and processes aligned to support the independence pathway. This is complemented by expanding the use of assistive technology and telehealth[15] including for citizens within residential and nursing homes and a 24/7 rapid response service Joint Emergency Team.

A key strategic enabler is to maximise the use of Assistive Technology across social care and health to promote and maintain independence and health; to enable citizens to self-care where possible or to support citizens where needed. The vision is to create an integrated Assistive Technology Service which encourages joined up equipment solutions dependent on a citizen's needs. This supports the vision for Health and Care Services to realise the benefits of whole system model transformation including *'further access to the assistive technology service'*. The scheme fits with the CCG Commissioning Strategy priorities around long term conditions and improving the health and wellbeing of the frail and elderly, and the Local Authority priority of joint working to drive collaboration, integration and efficiencies.

[15] The delivery of health-related services and information via telecommunications technologies. Telehealth could be as simple as two health professionals discussing a case over the telephone or as sophisticated as doing robotic surgery between facilities at different ends of the globe.

Work includes:

- Making changes to the integrated assessment and planning pathway with Assistive Technology becoming the default
- Putting in place systems that can order/monitor/track benefits
- Putting in place a culture change programme (training/engagement) on the use of telecare[16]/telehealth/ assistive technology to reduce care package costs and time spent on assessment and support planning (initially focusing on self-management for long term conditions and falls prevention)
- Using technology, such as Skype to provide support for people with long term conditions; and
- Developing, implementing and adopting an integrated approach, to achieve both Health and Social care outcomes, by the use of Assistive Technology, to improve the quality of care, enhance user lifestyle choice, promote independence/self-management and secure expedient benefits for the City of Peterborough and its citizens.

3.10 Paper-free NHS

3.10.1 Aim(s)

- Develop plans and a roadmap to comply with NHS England guidance (*The Forward View in Action: Paper-free at the Point of Care – preparing to develop local digital roadmaps*: published September 2015)
- Ensure that we have an effective programme management framework in place.

3.10.2 Work planned for 2016/17

- Building on work started in 2015/16, develop further the digital roadmaps required for the System
- Eliminate the use of fax and replace with secure email for the transmission of patient-identifiable data
- Develop plans which set out how the System intends to provide 'paper-free' care at the point of delivery by 2020
- Assess the implications of the forthcoming NHS England "Insight Strategy" which will seek to make better use of patient outcome and experience data (publication of strategy expected April 2016)
  Prepare for the introduction by Health Education East in April 2016 of a new knowledge and skills framework for all levels of the health, care and social care workforce.

4.0 Next Steps

If you wish to comment on this paper, please contact Tom Dutton, Head of Operational Planning, NHS Cambridgeshire and Peterborough CCG (tom.dutton@nhs.net).

[16] The term used for offering remote care of elderly and physically less able people, providing the care and reassurance needed to allow them to remain living in their own homes. The use of sensors may be part of a package which can provide support for people with illnesses such as dementia, or people at risk of falling.