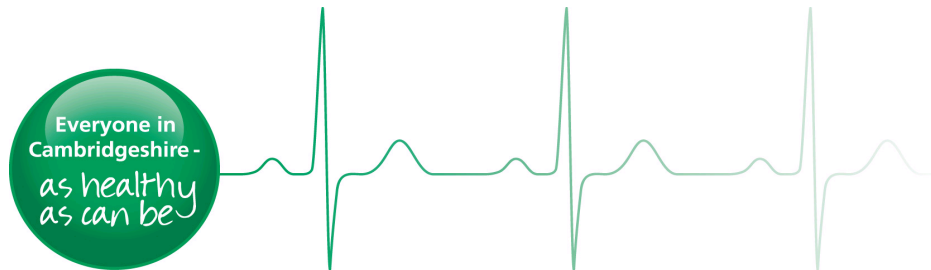


# A STRATEGIC PLAN FOR CAMBRIDGESHIRE

## 2010 to 2015



**Version 5.3**  
**Created 7<sup>th</sup> January 2010**

## Table of Contents

Chapter Number	Chapter Title	Page
	Executive Summary	3
<b>1</b>	Context	5
<b>2</b>	Our Strategic Challenge	15
<b>3</b>	Our Strategic Solutions	22
<b>4</b>	Improved Ways of working	51
<b>5</b>	Financial and Activity Plan in more detail	56
<b>6</b>	Governance	65
<b>7</b>	Impact Assessment	69
<b>8</b>	Conclusions	73
<b>Annex A</b>	Initiatives from last Year's Strategy	74
<b>Appendix 1</b>	Commissioning Portfolio for the Financial year 2009/10	78
<b>Appendix 2</b>	Impact Assessment Criteria	79
<b>Appendix 3</b>	Health Outcome Metrics	80
<b>Appendix 4</b>	Explanation of the assumptions used to create the Base Case	81
<b>Appendix 5</b>	Five Year Financial Plan	82
<b>Appendix 6</b>	Getting more for every Pound spent	83

## Executive Summary

Since we developed our first Strategic Plan eighteen months ago, much has changed locally and nationally.

The downturn in the global economy will have a far-reaching affect on the finances of the entire public sector. Although we do not yet know the exact implications for the NHS, it seems certain that the recent period of significant year-on-year funding increases is at an end.

Meanwhile, demand for health services continues to grow unabated as the population grows and ages and as new treatments and technologies are developed.

It was against this background that we decided to conduct a fundamental review of our Strategic Plan. We knew that not all of the commitments set out in our previous plan would be affordable in this new financial context. We also knew that we would have to consider making some big changes to the way we work, in order to be confident of being able to continue to commission services that are comprehensive, responsive and of high quality for the people of Cambridge and Shropshire.

This plan sets out our initial response. Our approach has been to identify a small number of areas where we believe we will have a big impact, and to focus on these. By doing so, we will be able to prepare for what is likely to be a very difficult financial environment while still making progress against the four priority areas we identified in our previous plan:

- Promoting health and preventing disease
- Older people's health and care
- Patient experience and customer care
- Safe, sustainable and affordable health services

In chapter 1, we summarise our local context. In chapter 2, we set out the five key challenges we think we will face over the next five years, including a potential financial gap of almost £100 million by 2013/14 if we do not take action now.

Chapter 3 sets out our response to these challenges by describing our six strategic change programmes, as well as making clear which initiatives from our previous plan we will continue to progress.

Our six programmes are: in partnership with GPs, developing a more devolved system of commissioning rooted in the local knowledge and expertise of primary care; changes to planned care in hospital and to the way we work with providers of health care; a more prioritised approach to changing the way services are provided for people with long term conditions; a sharper focus to our work on prevention, drawing on recent evidence about clinical and cost effectiveness; and an ambitious efficiency programme designed to get more for every pound we spend.

We have focused on these six areas because in each case they have the potential to result in improved services as well as significantly reduced costs.

Chapter 4 reaffirms our commitment to working with our public sector partners in Cambridgeshire to find new ways of delivering services that are of high quality and financially sustainable. In this chapter, we also describe the new arrangements we plan to introduce in order to ensure that we deliver on our commitments.

Chapter 5 details our financial assumptions and the modelling we have used over the five year period of the plan. Chapter 6 sets out how we have developed this plan and some of the risks we foresee, while Chapter 7 outlines some of the broad implications for patients, provider and our own staff.

From here, the next step is to develop detailed delivery programmes for each of the initiatives included in this plan. This work is already underway, as we know that we need to act decisively and swiftly in order to prepare for the challenges that lie ahead.

Strategic  
Change  
Programmes

New commissioning  
system

Elective / Planned  
Care

Sustainable supply  
side

Long Term  
Conditions

Prevention

Getting more for  
Every Pound spent

Key Enablers

## Chapter 1 Context

In this Chapter, we set out a brief overview of NHS Cambridgeshire and selected information derived from the Joint Strategic Needs Assessment and other sources of information. If you want to know more about us or the work that we do, please go to: [www.cambridgeshire.nhs.uk](http://www.cambridgeshire.nhs.uk).

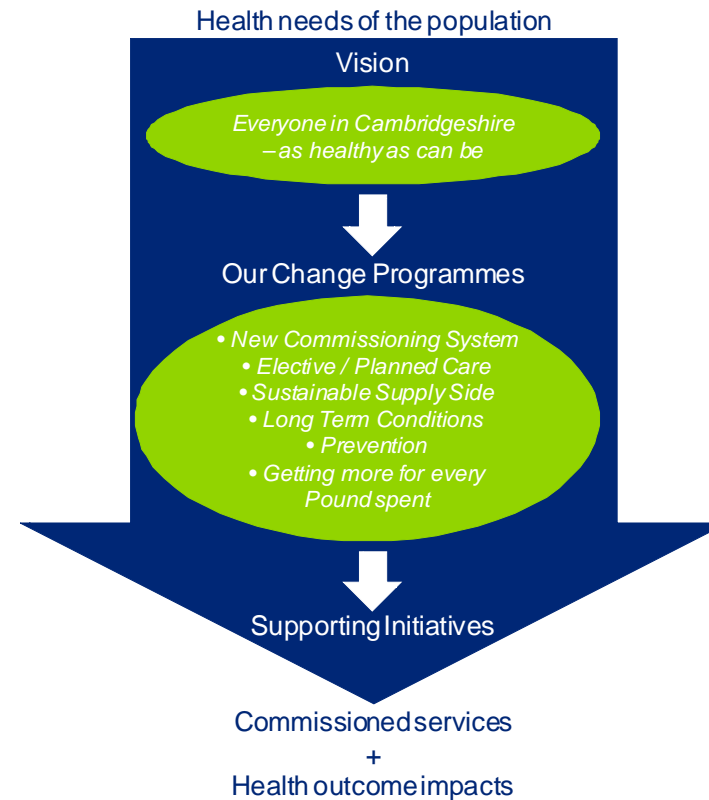
### An Overview of our Strategic Approach

The diagram opposite summarises our approach in drawing up this new Strategic Plan. We started by reviewing the health needs of our population. We used a variety of sources of information for this, including the Joint Strategic Needs Assessment. We also compiled a detailed compendium of information covering topics ranging from performance benchmarking through to modelling different future scenarios.

Guided by our strategic vision and, using all available information, we identified six major strategic change programmes. Each programme has supporting initiatives which will turn our strategic vision into reality.

In drawing up the detail of this plan, we were guided by the four guiding principles which we set out in last year's plan:

- Promoting health and preventing disease
- Older People's health and care
- Safe, sustainable and affordable health services
- Patient experience and customer care.



## **Our Strategic Vision**

Last year, we set out our strategic vision which can be summarised briefly as:

**“Everyone in Cambridgeshire, as healthy as can be”.**

In drawing up our vision, we took into account that the population of Cambridgeshire is diverse, ranging from those people who are relatively well and affluent to those who experience deprivation and the impact that this has on their health and well-being. In addition, many people travel through the County every day and will need, at times, some form of health and/or social care intervention whether this is for the short or long term. Although the strategic context has changed since we drew up our vision statement last year, we believe that we can still deliver it.

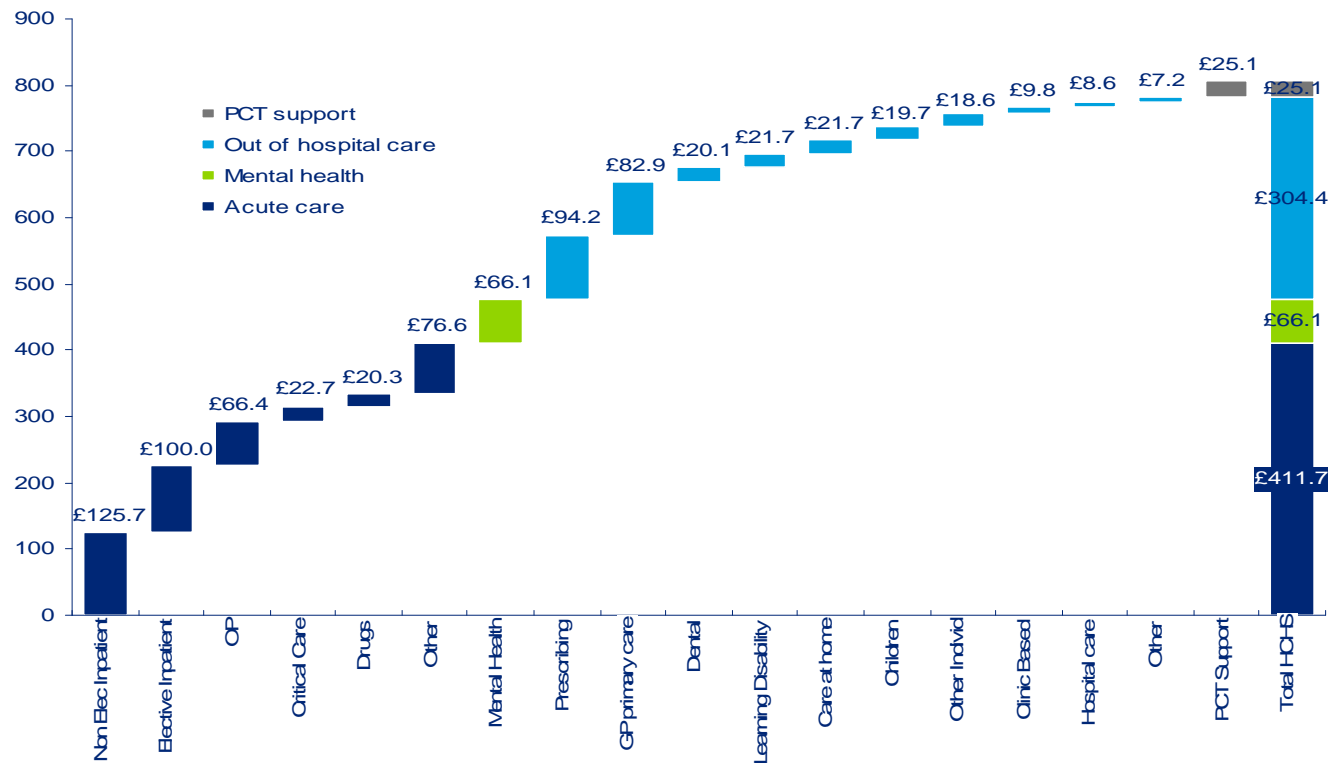
Over the next five years, we aim to:

- support people in understanding their own health and well-being so that they themselves can contribute to staying healthy
- commission accessible and timely health and social care services for those who need them within the resources available

We are responsible for improving the health of the population of Cambridgeshire by assessing health needs and by commissioning services from providers in response to those needs. We commission services from other NHS organisations and are responsible for developing primary care services. To do this, we have a budget of over £800 million which we receive from the Government each year to pay for these services and associated infrastructure. In the next page, we have summarised how we spend the money we receive from the Government.

### Our Finances at a Glance

Here, we have set out the forecast expenditure (in £'000) for the financial year 2009/10 and split it by service area. Half of our budget is spent in the acute hospital sector of which Addenbrookes and Hinchingsbrooke Hospitals form the largest proportion. We also spend a significant amount of money in Primary Care services. Later in our Plan, we set out how we would like to develop this valuable pool of expertise to transform patient care for the future. In Appendix 1, we have set out more detail of our commissioning portfolio for the financial year 2009/10.



## Insights gained from last year's Strategic Plan

### Our Public Consultation

In Spring 2009, we held a 13 week public consultation to seek views on last year's five year strategic plan and whether we had got it right. The campaign had a strong public focus and it aimed to reach a wide audience as well as specific stakeholders important to the commissioning role of NHS Cambridgeshire.

#### We learned that:

- Public perceptions showed that people are willing to support our five year vision and take more responsibility for their health and staying healthy
- Media coverage was positive overall and focused on how we could spend money more wisely with an emphasis on moving services closer to home and reducing the burden on hospitals, such as A&E
- There was overall consensus that people should keep themselves healthy and be responsible for their own health. This included adopting positive lifestyle behaviours such as stopping smoking and maintaining a healthy weight
- Results showed that respondents who do want advice around staying healthy want to receive more information and leaflets on health and healthy living
- The findings showed that there is strong support for our approach to how we spend our money over the next five years

### World Class Commissioning Assurance

Last year, we drew up our first Strategic Plan and submitted it as a final draft to the World Class Commissioning Assurance Panel in December. The Panel assessed our plan with health outcomes, organisational competencies and governance in mind.

#### The Panel gave us some headline messages first:

- We could become "world class" quickly, but must develop a more strategic approach to its commissioning intentions that addresses the major challenges ahead
- We have demonstrated significant strengths, which we should build on. Examples cited by the Panel were exemplary performance in financial turnaround, demonstration of strategic leadership, remarkable depth in partnership working with the County Council, our approach to clinical re-design and a clear patient engagement structure

#### Followed by 3 main recommendations:

We should:

- Develop a clear strategic plan with milestones on how it will create and ensure a financially stable position
- Ensure that the headline measures are articulated in the strategic plan
- Think about options to create more strategic capacity and quickly put this in place

## Some Information about our Population

More detail is available from the Joint Strategic Needs Assessment on [www.cambridgeshire.nhs.uk](http://www.cambridgeshire.nhs.uk).

### Population Change in Cambridgeshire

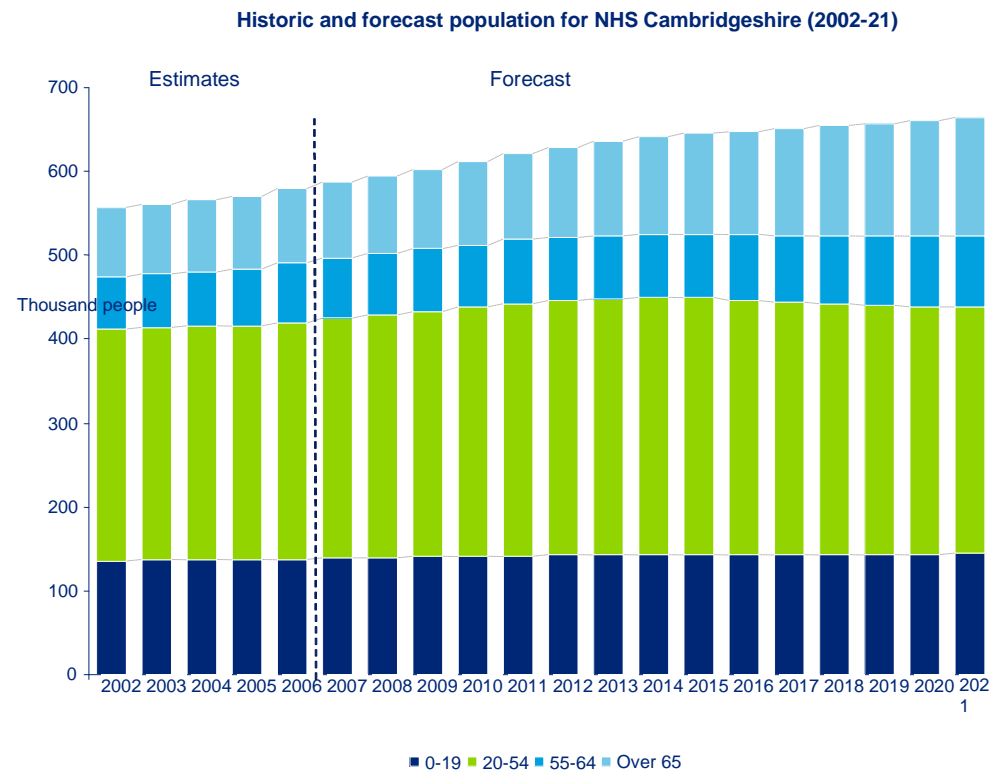
Just over 600,000 patients are registered with GPs in NHS Cambridgeshire as at July 2008.

