Fit for the Future
Working together to keep people well

Cambridgeshire and Peterborough Sustainability and Transformation Partnership

Memorandum of Understanding

Cambridgeshire and Peterborough Health and Care System

November 2017

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

Date effective: **[Date to be confirmed]** Signatories 'The partners', the CEOs/Accountable Officers and Chairs of:

1. NHS Cambridgeshire and Peterborough Clinical Commissioning Group (C&PCCG)
2. Cambridgeshire University Hospital NHS Foundation Trust (CUHFT)
3. Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
4. Cambridgeshire Community Services NHS Trust (CCS)
5. North West Anglia NHS Foundation Trust (NWAngliaFT)
6. Papworth Hospital NHS Foundation Trust (Papworth)
7. Peterborough City Council (PCC): (CEO & HWB Chair) – Appendix 1 only
8. Cambridgeshire County Council (CCC): (CEO & HWB Chair) – Appendix 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, Cambridge University Health Partners, NHS England Specialised Commissioning, GP Federations, practices or third sector organisations.

Introduction

Purpose: The local health economy within Cambridgeshire & Peterborough CCG has agreed a single Sustainability and Transformation Partnership (STP) plan 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 Partnership. 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. Partners are expected to actively engage with each other. Individual major decisions should be raised at the STP Board and Health and Care Executive (HCE) so that the impact on other organisations can be considered.

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, the responsibility for System decisions are delegated to the STP Board (some decisions may be delegated to HCE), this MOU and the associated Terms of Reference for all relevant System groups will be amended. While, at no stage, can the powers of the STP Board or 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 Cambridgeshire and Peterborough (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 does not)

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 and 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 the STP Board 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 STP Board and 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 (DTOC). Common pathway designs will be in place across all three 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 seven 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 Peterborough and Stamford Hospitals NHS Foundation Trust and Hinchingbrooke Healthcare NHS Trust 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 a 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: The HCE will be accountable to the STP Board for delivery of the STP, as such, all System projects will be agreed by the HCE, and under the supervision of a Delivery/Enabling 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. Integrated Neighbourhoods: translating the proactive and preventative care schematic into operational practice, supporting sustainable general practice
    ii. Urgent and Emergency Care: achieving best practice non-elective bed-days per capita
    iii. Planned Care: standardising referral and treatment protocols in line with best practice
    iv. Children, Young People and Maternity: 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: leadership, planning, skills development, recruitment and retention
    viii. General Practice Forward View (GPFV)
- 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 C&P, 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, and
    - Subsidiarity: change happens bottom up, and neighbourhoods across C&P differ significantly.
- Each System project will have a named Senior Responsible Officer (SRO) (Exec level) who is accountable for delivery of the project.
- 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.

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 2018/19 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 and 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.
- All parties will exhibit win-win-win behaviours (for patients, providers and commissioners) – any financial recovery plans will be approached as *System* financial recovery plans.
- Contract mechanics for 2017/18 and 2018/19: 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/Enabling 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/Enabling Groups will track savings against pre-determined trajectories in a robust and timely manner, with the Executive Programme Director's guidance and SDU support. A named SRO for each project is responsible for making sure savings trajectories are met and/or securing recovery proposals where implementation is not on track.
- Investment: A System Investment Fund (SIF) for system wide investments has been established and is made up of contributions from Partners. In 2017/18 it is likely that due to cash constraints top-up funding will be required and that a System bid to NHS England will be made. Decisions on how to spend this System wide investment and re-investment pot will be taken collectively via an approved gateway process and the Investment Committee. Analysis will be undertaken first to ensure existing resources cannot be safely redeployed/or productively improved before investment can be made. The SIF will come from any STF funds, recycled savings and the CCG's 1% hold-back.

Commitment 6: One set of governance arrangements: the STP Board and the groups reporting to it (HCE, Care Advisory Group, System Delivery Board, Financial Performance and Planning Group, Investment Committee, Clinical Communities and Delivery/Enabling Groups) will be the vehicle through which System business is conducted. All existing arrangements will either be dissolved or aligned.

As much business, as possible that pertains to the system will be conducted via the system governance described in STP Governance Framework. 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 STP Board and HCE's powers must be anticipated, and accommodated in planning. The STP Governance Framework describes decision making processes and roles and responsibilities of individual groups and organisations in detail.

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 Executive Programme Director will be created from October 2016. The Independent Chair and Executive 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 (delegated by the STP Board) to employ staff, funded jointly by NHS Partners (see Appendix 2). 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, problem solving capacity to the system and coordinating of assurance to NHS England/NHS Improvement. However, it will be responsible for giving assurance to the STP Board 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 Delivery/Enabling Group chairs 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 two 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 do not 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 STP Board, HCE, Care Advisory Group, System Delivery Board, Financial Performance and Planning Group, Investment Committee, Clinical Communities and Delivery/Enabling Groups 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 Delivery/Enabling Group chair. 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 STP Programme Risk Register maintains emerging risks to both the agreed delivery plan and agreed mitigations;
    - Care Advisory Group, System Delivery Board, Financial Performance and Planning Group, Investment Committee, Clinical Communities and Delivery/Enabling Groups are required to adhere to the STP's Assurance Framework and Risk Register.
    - 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 Executive Programme Director to the employing CEO via the System Delivery Board.

- 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 in accordance with the STP's Risk Assurance Framework.

Appendices

1. Local Authorities and the C&P Sustainability and Transformation Plan.
2. SDU Financing: Funding split (%); Initial budget for the SDU; legally binding arrangements for sharing SDU costs (expected and unexpected)