By 2021, there will be a further 90,000 people living in Cambridgeshire. The largest actual increases and proportional increases are expected in South Cambridgeshire and Cambridge City, where a number of significant new housing developments are planned, including the new town of Northstowe.

We expect the population of 0 to 19 year olds to increase by 4% between 2006 and 2021 in Cambridgeshire. Cambridge City and South Cambridgeshire are projected to have noticeable increases and in Huntingdonshire a noticeable decrease.

We expect the adult working age population to increase by nearly 8% between 2006 and 2021. A major part of this increase is expected between 2006 and 2011. The effect of the current economic downturn may need to be factored into these forecasts.

We expect the number of people aged over 65 to increase by 60% between 2006 and 2021 in Cambridgeshire. The greatest proportional increase is expected in South Cambridgeshire (87%) between 2006 and 2021, but there is a major increase forecast in all areas of the county, with the exception of Cambridge City.



Source: Mid-2007 population forecasts by single year of age and gender for NHS Cambridgeshire's catchment area, Research Group, OCS - Cambridgeshire County Council, 04.11.08

## Socio- economic Landscape

As a County, Cambridgeshire has a high proportion of its population classified under the ABC1 social grade, relative to the national average.

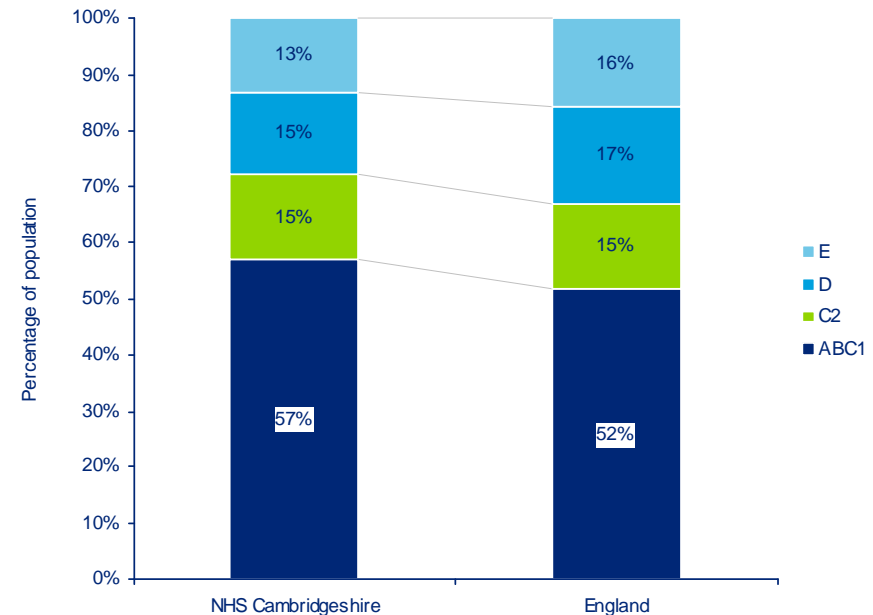
Almost 5 per cent more individuals are in social grade ABC1 than the national average.

The ABC1 group typically expect more of GP services than other groups.

Only 28 per cent of the Cambridgeshire population is classified under the D and E social grades, relative to a national average of 33 per cent.

The exception to this picture is Fenland district, which has 38% of the population in social grades D and E.

Social grade classifications



1. People are classified by the Approximated Social Grade of their Household Reference Person. Social grades: AB = Higher and intermediate managerial/administrative/professional, C1 = supervisory clerical junior managerial/administrative/professional, C2 = skilled manual workers, D = semi-skilled and unskilled manual workers, E = on state benefit unemployment lowest grade workers
2. Table population includes all people aged 16 and over in households.

Source: Table SO66: Sex and approximated social grade by age, ONS, Market Research Society, 2001 census

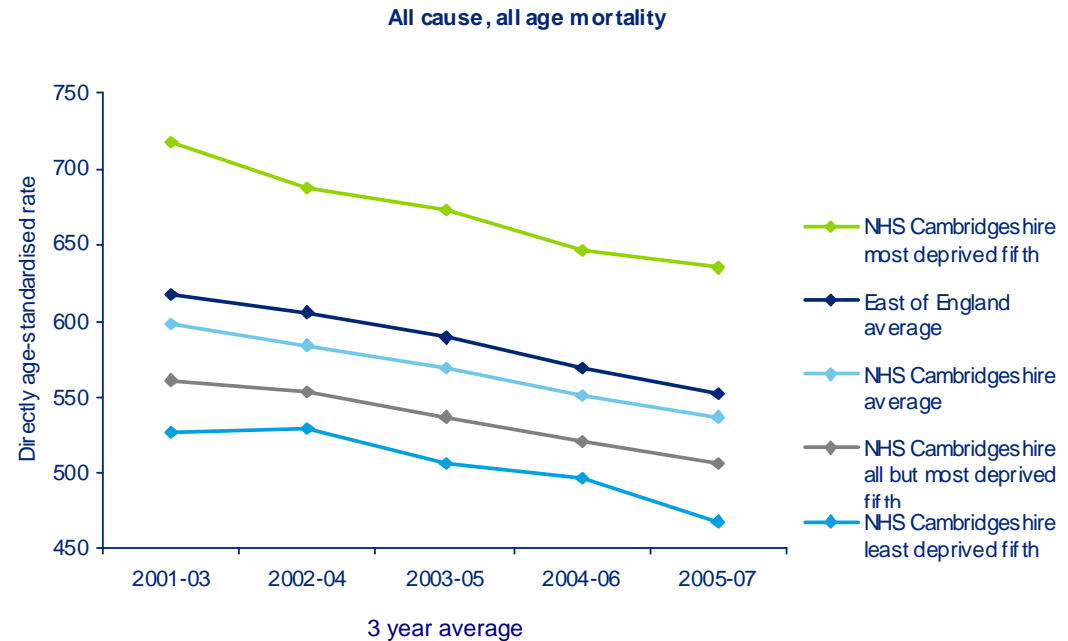
**Health Inequality – Life Expectancy**

Over time, life expectancy has been increasing across all groups identified.

Cambridgeshire’s life expectancy has been consistently higher than the East of England average level from 2001 to 2007.

However, the life expectancy of the most deprived fifth has always been below the East of England average over this period.

There is a 4 per cent relative difference between the most and the least deprived areas in Cambridgeshire.



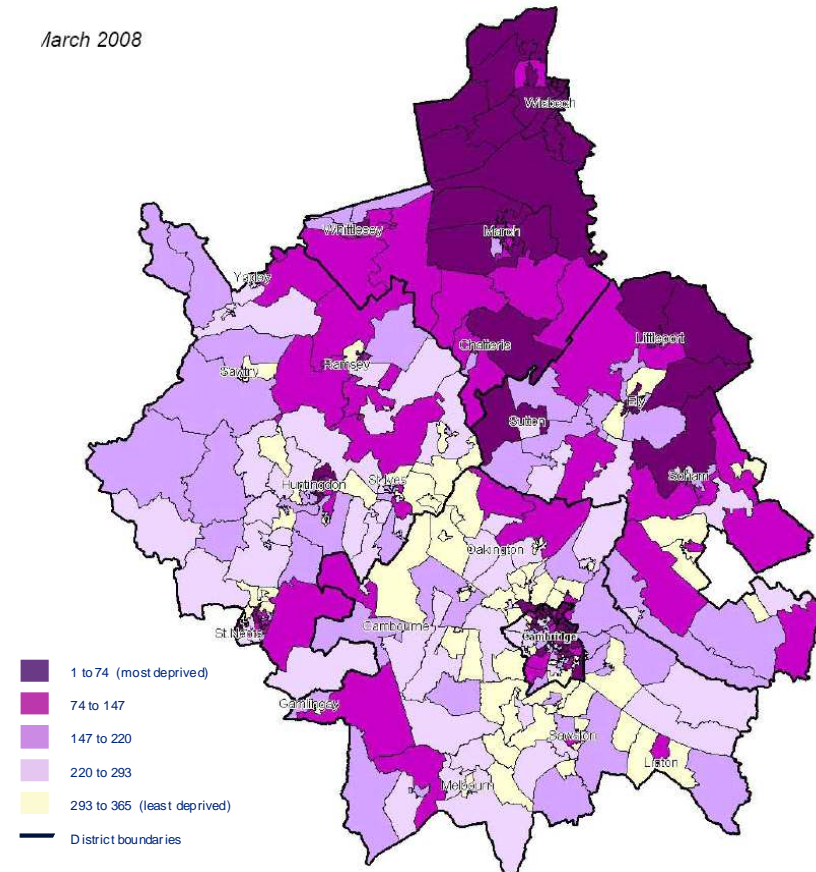
### Social Deprivation – County Wide Picture

Across all districts, Cambridgeshire has a lower deprivation score than the England average. The most deprived areas in Cambridgeshire are concentrated in the north east of the County. Deprivation varies greatly across the county, with Fenland, north-east Cambridge and parts of North Huntingdon having the highest levels of relative deprivation. The same pattern exists for children living in poverty.

Income deprivation for older people is more widely dispersed. Mapping of adverse lifestyle behaviours and health outcomes across Cambridgeshire follows the pattern of deprivation. In Fenland, the most deprived areas are concentrated in Wisbech and surrounding rural areas. In Cambridge City, the most deprived areas are in the north and east of the town. There are areas of higher deprivation in North Huntingdon and St Neots, and in Littleport and North Ely in East Cambridgeshire. South Cambridgeshire has low deprivation, although there is a significant Traveller population, likely to have poorer outcomes.

The Index of Multiple Deprivation Map of Cambridgeshire (2007 position) is shown opposite.

March 2008



## Health Conditions

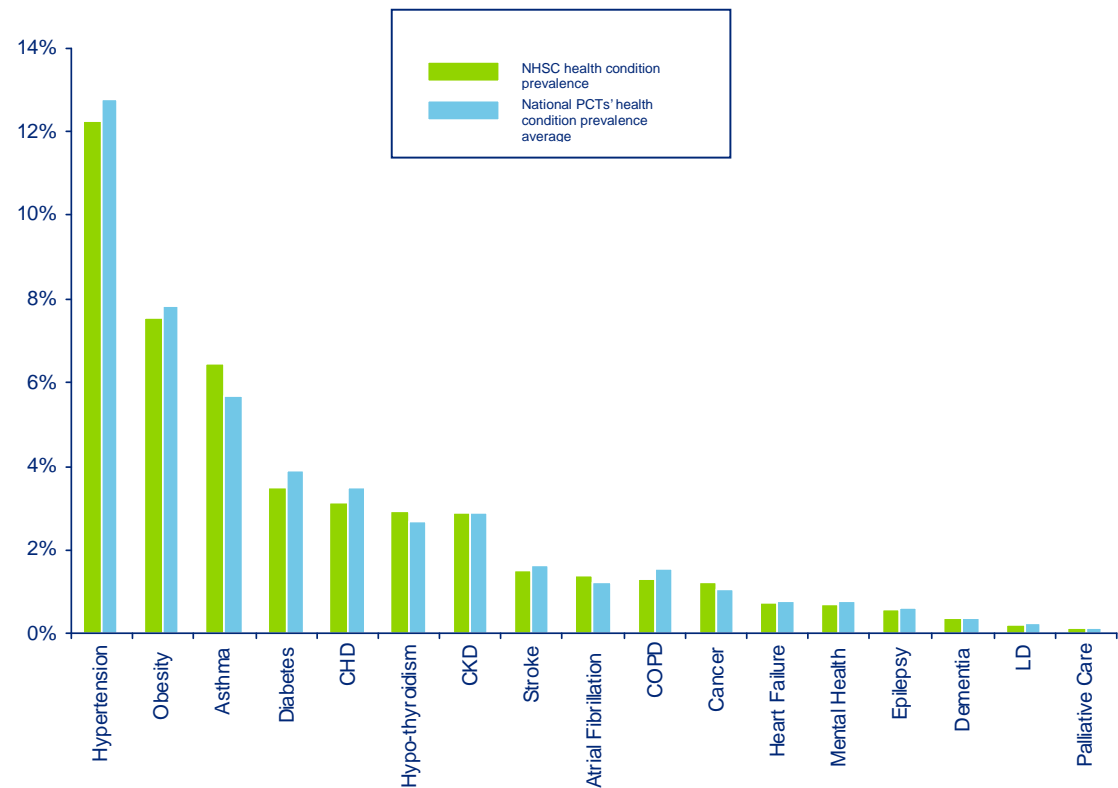
Prevalence of health conditions in NHS Cambridgeshire, as recorded by GP practices is generally lower than the national average (as would be expected) but higher than ONS comparator PCTs with similar demographics. Higher rates in relation to comparators may be a genuine prevalence issue, or reflect more complete recording.

GP recorded asthma and cancer prevalence are above the national average by 0.8% and 0.2% respectively. This may relate to higher rates of diagnosis and recording, as death rates of cancer are lower than the national average.

Hypertension and obesity are the most prevalent conditions in NHS Cambridgeshire as recorded on GP Registers. Recorded prevalence of hypertension and obesity on GP registers are 12% and 8% respectively. However actual prevalences are likely to be considerably higher than this. ERPHO has predicted the likely increase in prevalence of some common health conditions in Cambridgeshire to 2015. Estimated (rather than GP recorded) prevalence for COPD in Cambridgeshire is currently 2.5% and is projected to increase to 2.6% by 2015. Estimated prevalence of diabetes is 4.6%, projected to rise to 4.7% by 2015. Estimated prevalence of coronary heart disease is 4.6%, projected to rise to 4.9% by 2015.

### Health condition prevalence in NHSC relative to the National PCT average

% Prevalence out of Total Population 2007-08



Notes: CHD = Coronary Heart Disease, CKD = Chronic Kidney Disease, Stroke = Stroke and Transient Ischaemic Attack, COPD = Chronic Obstructive Pulmonary Disease, Heart Failure = Left Ventricular Dys-function, LD = Learning Disabilities

Source: Quality and Outcomes Framework, 2007/08 (note this data is not standardised for age)

In summary, the key messages are.....	
<b>Population Change in Cambridgeshire</b>	<p>Significant population growth is expected in Cambridgeshire over the next 12 years. Our population is ageing and we need to plan with partner agencies how we will address the implications of this for services.</p> <p><b>We need to plan the infrastructure needed for new settlements and ensure that services are available and adequate to meet the needs of our ageing population.</b></p>
<b>Socio- economic Landscape</b>	<p>We have a high proportion of our population classified under ABC1 who typically have high expectation of and demand for services. However there are specific population groups who may not have the access to health services they need. Access to elective hospital care is good but may not always be related to need.</p> <p><b>We need to make sure that we target services to meet health need rather than simply expectation.</b></p>
<b>Social Deprivation – County Wide Picture</b>	<p>The most deprived areas in Cambridgeshire are concentrated in the north east of the County; Fenland, north-east Cambridge and parts of North Huntingdon have the highest levels of relative deprivation. The same pattern exists for children living in poverty, adverse lifestyle factors and poorer health outcomes.</p> <p><b>We need to review how we allocate our resources within the County to ensure that we are targeting our resources appropriately.</b></p>
<b>Health Inequality – Life Expectancy</b>	<p>Overall, life expectancy has been increasing but there is a 4% relative difference between the most and the least deprived areas in Cambridgeshire.</p> <p><b>We need to focus specific interventions on key populations.</b></p>
<b>Health Conditions</b>	<p>Recorded prevalence of health conditions in Cambridgeshire is largely lower than the national average but growth rates are higher for some conditions, especially in cancer and heart failure. Death rates from both cancer and circulatory disease are falling in Cambridgeshire, so this may reflect better diagnosis. We know from the JSNA that a large number of people have lifestyle factors which will adversely affect their health.</p> <p><b>We need to target our resources intelligently and work with local people to encourage them to adopt health-promoting lifestyle behaviours.</b></p>

## Chapter 2 Our Strategic Challenge

In this Chapter, we set out an overview of the strategic challenge ahead, drawn from a detailed and comprehensive fact base. Many of the themes here will continue into future years and become more pressing unless we take corrective action.

### Headline 1: We are facing an increasingly difficult financial position

We expect to achieve financial balance at the end of the 2009/10 financial year but our underlying financial position is deteriorating. Looking ahead, we expect the impact of the economic recession on future public sector finances to be very significant – probably the most significant in the last 10 years. The NHS cannot expect to receive the same level of increase to its finances – indeed, the most likely case is that there will be no increase from 2011/12. We have modelled several financial planning scenarios and have selected a scenario which we believe would be the most likely (this is not necessarily the most significant in terms of change).

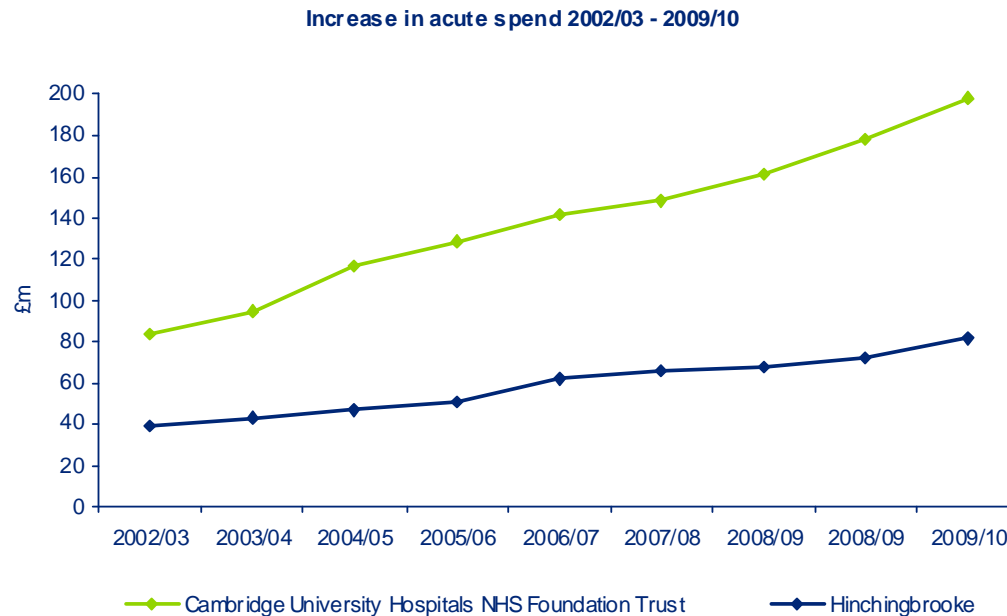
#### In summary:

- a) our underlying financial position is deteriorating
- b) from 2011/12, our funding from the Government is unlikely to increase for several years at least thereafter. This is termed 'flat cash'
- c) Using the 'most likely planning scenario, we will have an overall budget gap of nearly £100 million in five years' time if no corrective action is taken (see graph opposite)



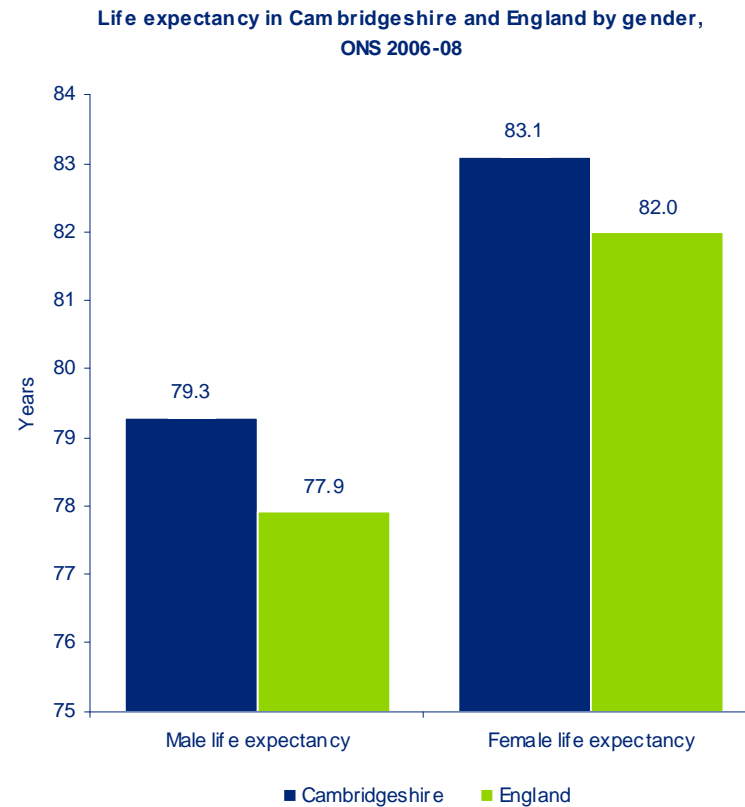
**Headline 2: We have struggled to manage demand in secondary care over a sustained period**

NHS Cambridgeshire is experiencing over performance in secondary care at all major providers, but especially at Addenbrookes, the largest secondary care provider. Over performance is appearing in slightly different areas at each provider and needs to be properly understood, in order to be addressed. Our goal has been to hold secondary care steady and to begin to shift activity to reduce activity in secondary care. We have failed to achieve this goal and will need to employ new measures to control activity and to incentivise flow to more local settings. Over the past eight years, growth in our expenditure at our major acute hospital providers has been greater than the growth in our resources overall. As an example, had our investment in Addenbrookes and Hinchingsbrooke Hospitals from 2002/03 to 2009/10 been in line with the growth money we received, we would have spent £63 million less than we did.

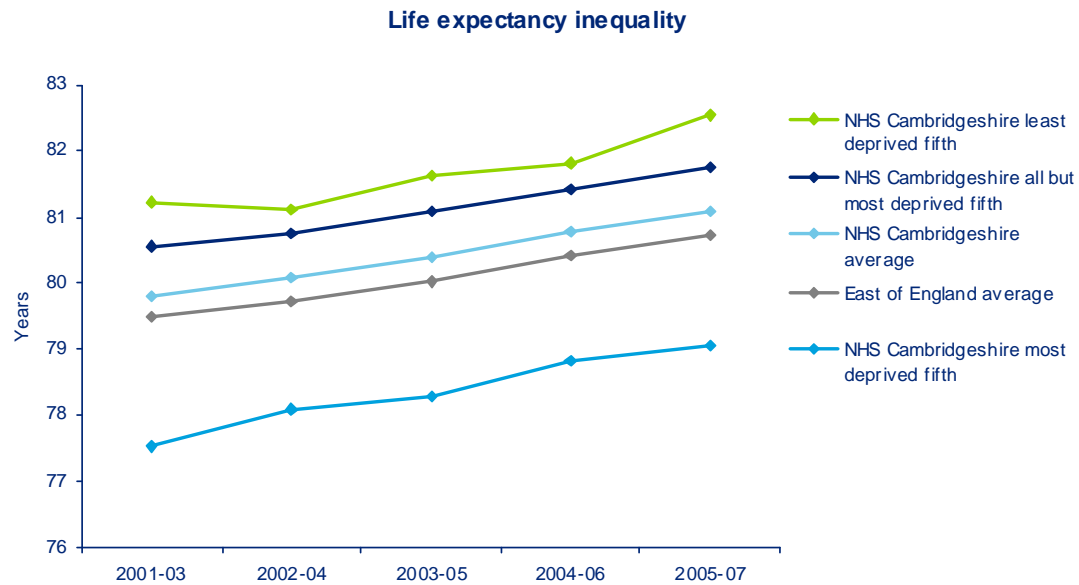


**Headline 3: Although people in Cambridgeshire generally live longer, healthier lives than average ...**

The population of Cambridgeshire generally live longer and have healthier lives than the England average, with life expectancy over a year greater in Cambridgeshire than England for both males and females.



... this masks significant inequalities .....



The difference in average life expectancy between people living in the most and least deprived parts of Cambridgeshire is over 3 years.

..and there are some worrying signals about the longer term determinants of health.

Obesity both for children and adults, smoking rates, lack of physical activity and harm due to alcohol are all key focus areas where current performance is below what we and our partners can be satisfied with.

Indicator	Cambs	Cambridge	East Cambridge	Fenland	Huntingdonshire	South Cambridge-shire
Obese children	Light Green	Yellow	Yellow	Yellow	Light Green	Yellow
Adults who smoke	Light Green	Yellow	Yellow	Yellow	Yellow	Light Green
Physically active adults	Yellow	Red	Yellow	Red	Yellow	Yellow
Obese adults	Yellow	Yellow	Yellow	Red	Yellow	Yellow
Hospital stays for alcohol related harm	Red	Red	Light Green	Red	Red	Light Green

**Key**

- Significantly worse than EoE/Eng at 95%/99.8% confidence level
- Not significantly different from EoE/Eng at 95%/99.8% confidence level
- Significantly better than EoE/Eng at 95%/99.8% confidence level
- No significance can be calculated

**Headline 4: We must plan now the services and care needed for our ageing population.**

Earlier, we set out an overview of the population forecasts.

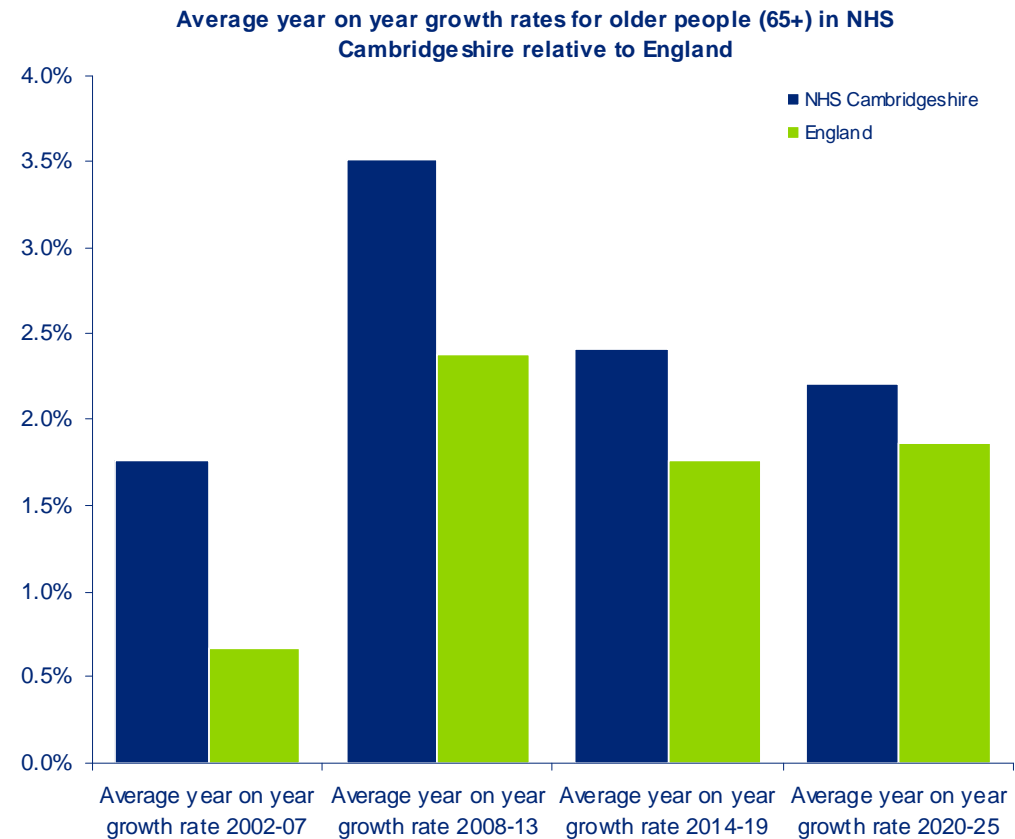
Significant population ageing is expected in Cambridgeshire over the next 15 years.

Between 2006 and 2021, an increase of about 90,000 in the population of Cambridgeshire is forecast, including an increase of over 50,000 people aged 65 and over.

Population ageing is most marked in the rural districts of South Cambridgeshire and Huntingdonshire, but will have significant impact in all districts.

The number of people aged 15-64 per person aged over 65 (dependency ratio) is forecast to drop by about 30% between 2006 and 2021 in Cambridgeshire.

This will have a significant impact on the health and social care services that we provide in the future.



**Headline 5: We are committed to delivering on key priorities but we urgently need to create capacity for radical strategic change by reducing the number of projects**

In last year's Strategic Plan we set out a wide range and number of projects which were intended to help us deliver on our key priorities including those set out in national policy frameworks and in NHS East of England's '*Towards the best, together*'. The challenge we set ourselves was significant: 49 strategic goals supported by nearly 400 action points.

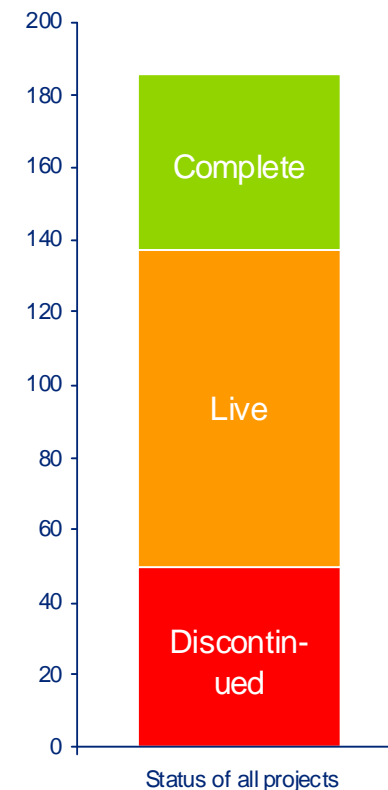
We have reviewed all projects set out in last year's Plan for two reasons:

- a) to monitor performance against plan
- b) to identify which projects are crucial enough to continue in new, more constrained times

We have taken a hard look at the level of activity in the organisation, the money spent and the outcomes achieved. We have applied a standard set of impact assessment criteria to all special project activity to help us slim down and focus on top priorities for the years to come. We are also keen not to lose ground where we have made strides and to encourage projects and methods that achieve timely results.

Our review has resulted in a streamlined and better defined work programme, which we explore further in the next chapter.

**Progress on initiatives from last year's strategy**  
Number of projects



## Chapter 3 Our Strategic Solutions

In this Chapter, we set out the strategic solutions necessary to address effectively the challenges outlined in the previous chapter.

### To recap ...

We have a series of key challenges which have led us to create a programme of major change:

- A rapidly deteriorating financial position
- Increasing activity in secondary care
- Challenge in closing gaps relating to health outcomes and inequalities
- And our internal challenge of trying to do too much with our constrained resource

Our thinking has been supported by the four guiding principles which we set out in last year's plan:

- Promoting health and preventing disease
- Older People's health and care
- Safe, sustainable and affordable health services
- Patient experience and customer care.

Having looked at the scale of the challenge ahead, it is very clear that we are not in a position to make incremental changes. Our financial position and related challenges require a new approach to commissioning in Cambridgeshire. Although we have a set of 'belt-tightening' efficiencies that we will pursue aggressively in the short term, these alone will not be enough. We need a sea change in both commissioning and provision to do this, and this is what we propose here.

Each of the solutions presented in this Chapter has been assessed using the Impact Assessment Criteria agreed at our stakeholder workshop held on 10<sup>th</sup> November 2009. The criteria are set out in Appendix 2.

## Our Strategic Change Programmes

We have six Strategic Change Programmes which encompass our key priorities, our game changing strategies and our short term efficiency measures. The diagram below gives an overview. The Strategic Change Programmes are supported by several key enablers. All programmes have been reviewed using the Impact Assessment Criteria in Appendix 2.



## Strategic Change Programme 1: New Commissioning System

### Why Change?

Our current model of commissioning operates at a county wide level and was established a couple of years ago when a different strategic context prevailed. It is the Primary Care Trust that assesses needs, plans and commissions services, places contracts and ensures that health providers are meeting the required standards.

This centralised approach to commissioning has not resulted in the changes that we were hoping to achieve. For example, one key objective we have set ourselves over several years has been to see less activity in hospitals and more in a community setting. Instead, the reverse has happened – we have invested more in hospital services year on year.

One of the key reasons for this is that our existing system is too far removed from clinicians on the ground who make decisions every day about the treatment individuals receive, in particular GPs. This means there is a disconnect between clinical and financial responsibility, and that the group that probably knows most about patients' needs – GPs – are not fully involved in designing the pattern of services that are provided.

Although we have tried to narrow this gap by sharing commissioning responsibility with local Practice Based Commissioning (PBC) groups, this has not resulted in radical change because:

- Practice Based Commissioners do not have the authority to make significant changes quickly – they operate with indicative budgets only, and have to seek approval from the Primary Care Trust before even relatively minor changes are made;
- PBC consortia have dedicated management resource but it is not enough or of sufficient seniority;
- Our governance framework for business cases is excessively bureaucratic and causes confusion. It takes too long to implement innovative service solutions on the ground;
- There is little real incentive for GPs and other primary care staff to devote time and energy to commissioning

### What do we intend to do about it?

We want to introduce a radical new system of commissioning in Cambridgeshire, a system that has at its core clusters of GP practices taking on responsibility for commissioning health services for their patients. Under this devolved system, we will seek to agree real commissioning budgets with each cluster, and will devolve as much authority to them as possible. The clusters will

operate within a transparent governance framework that is agreed with the Primary Care Trust, clearly setting out the roles and responsibilities of each party. We will invite a first 'wave' of clusters to come into operation at the start of 2010/11. We will jointly evaluate the progress made formally and, depending on the results, will invite future waves to participate. Participation in this system is voluntary, but we hope that 15-20% of practices will agree to join the first wave.

We are continuing to discuss the details of how this new, devolved commissioning system will operate with GPs, but key features of these clusters are likely to be that they will:

- Be clinically led and managed
- Have a catchment population of between 50,000 and 100,000 people (although this would be largely determined by practices)
- Be able to commission most services within NHS Cambridgeshire's commissioning portfolio directly with service providers
- Be able to ask NHS Cambridgeshire to commission selected services on their behalf ('block back') which require more specialised commissioning support e.g. rare cancers which are normally commissioned for a population of 1 million or more
- Be free to decide what management support is required and where to obtain these skills from
- Be responsible for producing operating plans to achieve their contribution to NHS Cambridgeshire strategic plan targets
- Work alongside NHS Cambridgeshire to draw up contracts and performance manage service providers
- Would be rewarded in proportion to the success they achieve against the agreed performance framework
- Would accept a share of the risk of failure

We have assumed that, initially at least, clusters will not wish to take a lead in shaping the local contribution to commissioning specialised services and that they will 'block back' commissioning responsibility to NHS Cambridgeshire. Drawing on the views of clusters, NHS Cambridgeshire will continue to contribute actively to the work of the East of England Specialised Commissioning Group, its Board and the various working groups which have been set up to support it.

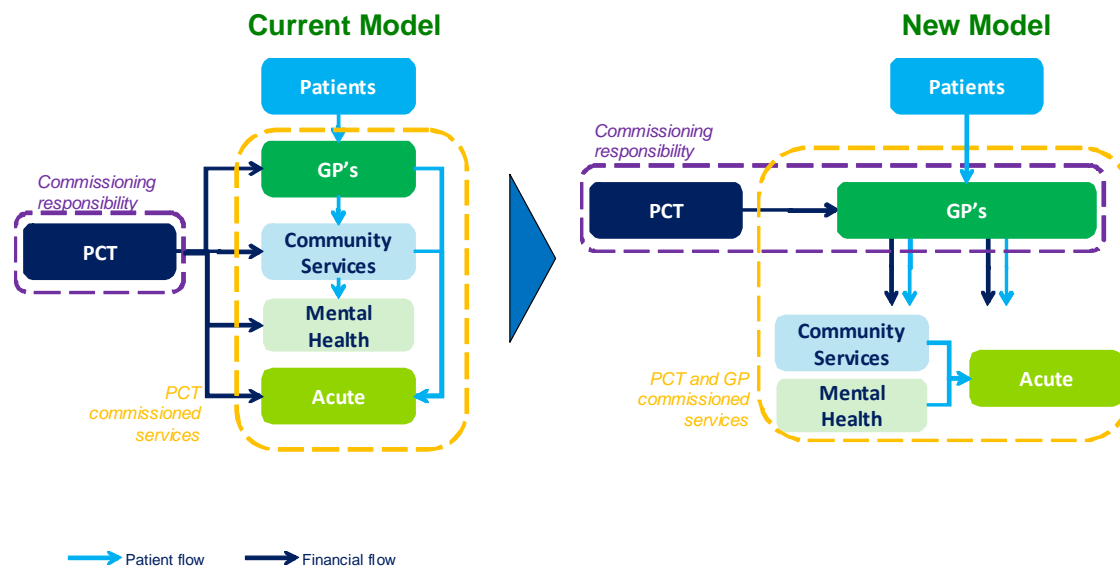
### How do we intend to deliver it?

Short Term 2010/11	Medium Term 2011/12 to 2012/13	Long Term 2013/14 and beyond
During the remainder of 2009/10, work with a wide range of GPs and practices to jointly design a 'prospectus' setting out how commissioning clusters will work, and invite	Launch subsequent waves of commissioning clusters  Conduct a local evaluation of progress	Work with leading clusters to explore moving to new organisational forms, such as integrated care organisation

<p>applications for the 'first wave'</p> <p>Seek formal endorsement for the approach by the NHS Cambridgeshire Board at a meeting in public</p> <p>Launch the first wave of clusters in April 2010, and design arrangements for evaluation</p> <p>Evaluate the progress made by the first wave, and, depending on results, invite applications for a second wave</p> <p>Agree any necessary changes to the governance framework</p>	<p>and achievement</p> <p>Assess the feasibility of linking this work to a Total Place pilot (via Making Cambridgeshire Count)</p> <p>Review whether the scope of early clusters can be expanded to encompass, for example, social care</p> <p>Review the impact on NHS Cambridgeshire's organisational structure and resources</p>	<p>Commission an external formal evaluation of all cluster arrangements e.g from Audit Commission;</p>
---	---	--

**What do we hope to achieve from this change?**

The diagram below illustrates the change in the commissioning model:



Other expected benefits include:

- Services commissioned as close to the patient as possible
- The innovation of front-line clinicians harnessed
- Active and fully engaged clinical leadership empowered to transform patient care and patient experience for the better
- More personalised care available to patients
- Responsible risk-taking with reward and accountability explicitly set out and actioned
- Reduced unit cost of services delivered by providers
- More effective contract management
- Greater accountability to our patients

### **What will success look like?**

By 2013/14, almost all health services will be commissioned by Primary Care led Commissioning Clusters. Primary Care leaders will be in charge of the money allocated for their 'patch' and, on behalf of their Commissioning Clusters, will have the authority delegated from NHS Cambridgeshire to spend it on services which meet their patients' health needs. They will take on the risks and well as the rewards, as they set and performance manage their contracts for services.

Over time, health inequalities will be narrowed as a result of this more devolved commissioning system, as we will set cluster budgets based on weighted capitation. This means that areas that have been historically under-funded (and that tend to experience the worst outcomes) will be addressed.

### **How will we measure it?**

We will agree key success measures as part of the detailed delivery plan for this initiative. However, key metrics are likely to include:

- Referral rates per 1,000 weighted population
- Prescribing rates per 1,000 weighted population
- The financial performance of each cluster
- Patient complaints and patient survey data

**What needs to be resolved for this to happen?**

- Build on the conversations we have had with Primary Care leaders to draw up a comprehensive accountability framework
- A high degree of interest and commitment from Primary Care and NHS Cambridgeshire to make this work
- Carefully frame the rewards and sanctions to ensure that public money is spent responsibly and that we are meeting the health needs of our population
- An agreed approach covering some practices who may opt out of the arrangement or refuse to co-operate
- NHS Cambridgeshire staff will be affected by the proposed changes; they will need support throughout
- A clear communications plan to ensure that our patients and members of the public know why we are doing this and the range of benefits to patient care that we expect to achieve as a result

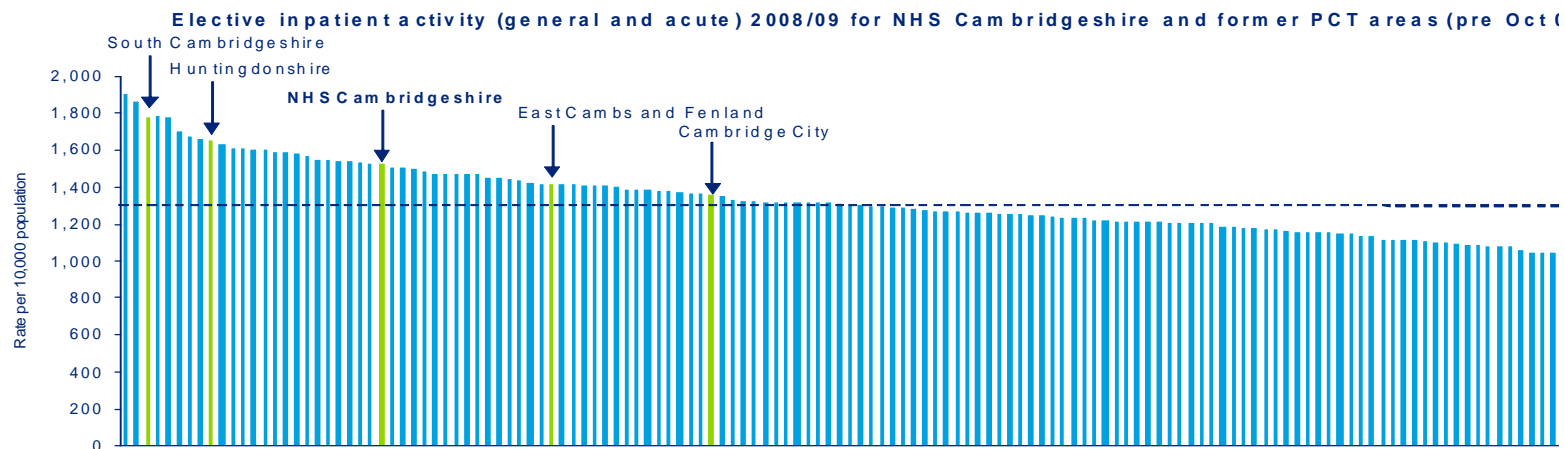
## Strategic Change Programme 2: Elective / Planned Care

### Why Change?

We struggle to manage the demand for acute hospital care. The Audit Commission in their report *More for Less* (Audit Commission. Health Briefing November 2009; *More for Less: Are productivity and efficiency improving in the NHS?*) illustrates the national situation very clearly:

- All of the 6.5% increase in NHS Cambridgeshire funding in 2008/9 was swallowed up by acute trusts despite the increase in the tariff being much less than just 2.3%
- The number of in patients increased by 4% and the number of outpatients by nearly 8%
- Primary Care Trusts made little or no in road in 2008/9 to transferring care from hospital or in decreasing demand

In Cambridgeshire, the biggest pressures are in elective or planned care. NHS Cambridgeshire is above the England rate for elective inpatient activity, with the highest rate in South Cambridgeshire and the lowest in Cambridge City. The graph below illustrates the situation.



**What do we intend to do about it?**

- We will work with local GPs to design an effective system for referral management, in order to ensure that only patients that really require hospital based care are referred there
- Ensure compliance with existing clinical policies and that we pay only for those services which comply with those policies
- Stop investing in services which are not proven to be clinically effective and/or are no longer required due to the establishment of new clinical pathways of treatment and advice
- Work with GP Commissioning Clusters to commission services using clinical pathways as the 'contracting currency'. Services which are provided outside of the agreed clinical pathways will not be funded
- Increasingly use health outcome based service specifications so that we are clear from the outset what we wish to commission and how this will address the health needs of our population
- Look at new ways of enabling GPs to obtain swift advice and support in making the decision to refer a patient to hospital
- Work with GPs to assess whether the senior 'clinical navigator' role that is used in some parts of the United States to speed people's progress through hospital care could be of value locally

**How do we intend to deliver it?**

Short Term 2010/11	Medium Term 2011/12 to 2012/13	Long Term 2013/14 and beyond
<p>Referral management process agreed and system implemented.</p> <p>Initial systems in place to give swift advice to support clinical decision-making</p> <p>Forensic approach to clinical thresholds implemented</p> <p>Investigate the potential merit of training experienced clinical staff to act as 'clinical navigators' to smooth the patient's progress through hospital</p>	<p>Work with commissioning clusters and other clinical staff to develop clinical pathways as the 'contracting currency'</p> <p>Pilot the use of outcome based service specifications.</p> <p>Systems fully implemented to enable GPs to obtain swift advice and support for clinical decision-making</p>	<p>Work with Primary Care Commissioning Clusters to commission using health outcome based service specifications</p>

### **What do we hope to achieve from this change?**

- Reduced demand for elective care and funded capacity for those patients who need it
- GPs empowered to explore other options for obtaining the professional advice and support they need to care for their patients' health needs
- All elective care is given within agreed referral and clinical policies

### **What will success look like?**

NHS Cambridgeshire and local GPs working in partnership to target the demand for elective care to those patients whose health needs require it. As a result, we will have a sophisticated referral management system in place during 2010/11 which will continue to evolve. From 2011/12, we anticipate that the Primary Care Commissioning Clusters be responsible for and lead the new referral management process.

### **How will we measure success?**

We will agree key success measures as part of the detailed delivery plan for this initiative. However, key metrics are likely to include:

- Elective referral rates per 10,000 weighted population
- Elective inpatient activity (general and acute) rates per 10,000 weighted population
- Patient complaints and patient survey data

### **What needs to be resolved for this to happen?**

- A joint approach between local GPs and NHS Cambridgeshire to referral management
- A better and more detailed understanding of the dynamics of the referrals process
- Agreement on the elective clinical pathways which should be retained and/or transformed

## Strategic Change Programme 3: Sustainable Supply Side

### Why Change?

There are several reasons why we need to look again at the current range and pattern of services across Cambridgeshire.

#### **The current pattern of care will become unaffordable**

There has been underlying growth in the amount of money we spend on acute hospital care in recent years. This has placed significant pressure on our finances, which will get worse in the years to come if these trends continue. We need to stabilise this position as quickly as possible, so that we can create an appropriate environment in which to build our new commissioning system.

#### **The provider landscape is already changing**

For example, the future of Hinchingsbrooke Hospital is being shaped by means of a major procurement for an operating franchise, led by NHS East of England. This is intended to result in a new organisation taking over the day-to-day running of the hospital. This organisation will pay a fee which will be used to pay off a proportion of the hospital's historic deficit.

We are also looking at options for the future for our provider arm, Cambridgeshire Community Services. These include becoming a 'stand alone' NHS trust, or integration with another provider.

#### **We need existing and potential providers to become more innovative and to offer alternative pathways**

Over the next five years, we will need all providers – both existing and potential – to be bold and radical in developing new approaches to providing care. For example, we know that we could make far greater use of enabling technologies that allow experts based in hospitals to help to manage people's care remotely.

However, to enable us to address each of these issues in a considered fashion, we need to take a range of measures designed to create a period of stability, so that we can introduce the changes needed and live within our means.

### **What do we intend to do about it?**

We are currently discussing changes to elements of the 'payment by results' system with our main hospital providers. Under payment by results, hospitals are rewarded for activity undertaken and, as a result, are strongly incentivised to increase their capacity and attract additional work. While this was appropriate when our principal objective was reducing waiting times, it will not be sustainable in the more challenging financial environment we now face.

By agreeing to change elements of payment by results, we hope to re-balance risk and incentives between ourselves as commissioners and local hospitals as providers. For example, if hospitals are not paid at full price for activity above an agreed threshold, then there will be a powerful shared incentive to focus hospital services on those that need them most and to find alternative community based options.

In addition to making changes to payment by results, we will seek to use other contractual levers to build a period of stability. A key element of this is our work on clinical thresholds as part of our planned care initiative, but a second strand will be capping/containing activity that hospitals themselves generate such as out-patient follow up attendances, consultant to consultant referrals, conversion rates and excess bed days.

Finally, at present we pay a temporary subsidy to Hinchingsbrooke Hospital to support maternity services. Partly as a result of larger than anticipated increases in activity across the hospital, the Trust is now in a much stronger financial position. In recognition of this, we have already signalled that we intend to withdraw this premium payment from 2010/11.

We will also continue to:

- Work with NHS East of England to agree how best to maximise the benefits and opportunities arising from the operating franchise procurement at Hinchingsbrooke
- Work with Cambridgeshire Community Services to shape the future of the newly emerging organisation
- Use all of the levers available to ensure that we reap the benefits of increased competition and contestability and secure better patient choice and improved service quality

**How do we intend to deliver it?**

Short Term 2010/11	Medium Term 2011/12 to 2012/13	Long Term 2013/14 and beyond
<p>Seek to change elements of the Payment by Results system to stabilise our cost base. By changing the pattern of incentives, we can address the recent trend of steeply rising costs</p> <p>Use contractual levers to contain activity that is hospital generated, such as outpatient follow ups</p> <p>Stop paying a premium over and above tariff</p> <p>Support the Hinchingsbrooke franchise process to determine whether it will be possible to maintain the full range of services in a more challenging financial environment</p> <p>Work with Commissioning Clusters to agree priorities for market development and competition</p> <p>Encourage new and potential providers to develop innovative proposals for new ways of delivering patient care</p> <p>Develop clear plans for commissioning urgent care</p>	<p>Determine whether to continue with the change of elements of payment by results</p> <p>Implement the preferred option for sustaining selected services currently provided at Hinchingsbrooke Hospital</p> <p>Use the procurement process to introduce more competition and contestability into the health care market. This may mean providing support for new entrants to the market for a defined period of time to enable them to gain a foothold</p> <p>Together with the Commissioning Clusters, introduce measures to cut unit costs of treatment and care, for example, by reviewing selected patient pathways and finding alternative ways of providing them with the same quality of care for less cost</p> <p>Work with Commissioning Clusters to agree priorities for market development and competition</p>	<p>Commission an external review of the health care market to assess the extent of sustainability of service provision and whether best value for money is being obtained</p> <p>Support consolidation of providers and segmentation of services to create balance and sustainability in the health economy</p>

### **What do we hope to achieve from this change?**

- A period of financial stability
- A sustainable network of service provision across the County with sufficient plurality, competition and contestability
- Incentives for over-performance removed
- A more sophisticated commissioning and contracting framework led and managed by the new Primary Care Commissioning Clusters

### **What will success look like?**

We will have a more balanced range of services provided across primary, community and acute hospital care settings which are affordable and sustainable.

### **How will we measure success?**

We will agree key success measures as part of the detailed delivery plan for this initiative. However, key metrics are likely to include:

- Patient satisfaction
- Gap between planned and actual activity levels
- Clostridium Difficile rate per 1000 bed days in patients aged 2 and over (World Class Commissioning Outcome Metric)

### **What needs to be resolved for this to happen?**

- Acceptance by service providers of the temporary change to elements of the Payment by Results system during a time when national tariffs are being reduced;
- Greater clarity on whether it will be possible to continue to commission the current range of hospital services from Hinchingbrooke Hospital in a more difficult financial environment

## Strategic Change Programme 4: Long Term Conditions

Last year's strategic plan set out an ambitious programme of service re-design, particularly around services for people with long term conditions. A programme of service reviews encompassing 19 clinical pathways was identified, with most of the review activity occurring in the first three years of that strategic period. In addition to service reviews, we also intended to re-commission some services.

### Why Change?

Improving services for people with long term conditions is always likely to be a priority, as so many people are affected by one or more condition, and caring for them costs the health service a great deal of money. However, the broader financial climate means that we now need to identify and prioritise those conditions where the evidence is strongest that making changes will improve service quality and save money.

Other reasons to change our approach at this point include:

- A significant proportion of people being seen in hospital have a long term condition, and there is good evidence that more proactive community based care would be more appropriate
- We also need to be more ambitious on our priority areas: nationally and internationally, some commissioners are achieving a 50% shift of services away from hospital in favour of a community setting. By contrast, last year's strategic plan aimed for a 20% shift of services
- The cost of care is high – often higher than national average and peer comparators, while our prevalence is average e.g. Diabetes / Endocrine. The table below illustrates this
- The NHS Productivity Potential and NHS Comparators show potential savings in NHS Cambridgeshire from moving to top quartile for emergency admissions for chronic obstructive pulmonary disease, diabetes complications, and heart failure. The conditions have been identified as those where community care can avoid the need for hospitalisation.
- The NHS Institute for Innovation and Improvement Opportunity Locator shows that NHS Cambridgeshire has a shift potential by reducing the number of avoidable emergency admission for heart disease, COPD, stroke, diabetes, asthma and epilepsy and hypertension

Category	07/08 NHSC level	07/08 national average	% from avg	07/08 cluster* avg	% from cluster avg	NHSC CAGR (04/5-07/8)	National CAGR (04/5-07/8)
Spend (£m per 100,000 population)	£5.6m	£3.9m	43%	£4.3m	31%	20.40%	7.30%
Activity (admissions per 100,000 population)	329	327	1%	294	12%	-1.54%	4.58%
Outcome (prevalence of diabetes per 100,000 population)	4,198	4,119	1.9%	-	-	4.70%	5.39%

\*Cluster is defined as Prospering Southern England PCTs: Mid Essex, Oxfordshire, Buckinghamshire, Surrey, West Kent, West Hertfordshire and Berkshire West

- Our current planning cycle is taking too long to implement and is proving to be a frustrating experience for those leading service re-design, clinicians and patients.
- We currently have too many initiatives underway, which slows progress.

### What do we intend to do about it?

In our review we have considered the population burden of disease, the effectiveness of interventions and the opportunity for productivity. As a result of this review, we intend to:

- Focus on three clinical pathways and apply an “industrial scale” approach to service transformation. The priority is given to Diabetes and Chronic Obstructive Pulmonary Disease along with Stroke Care, where pathway redesign is at an advanced stage. Our pathways can be better, safer and cheaper
- Pilot the use of the combined model for risk stratification, working with selected GP practices. Targeting interventions to patients according to predictors of high utilisations of hospital services enhances opportunities for savings of long term costs. The combined risk tool identifies those at high risk, particularly those with heart failure. Interventions to improve care co-ordination or integration are likely to improve quality of care, but are much less likely to reduce costs. The strongest evidence for cost reduction comes for patients with heart failure
- Continue our background work to review pathways for people with dementia, stroke and dermatological conditions and heart failure
- Continue with the remainder of clinical pathway reviews and their re-commissioning as set out in last year’s Plan but with a lower priority and longer time scale

**How do we intend to deliver it?**

Short Term 2010/11	Medium Term 2011/12 to 2012/13	Long Term 2013/14 and beyond
<p>Start with Stroke Care and aim to have new pathways implemented before the end of 2010/11</p> <p>Work up service specifications for Diabetes and Chronic Obstructive Airways Disease</p> <p>Ensure that this work is explicitly led by Primary Care clinicians who are supported with the appropriate expertise and resources</p> <p>Pilot the use of the Combined Model tool for risk stratification on patients, including heart failure</p> <p>Evaluate the costs and benefits of the different tools that exist to ensure that we invest in and implement the appropriate tools in the appropriate conditions</p> <p>Re-focus the work of the clinical re-design team to give these three pathways the highest priority and ensure that the associated resources for procurement and contract management are in place to assist</p> <p>Apply professional programme management techniques to ensure that the individual projects within this programme are managed to time and budget</p> <p>Agree the specific performance and clinical quality outcomes we seek to achieve for the service</p>	<p>Complete an interim evaluation of Stroke Care, in conjunction with LInKs</p> <p>Implement Diabetes and Chronic Obstructive Airways Disease pathways</p> <p>Review our acute hospital capacity and cost assumptions and plans – adjust in the light of the changes achieved</p> <p>Review remaining pathways from last year's strategy to identify candidates for further industrial scale change, including dementia, dermatology and heart failure.</p>	<p>Re-profile our commissioning budgets and long range plans accordingly</p> <p>Commission an external evaluation of the change programme and benefits to patient care</p>

### **What do we hope to achieve from this change?**

- Clinicians are at the forefront of service transformation and are adequately resourced to do this effectively
- Significantly reduce avoidable hospital admissions
- All services have detailed and clear service specifications with health outcomes identified explicitly and performance managed through service contracts with providers
- All services are clinically safe, affordable and designed to meet best prevailing clinical and organisational practice

### **What will success look like?**

Patients with long term conditions will receive as much care as clinically appropriate close to their home. From the start of their care and throughout their clinical journey, they will have one point of contact, a care keyworker, who will co-ordinate the components of their care pathway with the various care agencies. This will ensure that the patient receives a seamless service. Acute hospital care is provided to those who need it and there is sufficient capacity to ensure that access is swift and timely. Pathways will be safer, better and less costly.

### **How will we measure it?**

We will agree key success measures as part of the detailed delivery plan for this initiative. However, key metrics are likely to include:

- The percentage of patients with diabetes who have an HbA1c of 7.5 or less (World Class Commissioning Outcome Metric)
- Directly standardised admission rates per 100,000 population for bronchitis, emphysema and other chronic obstructive heart disease (World Class Commissioning Outcome Metric)

### **What needs to be resolved for this to happen?**

- Establishment of the Programme Management Office and associated programme governance structure
- All service re-design projects to be reviewed in detail and re-prioritised

- Communications plan produced and publicised to ensure that patients and the public are aware of why we are making these changes
- Identification of potential for double running costs during the period of transition and how these would be funded. For example, patients will already be waiting on a hospital waiting list and will need to be seen whilst the service changes are being made
- Provision of training and support arrangements for staff in the front line of change
- Building capacity in Primary Care and promoting self care

## Strategic Change Programme 5: Prevention

### Why Change?

In recent years, the public health focus has been on achieving targets for improving health and on reducing health inequalities. These objectives remain the core purpose of preventive work. However, the prospect of severe public sector financial constraint over the coming years requires a shift of emphasis towards those preventive activities most likely to reduce cost pressures on health and social services in the short to medium term.

As the population ages, the number of people with long term conditions is increasing. Evidence is accumulating on the potential for simple lifestyle changes to both improve health and reduce expenditure, such as increases in regular physical activity and giving up smoking. As an illustration, recent evidence from Norfolk, which has similar population characteristics as Cambridgeshire, has shown that 40-79 year olds with healthy lifestyle behaviours are less than half as likely to have a stroke over a decade than people with less healthy behaviours.<sup>1</sup>

Regional modelling studies predict that an increase in the effectiveness of tobacco control will result in short to medium term cost savings to the health system. This is chiefly due to the expected reduction in heart disease and can be demonstrated over a five year period. Other areas of public health activity are being subjected to similar scrutiny with the aim of prioritising those preventive interventions most likely to reduce cost pressures on the healthcare system in the short to medium term.

Cambridgeshire has some particular local issues which result in increased health and care costs. For example, in Fenland the rates of some adverse lifestyle factors and associated long term conditions like diabetes and heart disease are higher when compared with the rest of the county. Alcohol related hospital admissions are high in Cambridge City, Huntingdonshire and Fenland, as are rates of road traffic deaths and injuries in much of the county.

For many of these areas, preventive work is most cost effective when carried out in partnership with other agencies. The NHS can make some interventions but others (including interventions to reduce excessive alcohol consumption or dangerous driving) may be better led by the police or local authorities.

---

<sup>1</sup> Myint, Luben et al. Combined effect of health behaviours and risk of first ever stroke in 20040 men and women over 11 years' follow up in Norfolk cohort of EPIC prospective population Study. *BMJ* 2009; 338; b349

### What do we intend to do about it?

We will use the evidence available on tobacco control and smoking cessation to implement proven measures that will reduce health service costs over a five year period.

We will review evidence as it becomes available from the National Institute for Clinical Excellence and other sources on cost-saving preventive measures and will:

- ensure that existing contracts for preventive work and pathways for long term conditions are making full use of this evidence base and include a range of cost saving or highly cost effective initiatives
- evaluate preventive interventions carried out under contract for their effect on health service costs as well as on health outcomes. (This evaluation has already been built into the health trainer strategic initiative commissioned in 2009/10)

We will continue and strengthen work with partner agencies to develop and implement policies, initiatives and where appropriate joint posts or joint teams, which support preventive work.

Elements of partnership working are already strong in Cambridgeshire, and part of our strategic focus will be ensure that the local benefits of these partnerships are fully available to Primary Care Commissioning Clusters by creating efficient mechanisms for local engagement.

### How do we intend to deliver it?

Short Term 2010/11	Medium Term 2011/12 to 2012/13	Long Term 2013/14 and beyond
<p>Implement our strategy to further reduce smoking prevalence – using findings of regional scoping study</p> <p>Review evidence of likely effects on costs of health and social care services from preventive interventions – including interventions as part of long term conditions pathways</p>	<p>Continue to implement and evaluate preventive strategy, shifting resources to those areas of work with demonstrable positive effects on both health outcomes and health and social care costs</p> <p>Integrate workforce and resources across public agencies where this</p>	<p>Evaluate outcomes of preventive strategy, and build on successful aspects of workforce development, partnership and market development to ensure resources are focussed into the most effective interventions for both shorter term and long term health outcomes emphasising those programmes with the most favourable benefit to cost ratio for the</p>

<p>Develop an evidence based strategy for prevention in partnership with local authorities and other relevant agencies</p> <p>Evaluate the likely effects on health and health service finances of current initiatives to develop the workforce for prevention (health trainer initiative, Addenbrookes initiative) and adapt commissioning of services in response to this</p> <p>Encourage diversity in the market where this improves efficiency and outcomes</p> <p>Engage GP Commissioning Clusters in locality partnership working outside the NHS through developing focussed initiatives with clear objectives and outcomes</p>	<p>reduces duplication and achieves the most efficient outcomes</p> <p>Maintain a varied market of providers across sectors</p> <p>GP Commissioning Clusters strengthen engagement and leadership role in locality partnership arrangements</p>	<p>residents of the region</p>
---	---	--------------------------------

**What do we hope to achieve from this change?**

- Strong preventative work which will improve health outcomes and reduce health inequalities but will also help to address the financial challenges which the Cambridgeshire health system faces
- Maximise efficiency and cost effectiveness through joint preventative work with partner agencies, using a range of service providers
- Full engagement of local commissioning clusters in locality partnership working, with clear successes as a result

**What will success look like?**

- Further reductions in the numbers of people smoking in Cambridgeshire, with consequential reductions in use of health services in the short to medium term - as well as longer term improvements in health outcomes
- Higher priority for preventive interventions which have the potential to yield cost savings to the health service and in some cases wider society as well as improvement in health outcomes

- Integrated partnership working between Primary Care Commissioning Clusters and non-NHS partners, with demonstrable outcomes

### **How will we measure it?**

We will agree key success measures as part of the detailed delivery plan for this initiative. However, key metrics are likely to include:

- Rate of smoking quitters per 100,000 population aged 16 and over (World Class Commissioning Outcome Metric)
- Prevalence of obesity in year 6 children (World Class Commissioning Outcome Metric)

### **What needs to be resolved for this to happen?**

- A shift in emphasis in preventive work towards activities most likely to ease cost pressures on the health services, as well as improving health outcomes and reducing health inequalities in the longer term
- A change in culture amongst local providers and partners, so services evolve and flex to deliver 'what works' in terms of both health outcomes and finances
- Further understanding by Primary Care Commissioners of the 'win-wins' that can be generated by local partnership working

## **Strategic Change Programme 6: Getting more for every Pound spent**

### **Why Change?**

Our financial position is already stretched, principally as a result of higher than planned expenditure on our hospital contracts. This pressure will increase markedly after 2010/11, when we anticipate that we will no longer receive year on year increases in funding. As we have set out in this chapter, we believe that we need to make significant changes to both the way we commission and the way care is provided in order to meet this challenge.

However, in addition to the changes we have set out, we know that there are a number of areas where we could increase productivity and get better value for money. Although we do not believe that these 'pure efficiency' savings will be enough on their own to bridge the financial gap we are projecting, it is imperative that we drive out savings wherever we can. This will be key in stabilising our short term financial position while we make the key changes described in this chapter.

### **What do we intend to do about it?**

We have thoroughly reviewed national, regional and local data and intelligence to identify opportunities for improving productivity. The main areas we plan to address are set out in Appendix 6 but our work so far suggests that over the strategic period we could make savings of just over £41 million by targetting areas such as:

- managing acute activity and payment mechanisms
- prescribing and high cost drugs
- primary care and community service changes

In total, our plan sets out an expectation of saving just over £41 million during the strategic period.

### **What do we hope to achieve from this change?**

- Easing our short-term financial pressure
- Best value for money
- Better efficiency

**What will success look like?**

- We have a clear action plan with every initiative underpinned by strong delivery plans
- A sound financial platform from which we can operate and implement our new strategic agenda
- Best possible value for our investment
- Elimination of waste, inefficiency and a sharper focus on the initiatives that really matter

**What needs to be resolved for this to happen?**

- Visible leadership at every level of our organisation
- Clear mechanisms for tracking progress in delivering savings

## Delivering on our key commitments

Last year's Strategy set out a wide range of strategic goals and initiatives designed to meet national, regional and local priorities and within a context of a strategic investment fund each year. Since then, the strategic and financial context has changed dramatically – this means that our priorities need to change and we need to release organisational capacity to take forward our new priorities.

Following a series of intensive reviews, we have significantly reduced the number and range of ongoing commitments that we will undertake in this new Plan. The commitments that remain are primarily about fulfilling national and regional policy and meeting the health needs of our population. They are set out in Annex A and have been assessed using the Impact Assessment Criteria in Appendix 2.

They cover the following range of services areas, including:

Strategic Area	Services Covered	Notes
<b>Promoting Health and Preventing Disease</b>	<ul style="list-style-type: none"> <li>• Maternity Care</li> <li>• Children's Services</li> <li>• Addressing Health Inequality</li> <li>• Health Promotion / Disease Prevention</li> </ul>	
<b>Older People's health and care</b>	<ul style="list-style-type: none"> <li>• Older People's Services</li> <li>• Major Health Conditions</li> <li>• Mental Health</li> </ul>	Also covered in Strategic Change Programme 4: Long Term Conditions
<b>Safe, sustainable and affordable health services</b>	<ul style="list-style-type: none"> <li>• Developing the infrastructure and planning for new communities</li> </ul>	Included in Strategic Change Programme 3: Sustainable Supply Side
<b>Patient experience and customer care.</b>	<ul style="list-style-type: none"> <li>• Carers</li> <li>• Access to services</li> <li>• End of Life Care</li> </ul>	

## Reviewing our work programme

This plan covers a period which is likely to be turbulent for most public services. Given this, it will be important for us to keep our priorities under review, so that we are able to respond to changes and challenges that we are not yet able to foresee. We recognise that there are other important areas that we need to look at that are not covered by this plan, including urgent care. We are not yet in a position to lay out clear plans for urgent care, but are aware that we need to do so.

Earlier in the Plan (Headline 4), we identified that the population is ageing and that this would have an appreciable future impact on health and social care. One of the key commitments that we have taken forward into this new plan is the need to develop an integrated plan for Older People. This would build on the current Commissioning Strategy drawn up with Cambridgeshire County Council and informed by the work of the Cambridgeshire Care Partnership and other fora.

We will also seek to make best use of our Estate and will continue to work with our partners to ensure that there is a coherent strategic approach in place and that, where appropriate, economies of scale are achieved.

## Outcome metrics

As part of World Class Commissioning Assurance, all Primary Care Trusts are required to select a range of outcome metrics that they are reviewed against. In developing this revised plan, we have reviewed the metrics we selected last year to assess whether they remain relevant. As a result of this work, we have narrowed the range of indicators we are focussing on, in keeping with our determination to focus on a smaller number of high priority issues. We have also made some changes, to reflect the new direction set out in this plan.

Our revised indicators are:

- Health inequalities
- Life expectancy
- Clostridium Difficile rate
- Smoking quitters
- Prevalence of obesity in year 6 children
- Achieving independence for older people through rehabilitation and intermediate care
- Proportion of all deaths that occur at home
- Diabetes controlled blood sugar
- Admission rates from bronchitis, emphysema and other chronic obstructive pulmonary disease

These are summarised below; the numerical tables are attached in Appendix 3.

	Health Inequalities	Life Expectancy	Clostridium Difficile	Smoking Cessation	Obesity Prevalence in Year 6	Older People's Rehabilitation	Deaths at Home	Diabetes controlled Blood Sugar	Admission Rate due to COPD
New Commissioning System	✓	✓				✓	✓	✓	✓
Elective / Planned Care	✓	✓	✓				✓	✓	✓
Sustainable Supply Side	✓	✓	✓				✓		
Long Term Conditions	✓	✓		✓				✓	✓
Prevention	✓	✓		✓	✓				
Key Commitments	✓	✓	✓	✓		✓	✓		

✓ - Strategic Change Programme supports improvement in the chosen outcome

## Chapter 4. Improved Ways of Working

In this Chapter we give an overview of some of the wider actions we will need to take.

### Cambridgeshire first - working with our partners

One of Cambridgeshire's strengths is the excellent relationships that exist between the organisations responsible for planning and providing its public services. This has resulted in a high degree of integration, including services for older people, people with a learning disability and services for drug users.

Maintaining and further developing these relationships is a top priority for us, not least because we rely on one another in order to succeed. For example, we will not be able to fully progress our work on prevention without the active support of our partners.

Now, though, we all face a common challenge: preserving service coverage and quality in a prolonged period of financial constraint. We have agreed with our partners that we will do all we can to use this challenge as an opportunity to work even more closely together, critically examining what we all do, how we do it and how we can best use our combined resources, experience and skills.

More specifically, we have collectively designed a major programme called *Making Cambridgeshire Count*. This initiative, which involves hundreds of staff from nine of the key public organisations, was launched in September 2009 and is intended to generate bold and radical solutions which will enable public services to continue to flourish in the years to come.

Six 'inquiries' have been developed as part of the *Making Cambridgeshire Count* programme:

- How will we shift and use resources differently to tackle inequalities?
- How do we strengthen community cohesion and support new, growing and changing communities?
- How do we better work together as public services in new and innovative ways?
- How do we build on the strengths of Cambridgeshire, keeping the confidence and building the respect of our communities for the future?
- How can we motivate and support people in our communities to help us find new ways of delivering services that meet their needs and to help communities to help themselves?
- How can we meet the needs of a growing population if we have less money?

The recommendations from each of these inquiries are currently being considered, and senior representatives of the nine main bodies will determine which of these are developed into specific proposals during the early part of 2010.

Although we are awaiting further detail on the proposals that will be taken forward, we are committed to building on *Making Cambridgeshire Count* to develop new ways of working. In particular, we are keen to work with our partners to find ways of organising the commissioning and provision of services at a more local level. One example of this could be to expand the remit of a Primary Care Commissioning Cluster to encompass a broader range of services, such as social care. Another might be to identify a particular geographic area and designate a single 'lead' commissioner for public services that pulls together resources from a number of agencies, including our own. In addition, we are drawing up a comprehensive Estates and Assets Strategy which will have clear synergy with the work around joint asset management and back office functions.

These ideas will be developed throughout 2010 and we are absolutely committed to continuing to play a leading role.

### Information for commissioning

We do not yet have at our fingertips the information we need to be able to operate as world class commissioners. For example, at present we are not able to track in real time the contact individuals in Cambridgeshire have with the various health services that we commission. This causes us several difficulties, including:

- making it more difficult for us to be an information-led organisation
- limiting the insight we have into individual's health needs
- making it difficult for us to detect patterns or trends
- assessing whether or not people are using services that best meet their needs
- making anticipating future costs problematic
- making it more difficult for us to plan future services

We are not alone in this; most Primary Care Trusts across the country are in a similar position. Rolling out the National Programme for Information Technology across Cambridgeshire (for example, Summary Care Records) will help but will not fully resolve our information deficiencies.

As a result, we have agreed that this is a key issue that we need to address within the five year time frame of this strategic plan. To enable us to do this, we will develop a work programme which sets out:

- What an 'ideal' or gold standard commissioning information set might look like, including explicitly defining the information we require at each stage of the commissioning cycle
- Mapping how far away we are from that model at present, and what the key gaps are
- Assessing the extent to which rolling out the National Programme for Information Technology will help
- Developing costed options for filling identified gaps

This is clearly a major challenge. However, we are in a fortunate position in Cambridgeshire as a number of world-leading information and Information Technology companies have their U.K. bases here. We are keen to see whether we can make use of this local resource and plan to approach relevant organisations, in order to assess the potential of forming a collaborative venture.

There are also more immediate steps we will take, including:

- Ensuring that we strengthen our contracts with service providers by being more explicit about our information requirements
- Continuing to roll out System 1 and Lorenzo
- Introduce improved analytical tools and methodologies, including the use of Sharepoint
- Implement the East of England-wide Acute Invoice Validation system, which we manage on behalf of all 14 Primary Care Trusts
- Establish an information portal with local authorities to support the joint strategic needs assessment
- Ensuring that as part of our Organisational Development Plan, we continue to develop a culture that is information and intelligence led

## **Delivery – how we will ensure that our plans are implemented**

Our review of the progress we have made in implementing our previous strategic plan revealed a mixed picture. One reason why we have not made consistent progress is that we do not yet have a comprehensive or fully embedded approach to delivery. Addressing this shortcoming is a priority, and we have already started work on designing new delivery arrangements that will be implemented from early 2010. There are three main components to our approach:

### **Differentiating projects from ‘business as usual’**

In reviewing our progress, we have learned that there is insufficient clarity internally between activities that are projects, which tend to have a clearly definable outcome and are time-limited, and those activities which relate more to the day-to-day operation of our organisation, such as contract management.

This lack of clarity has made it difficult to apply a consistent approach to project management. Our first priority, therefore, is to agree the portfolio of projects that will fall within the remit of the Programme Management Office (see below).

### **Implementing a single approvals process for all project approval**

A second weakness we have identified in our current process is that there is more than one ‘entry point’ for new projects. This creates a number of difficulties, including:

- A risk that too many projects are agreed, diluting organisational focus on the top priorities
- Projects are not always evaluated against consistent criteria
- Opportunity costs are not always visible

To address this, we are developing a single process for evaluating all project proposals. Standard documentation will be used to ensure that all proposals are presented consistently and include all of the information required for proposals to be assessed against our agreed prioritisation criteria.

### **Establish a formal Project Management Office (PMO)**

We plan to introduce a formal 'interim' PMO in January 2010. Initially, this will focus on a number of the highest priority projects included in this plan, and the learning from this early work will inform the roll out of the 'full' PMO later in the year. The key functions of the PMO will be to:

- Agree the relative priority of each project
- Develop monitoring arrangements that are proportionate
- Ensure that there is clear accountability for each project
- Monitor the progress of individual projects
- Diagnose problems with projects and recommend appropriate remedial actions
- Report progress internally and to the Board

Each of these elements will be underpinned by a suite of standard documentation. To ensure that there is complete transparency about the status of every project, we plan to share all documentation and reports through Sharepoint.

## Chapter 5. Financial and Activity Plan in more detail

In this Chapter, we set out in more detail our financial and activity plans which demonstrate how we intend to live within our means and show the impact of the six Strategic Change Programmes.

### Producing the Base Case

In the Government's last comprehensive public spending review, NHS Cambridgeshire was notified of the uplift to our financial resources for 2009/10 and 2010/11. We have received notification from the Department of Health of how our resources are expected to change for future years. We have updated our financial planning accordingly. These factors will affect our plans for expenditure. In addition, growth in acute hospital activity will affect expenditure and we have analysed the trend in activity and estimated how this could change in the future. However, as forecasting is prone to unpredictability we have modelled several financial scenarios, in order to assess the potential size of the financial gap which we will need to address through our strategic change programmes. The result of this modelling has been narrowed down to three financial scenarios, included in Appendix 4.

These are:

- **The Base Case**, this is considered the most likely scenario
- **Scenario 1**, this is the worst case; and
- **Scenario 2**, the best case

The table below details the assumptions used to build up each of the three scenarios. These assumptions were guided by NHS East of England.

Assumptions used in financial scenarios	Base Case %	Scenario 1 (Worst) %	Scenario 2 (Best) %
<b>Resource Uplift</b>			
2010/11	6.5	6.5	6.5
2011/12 Onwards	0.0	0.0	2.5
<b>Provider Uplift</b>			
2010/11 (including 1% CQUIN)	1.0	1.0	1.0
2011/12 Onwards	(2.0)	(1.5)	(1.0)
<b>GP Prescribing</b>	5.0	5.0	5.0
<b>Primary Care</b>			
2010/11	0.0	0.0	0.0
2011/12 Onwards	1.0	1.0	1.0
<b>Dental</b>			
2010/11	0.0	0.0	0.0
2011/12 Onwards	0.2	0.2	0.2
<b>Non NHS</b>			
2010/11	0.0	0.0	0.0
2011/12 Onwards	0.0	0.5	(0.5)
<b>PCT Support Costs</b>			
2010/11	0.0	0.0	0.0
2011/12 Onwards	0.0	0.0	0.0
<b>Activity Increases</b>			
Population growth	1.4	1.4	1.4
Activity Increase above population	3.6	5.6	1.6
Case mix / Acuity	1.0	2.0	0.0

The size of the possible financial gap over the strategic period ranges from a worst case of £156 million to a best case surplus of £22 million with a gap of £97 million (the base case) being the most likely.

The table below shows the base case which identifies a gap of £97 million over the strategic period. 2009/10 shows a balanced financial position but there is an underlying recurrent deficit of £11.3 million. Therefore, there is a difference between the 2009/10 total spend and 2010/11 baseline expenditure of £10.1 million. The remainder of the underlying deficit is due to reduction in non

recurrent resources. As explained in the assumptions above, deflation rather than inflation figures are shown in the later years of the plan.

	2009/10	2010/11	2011/12	2012/13	2013/14
The Base Case	Total	Total	Total	Total	Total
	£'000	£'000	£'000	£'000	£'000
Baseline Expenditure	754,571	817,528	877,693	900,270	924,210
Inflation including CQUIN	14,127	10,418	(6,652)	(6,047)	(5,928)
Investments	38,690	48,747	28,229	29,987	35,298
Strategic Change Programmes		1,000	1,000		
<b>Total Expenditure</b>	<b>807,388</b>	<b>877,693</b>	<b>900,270</b>	<b>924,210</b>	<b>953,580</b>

<b>Debt Repayment</b>	<b>9,000</b>	<b>9,000</b>	<b>9,000</b>	<b>8,000</b>	<b>0</b>
-----------------------	--------------	--------------	--------------	--------------	----------

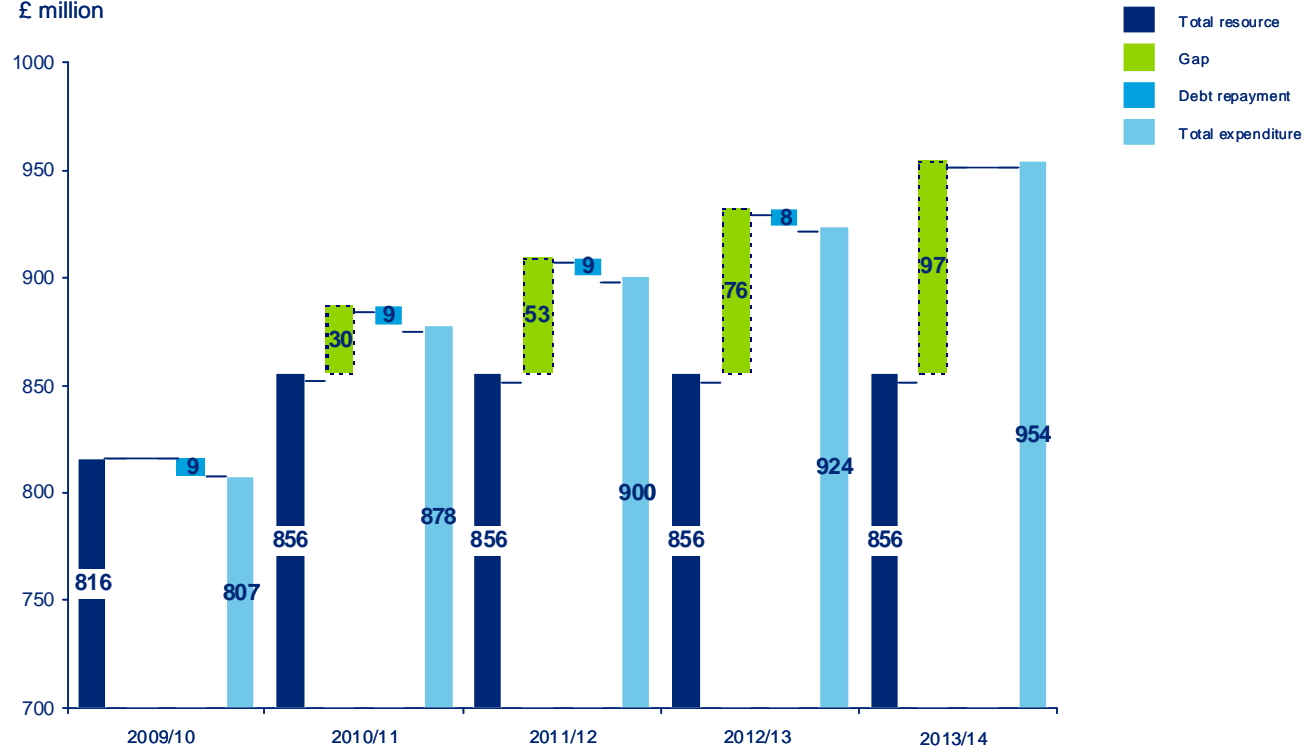
<b>Resources</b>	<b>816,388</b>	<b>856,461</b>	<b>856,461</b>	<b>856,461</b>	<b>856,461</b>
<b>Financial Gap</b>	<b>0</b>	<b>(30,232)</b>	<b>(52,809)</b>	<b>(75,749)</b>	<b>(97,119)</b>

As can be seen above, we have identified £1million in financial years 2010/11 and in 2011/12 in order to pay for the transitional and implementation costs whilst we are implementing our strategic change programmes. This is a temporary investment for a two year period, after which time we expect the strategic change programmes to be self-financing. The exact costs of the change programmes will be determined as part of the detailed delivery planning for each initiative. If these exceed £1m, we will seek to accelerate progress with Strategic Programme 6 – getting more for every Pound spent – in order to release additional funds.

The waterfall diagram overleaf illustrates the financial challenge faced under the Base Case Scenario.

**NHSC financial projections 2009/10 - 2013/14**

£ million



**How we are going to close the financial gap**

From a financial perspective, there are two approaches to closing the financial gap through the strategic change programmes. The first is to implement a range of 'pure efficiency' initiatives which will enable us to get better productivity from our existing system. This is Strategic Change Programme 6.

The table below summarises these initiatives showing the most likely savings scenario. However, these are provisional at this stage; the exact savings in each area will be determined as part of the detailed delivery plan for each initiative.

	2010/11	2011/12	2012/13	2013/14
<b>Getting more for every pound spent</b>	<b>Total</b>	<b>Total</b>	<b>Total</b>	<b>Total</b>
	<b>£'000</b>	<b>£'000</b>	<b>£'000</b>	<b>£'000</b>
Acute	6,692	8,067	8,442	9,522
Prescribing	4,500	9,000	10,000	11,000
Primary Care	1,650	3,033	3,666	4,900
Mental Health	600	2,400	2,400	2,400
Community	1,500	3,000	4,500	5,760
Dentistry	475	950	950	950
High Cost Placements	860	1,790	1,790	1,984
Back Office	0	750	750	750
Re-commissioning	1,626	2,362	3,672	3,982
<b>Total Getting more for every Pound spent</b>	<b>17,903</b>	<b>31,352</b>	<b>36,170</b>	<b>41,248</b>

We have scoped the maximum and minimum savings that could be achieved under these initiatives and the detail of these and the most likely scenario is attached in Appendix 6. This shows a savings range of £23 million to £62 million with £41 million being the most likely scenario.

The second approach to closing the financial gap is to implement the major transformational changes described in chapter 3 of this plan:

- Strategic Change Programme 1: New Commissioning System
- Strategic Change Programme 2: Elective / Planned Care
- Strategic Change Programme 3: Sustainable Supply Side
- Strategic Change Programme 4: Long Term Conditions
- Strategic Change Programme 5: Prevention

Activity modelling has been undertaken in order to assess the impact of the strategic change programmes under each financial scenario. In summary, the activity changes proposed fall into two main categories:

- Acute activity that we believe can be stopped or managed in primary care within existing resources
- Acute activity that can be transferred to a lower cost setting

We anticipate our Strategic Change Programmes will result in financial savings in areas other than activity. For example, our new commissioning model should result in reduced prescribing costs. However, as more work will be required to anticipate the extent of such savings, they have not been included in this plan.

For Strategic Change Programme number 3, no activity change has been assumed, but rather a reduction in the price paid for non-elective acute activity above the levels recorded for 2009/10. The table below shows the possible activity reductions and financial savings identified.

STRATEGIC CHANGE PROGRAMMES	Activity Reductions				Savings			
	2010/11	2011/12	2012/13	2013/14	2010/11 £'000	2011/12 £'000	2012/13 £'000	2013/14 £'000
<b>Strategic Change Programme 1</b>								
<b>Reduction in Activity</b>								
Outpatients	7,849	20,196	43,543	80,325	742	2,021	4,770	8,571
Electives	1,051	2,994	6,574	12,103	1,228	3,081	7,474	13,323
A&E	0	805	5,043	11,707	0	73	450	1,023
Non Electives	171	835	2,859	5,976	192	736	2,874	5,884
<b>Sub Total</b>	<b>9,071</b>	<b>24,830</b>	<b>58,019</b>	<b>110,111</b>	<b>2,162</b>	<b>5,911</b>	<b>15,568</b>	<b>28,801</b>
<b>Transfer of activity to less costly alternatives</b>								
Outpatients	1,944	2,743	5,278	12,759	90	154	383	1,128
Electives	117	347	911	2,234	168	461	1,195	2,595
A&E	290	908	3,471	3,645	27	83	309	318
<b>Sub Total</b>	<b>2,351</b>	<b>3,998</b>	<b>9,660</b>	<b>18,638</b>	<b>285</b>	<b>698</b>	<b>1,887</b>	<b>4,041</b>
<b>Strategic Change Programme 1</b>	<b>11,422</b>	<b>28,828</b>	<b>67,679</b>	<b>128,749</b>	<b>2,447</b>	<b>6,609</b>	<b>17,455</b>	<b>32,842</b>
<b>Strategic Change Programme 2</b>								
<b>Reduction in Activity</b>								
Outpatients	23,196	33,547	46,313	52,213	2,557	3,420	5,093	5,575
Electives	3,420	5,040	6,989	7,872	4,110	5,333	7,999	8,687
<b>Strategic Change Programme 2</b>	<b>26,616</b>	<b>38,587</b>	<b>53,302</b>	<b>60,085</b>	<b>6,667</b>	<b>8,753</b>	<b>13,092</b>	<b>14,262</b>
<b>Strategic Change Programme 3</b>								
<b>Temporary changes to Payment by Results</b>								
Non Electives					3,215	5,919	8,476	7,791
<b>Strategic Change Programme 3</b>					<b>3,215</b>	<b>5,919</b>	<b>8,476</b>	<b>7,791</b>
<b>Strategic Change Programme 4</b>								
<b>Transfer of activity to less costly alternatives</b>								
Outpatients		469	1,472	2,572		75	232	401
Electives		8	26	43		9	26	43
Non Electives		35	115	210		92	298	533
<b>Strategic Change Programme 4</b>		<b>512</b>	<b>1,612</b>	<b>2,826</b>		<b>176</b>	<b>556</b>	<b>977</b>
<b>Strategic Change Programme 5</b>								
Prevention	No activity reductions or savings projected within timescale of strategy							
<b>TOTAL</b>	<b>38,038</b>	<b>67,927</b>	<b>122,593</b>	<b>191,660</b>	<b>12,329</b>	<b>21,457</b>	<b>39,579</b>	<b>55,872</b>

We anticipate that there will be substantial savings as a result of our work on long term conditions. However, as the detailed delivery plans for our priority areas – COPD and Diabetes – are not yet complete, we have only included conservative estimates at this point.

The table below shows the impact of these savings on the £97 million financial gap identified in the base case.

Closing The Gap	2010/11	2011/12	2012/13	2013/14
	Total £'000	Total £'000	Total £'000	Total £'000
<b>Base Case Financial Gap</b>	<b>(30,232)</b>	<b>(52,809)</b>	<b>(75,749)</b>	<b>(97,119)</b>
<b>Getting More For Every Pound Spent</b>	<b>17,903</b>	<b>31,352</b>	<b>36,170</b>	<b>41,248</b>
<b>Gap After Getting More For Every Pound Spent</b>	<b>(12,329)</b>	<b>(21,457)</b>	<b>(39,579)</b>	<b>(55,872)</b>
<b>Strategic Change Programmes</b>				
New Commissioning System	2,447	6,609	17,455	32,842
Optimise Elective Pathways	6,667	8,753	13,092	14,262
Sustainable Supply Side	3,215	5,919	8,476	7,791
Industrial scale approach to Long Term Conditions		176	556	977
	<b>12,329</b>	<b>21,457</b>	<b>39,579</b>	<b>55,872</b>
<b>Remaining Gap</b>	<b>0</b>	<b>(0)</b>	<b>(0)</b>	<b>0</b>

As can be seen from the table, if these initiatives are successfully implemented, we will have a balanced financial plan for each year of the strategic period.

### Reviewing the Three Financial Scenarios

The impact of the three scenarios used to identify the possible size of the financial gap is shown below; the scenarios range from a surplus of £22 million to a worst case deficit of £156 million. The table overleaf shows the gap identified in the three financial scenarios and the effect achieving the maximum, minimum and most likely efficiency savings would have on the scenarios. If the worst case scenario were to happen resulting in a financial gap of £156 million to close then, in order to achieve financial balance, we would need to:

- Achieve the maximum efficiency savings identified in “Getting more for every Pound spent”; and
- Nearly double the activity reductions planned in the strategic change programmes

If the best case scenario were to happen, we would be in a position to work with commissioning clusters to agree priorities for investment, guided by our agreed criteria.

Closing The Gap For The Three Scenarios	Base Case				Scenario 1 (Worst case)				Scenario 2 (Best Case)			
	2010/11 Total £'000	2011/12 Total £'000	2012/13 Total £'000	2013/14 Total £'000	2010/11 Total £'000	2011/12 Total £'000	2012/13 Total £'000	2013/14 Total £'000	2010/11 Total £'000	2011/12 Total £'000	2012/13 Total £'000	2013/14 Total £'000
<b>Cumulative Gap</b>	(30,232)	(52,809)	(75,749)	(97,119)	(41,369)	(79,702)	(118,577)	(156,343)	(9,919)	(1,955)	14,708	22,171
	<b>Most Likely</b>				<b>Maximum Savings</b>				<b>Minimum Savings</b>			
<b>Getting More For Every Pound Spent</b>	17,903	31,352	36,170	41,248	28,394	48,698	57,151	62,105	10,719	18,499	21,729	23,426
<b>Remaining Gap</b>	(12,329)	(21,457)	(39,579)	(55,872)	(12,975)	(31,004)	(61,426)	(94,238)	800	16,544	36,437	45,597
<b>Strategic Change Programme</b>	<b>Most Likely</b>				<b>Maximum Savings</b>				<b>Minimum Savings</b>			
New Commissioning System	2,447	6,609	17,455	32,842	2,447	7,336	20,303	50,807	1,816	4,141	10,242	17,994
Optimise Elective Pathways	6,667	8,753	13,092	14,262	5,527	14,285	27,382	30,335	1,744	3,336	4,299	4,698
Sustainable Supply Side	3,215	5,919	8,476	7,791	5,002	9,207	13,185	12,119	1,429	2,631	3,767	3,463
Industrial scale approach to Long Term Conditions	0	176	556	977	0	176	556	977	0	176	556	977
<b>Total Big Ideas</b>	<b>12,329</b>	<b>21,457</b>	<b>39,579</b>	<b>55,872</b>	<b>12,976</b>	<b>31,004</b>	<b>61,426</b>	<b>94,238</b>	<b>4,989</b>	<b>10,284</b>	<b>18,864</b>	<b>27,131</b>
<b>Remaining Gap</b>	<b>0</b>	<b>(0)</b>	<b>(0)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(0)</b>	<b>5,789</b>	<b>26,828</b>	<b>55,301</b>	<b>72,728</b>

In conclusion, we are facing a significant financial challenge with a financial gap of nearly £100 million. Strategic change programmes have been identified in order to close this gap. Implementing these programmes will require major changes in the way that we work as an organisation. The risks associated with the changes are summarised in Chapter 6.

## Chapter 6. Governance

In this Chapter, we explain how we drew up the Strategic Plan and present a summary of the major strategic risks.

### How we drew up our Strategic Plan

NHS Cambridgeshire Board has led the formulation of the Strategic Plan through:

- The establishment of a Strategy Committee comprising Non Executive and Executive Directors and led by the PCT Chair
- Encouraging and providing robust challenge and scrutiny of strategic thinking through board development sessions, one-to-one meetings and email group correspondence

The Board has also been keen throughout to ensure that there has been sufficient involvement and engagement. In the following section, we have described how this was achieved.

### Participation and Involvement

#### Working in Partnership with our Key Stakeholders

Over the past months, we have worked closely with our key stakeholders to work through the strategic challenges ahead and ensure that our strategy takes their views into account. Examples of how we have undertaken this include:

- Holding a major conference (entitled *The Storm Scenario*) in June 2009 with over 70 leaders and opinion shapers within Cambridgeshire to facilitate wide-ranging discussion and to agree the areas for further consideration in our strategic planning. We held a smaller summit meeting of key decision-makers in July 2009 to identify in more detail potential strategic changes which could be considered for implementation together. This included input from the Director of Adult Services to ensure that the strategic agenda for Older People's care could be aligned where relevant
- Full and active contribution to the work of the Cambridgeshire Together Board, Cambridgeshire Care Partnership, Community Well-Being Partnership and the various strategic thematic partnership groups within the County to ensure that we play our part in taking forward county-wide and district-wide priorities
- Joint Top Team meetings (executive and non executive) with Cambridgeshire County Council to ensure alignment of strategic thinking across the NHS and Local Authority

- Holding a workshop in November 2009 to agree the Impact Assessment Criteria to ensure that we could assess and prioritise the ideas set out in our Plan. Taking an active part in *Making Cambridgeshire Count* which is led by Cambridgeshire County Council
- Meetings with all our existing and some potential providers

### **Working in Partnership with our Staff**

We were very keen to involve our staff in generating the ideas put forward in this Plan and to make sure that they knew how the strategic review programme was progressing and had the opportunity to contribute. Examples of how we have undertaken this include:

- Attending each directorate team meeting with a specific slot on their agenda
- Setting up a dedicated email account which staff could use to send their ideas, concerns and suggestions
- Holding a 'Big Ideas' workshop for staff in November 2009 led by external facilitators
- Using the Staff Newsletter at the initial stage to introduce the review programme
- Offering opportunities for one to one informal discussions with the Director of Strategy & Delivery

### **Working in Partnership with our Clinicians**

Examples of how we have undertaken this include:

- Holding several 'Big Conversation' meetings with key Primary Care leaders and opinion-shapers during October and November 2009 to explore the potential of the changes to the commissioning system set out in Strategic Change Programme 1
- Attending the Professional Executive Committee to brief them and to elicit their ideas and concerns
- Attending Practice Based Commissioning events and seminars
- Offering opportunities for one to one informal discussions with the Director of Strategy & Delivery

### **Working in Partnership with our Patients and Public**

Fortunately, we were able to benefit from the outcomes of the 13 week public consultation on last year's strategy. This proved to be an invaluable source of information and it provided useful pointers to what is seen to be important by local people. We are committed to engaging our patients and members of the public once again as we launch this new Strategic Plan.

### The Major Strategic Risks

We have undertaken a high level review of the major strategic risks. More detailed work will be undertaken during the operational planning stage to ensure that we are able to identify and put in place a more detailed mitigation plan.

Strategic Area	Potential Risk	Mitigated by
<b>New Commissioning System</b>	NHS Cambridgeshire will not be legally permitted to delegate real money to GP Commissioning Clusters	Legal advice sought at earliest proposal stage and checked before plans are formally approved
	GPs do not want to participate in the new system	Close working with GPs to ensure that all concerns are identified and addressed effectively. New system phased in over a period of time with evaluation of early schemes Required management infrastructure put in place to support GPs Incentives linked to good performance and targeted at direct benefits to patients
	Clusters may not have the purchasing power when dealing with major service providers who have a large catchment area	Clusters will be able to form consortia and join with NHS Cambridgeshire staff for this purpose
	We may not be able to afford this development	Short term investment has been identified to cover the transitional and set up costs of implementing the new system. Thereafter, the system will become self-financing
<b>Elective / Planned Care And Long Term Conditions</b>	The scale of transformation may not be as large as proposed	The number of patients with long term conditions is growing as is the uptake of acute hospital care. Recorded activity covers only a proportion of people whose lives could benefit from service transformation. The potential benefit identified in the Plan is feasible  The Plan deals only with three top clinical conditions. There are nearly 20 clinical pathways to be covered during the term of the plan
	Referrals to and uptake of elective care	Implementation in 2010/11 of a new referral management

	continue to increase	system, led by clinicians Where necessary, work with individual practices to understand the dynamics of the referral process. Work with acute hospital providers to identify the opportunities for changing referral pathways and service patterns
	Elective care is provided outside of agreed clinical policies	No payment will be made to the service provider
<b>Sustainable Supply Side</b>	Providers may not agree to temporary changes to elements of the Payment by Results System	Close working with providers to ensure that all concerns are identified and addressed effectively  Work together to identify the longer term benefits to both parties as a result of implementing the new changes
	The balance of services provided under Option 2 at Hinchingbrooke Hospital is unsustainable	The Option 2 programme has been reviewed and refreshed in the light of recent experience. It is based on more timely information and recognises the progress made to date since the original public consultation
	The benefits of increased competition and contestability are not realised	Working with NHS East of England, the latest thinking and approach will be applied to market development and this will be managed to implementation as a formal project overseen by the Programme Management Office
<b>Getting more for every Pound spent</b>	The efficiency plan does not achieve the required level of savings	Accountability for each element of the plan will be assigned to a lead Director who will oversee the implementation  The plan's performance will be monitored weekly by the Executive Management Team and swift corrective action put in place where required
		Review other PCTs plans to identify additional savings
<b>Finance</b>	The planning scenarios are not realistic	They have been guided by region wide work and will be updated as new information becomes available
<b>Workforce</b>	NHS Cambridgeshire staff react adversely to the proposed changes	Regular staff briefings and one to one support offered as required Opportunity for training and re-skilling made available throughout the term of the plan

## Chapter 7. Impact Assessment

In this Chapter, we have set out our initial assessment of the expected impact of our strategic change programmes. We will keep this under constant review.

### Impact for patients

In this plan we have set out six strategic change programmes. One of the purposes of these programmes is to ensure that we can continue to commission a comprehensive range of health services as we move into a much more challenging financial period.

However, this does not mean that services will remain the same. For example:

- As a result of introducing a new commissioning system based on clusters of GP practices, we would anticipate that new ways of providing care will be introduced, with more care provided in a community setting or at home. We would also expect there to be more choice locally, as clusters commission new and innovative services that are better tailored to local needs. Over time, clusters may wish to develop local health 'hubs' that combine a wider range of services such as GP services, diagnostics and outpatient clinics
- Changing planned care will result in the more systematic application of clinical thresholds to ensure that interventions are appropriate to patient's needs. This will mean that fewer people will be treated where the evidence suggests that there would be little or no benefit
- Ensuring that there is a sustainable supply side will halt the recent increases in activity in hospitals and will, over time, result in a shift in care towards more community based services. We would expect this shift to start slowly but gather pace as Primary Care Commissioning Clusters design and introduce new alternative services
- Our work on long term conditions will lead to a different pattern of care for people with Chronic Obstructive Pulmonary Disease (COPD) and Diabetes, with much more emphasis on helping people to actively manage their condition. We would expect patients with COPD or Diabetes to feel that they have much better and more tailored information as well as more accessible community based support. This will result in fewer emergency admissions for people affected by those two conditions

- As a result of our work on prevention we will have a much sharper focus on those services that are proven to lead to longer term cost savings, such as tobacco control. We will target our efforts on areas that currently have the poorest health outcomes in order to do all we can to narrow health inequalities
- As a result of our the efficiency savings we will make through our getting more for every Pound spent programme, we will free up resources which will enable us to make the key service changes we have set out in this plan

We will keep all services under review and if necessary will decommission low priority services. Any decisions we take on decommissioning will be transparent and will be guided by the prioritisation criteria set out in the plan.

### **Impact for existing Service Providers**

As we enter into a prolonged period of financial constraint, it will be imperative for all of our current providers to work with us to drive up productivity and to share risk fairly. More specifically, we will need our providers to:

- Develop detailed plans to reduce the unit cost of activity by, for example, reducing length of stay and increasing day case surgery rates in hospitals, or – in the case of out of hospital providers - increasing the proportion of time staff spend in direct patient contact
- Continue to focus on improving clinical quality, prioritising those areas that will also lead to lower costs such as reducing hospital acquired infections
- Be able to respond flexibly when pressures occur during the year, for example working with us to manage demand for individual services

The new commissioning system that we want to develop will also have a significant impact on our existing providers, for example:

- They will need to build strong relationships with Primary Care Commissioning Clusters so that they both understand and inform clusters' thinking about future patterns of service, and are well positioned to compete for these services if they are tendered
- There is likely to be an increased emphasis on community and home based provision, as well as services to keep people out of hospital; we would encourage providers to collaborate to develop innovative proposals for how this might be achieved
- Commissioning clusters are likely to want providers to develop services for the delivery of a wholly integrated service for people with specific long term conditions, together with clear proposals for sharing financial risk

### **Impact for potential Service Providers**

We anticipate that as Primary Care Commissioning Clusters develop, they will seek to move resources away from more traditional models of care as they seek out new ways of meeting the needs of their patients. This is likely to result in a range of opportunities for providers, for example:

- Increased access to diagnostics locally
- Development of new, more integrated services for particular groups of patients, such as older people or people with a long term condition
- Provision of a wider range of community based services including nursing, therapies and social care
- Greater use of technology such as telemedicine to enable more care to be provided closer to home
- Provision of commissioning support skills to clusters of GP practices

We know that one of the most powerful levers we have as commissioners is using the market to drive up quality and maximise value. We have learnt that this can result in innovative new services, such as our recent procurement for neuro-rehabilitation services at Brookfield's Hospital. Where appropriate, we will continue to test services and will encourage Primary Care Commissioning Clusters to do the same. Procurements that we are likely to progress in the near future include:

- Direct access audiology
- Sexual health services
- Patient transport services
- New primary care facilities linked to new housing development

### **Impact for NHS Cambridgeshire**

Implementing the strategic change programmes set out in this plan will have a number of implications for us as an organisation. In the shorter term these include:

- A sharper focus on a smaller range of high impact projects
- A much more structured approach to the development and management of projects

- A stronger emphasis on the delivery of efficiency savings in all that we do.

The introduction of Primary Care Commissioning Clusters also has major implications for the number and type of people that work here. As Clusters develop, they will take on much of the commissioning work currently done on a county-wide basis by NHS Cambridgeshire staff. To do this, they will need to develop their own commissioning capacity – this could be by employing staff directly, working with an external partner or by drawing on skills retained within NHS Cambridgeshire.

Although it is difficult to predict the choices Primary Care Commissioning Clusters will make, it is likely that over time the role of NHS Cambridgeshire will shift to focus less on direct commissioning and more on:

- Taking a more strategic, county-wide perspective and providing the overall planning framework
- Holding Primary Care Commissioning Clusters to account
- Commissioning county-wide services that Primary Care Commissioning Clusters ‘block back’ to it
- Providing commissioning skills and expertise to Clusters, where required

These are significant changes in both the short and long term. We have already updated our existing Organisational Development Plan to reflect the more immediate implications, and will carry out a more fundamental review once the exact impact of Primary Care Commissioning Clusters is clearer.

## **Chapter 8. Conclusions**

In our second chapter, we set out the five key challenges that we think we will face over the five year period of this plan: a very difficult financial environment; escalating expenditure in hospital care; concerns about inequalities and the longer term determinants of health; the rapidly ageing population; and our need to focus on a smaller range of initiatives.

In the remainder of the plan, we set out how we intend to address these challenges, while continuing to deliver on the highest priority commitments we made in last year's plan on older people, promoting health, safe and sustainable services and patient experience.

Building a new commissioning system rooted in the knowledge and expertise of primary care will, we think, result in services that are much more tailored to the needs of defined communities as well as delivering better value for money. We are optimistic that this new system will result in better, more sustainable services for key groups such as older people, as GPs will have the power to put in place a pattern of services that best meets their individual needs. We also think that this new system will make a contribution to narrowing health inequalities, as it will result in increased investment in the more deprived parts of the County.

Our changes to planned care and to the broader supply side are both intended to have an impact in the short term by containing our expenditure on hospital services. In the medium term, our plans should help to ensure that only patients that require the specialist resources provided by hospitals are treated there, and should result in more choices about where, and how, people are treated.

By focusing our efforts on a smaller number of long term conditions, we will increase the impact we are able to have. As an example, this will result in better health outcomes for people with COPD and Diabetes, as well as improving value for money. Our commitment to explore in detail predictive modelling will bring benefit to people who have complex health needs, by helping to predict their future needs and respond accordingly. We anticipate that this will be particularly beneficial to older people.

We plan to bring a sharper focus to our work on prevention by channelling our efforts into those interventions where there is clear evidence of both clinical and cost effectiveness. We will start with tobacco control, where the evidence is compelling.

Our work on efficiency will be critical, not just to help us bridge the financial gap we are likely to face, but also to release funds to support the implementation of our strategic programmes.

Finally, we are well placed in Cambridgeshire to respond to the pressure the whole public sector is likely to come under. There are excellent relationships between partner organisations, and a strong history of joint commissioning. We want to build on these foundations and play a full and active role in designing a new pattern of public service that is integrated, responsive and sustainable.

### Initiatives from Last Year's Strategy

We set out in last year's Strategy a wide range of strategic goals and initiatives designed to meet national, regional and local priorities and within a context of a strategic investment fund each year. We reviewed all of the goals and used the impact assessment criteria in Appendix 2 as a means of deciding which ones should be continued.

Consequently, we have reduced the number and range of initiatives that we will undertake in this new Plan. The initiatives that remain are primarily about fulfilling our commitments to national and regional policy and meeting the health needs of our population. The table below sets them out. The total investment for each service area is shown in brackets.

<b>Service Area</b>	<b>Short Term 2010/11</b>	<b>Medium Term 2011/12 to 2012/13</b>	<b>Long Term 2013/14 and beyond</b>
<b>Maternity Care</b>	Better choices in maternity care and one to one midwifery care available	Better access to maternity services for parents who normally cannot access them easily	Draw up maternity and child health access and capacity plans for future commissioning
<b>Children's Services (£1,593k)</b>	Consolidate childhood obesity pathway and review early years and schools policies for healthy eating Consolidate reduction in waiting times for non-consultant led services to 18 weeks from referral	Increase number of joint funded weight management programmes  Evaluate	Develop wider range of community weight management programmes in different settings  Improve waiting times further, where possible
<b>Addressing Health Inequality (£1,634k)</b>	Implement obesity, sexual health and school based services in 20% most deprived areas  Deploy health trainers to these practices to support this work	Continue to implement obesity, sexual health and school based services in 20% most deprived areas  Start roll out of health trainer scheme to rest of the County and set up community development workforce	Interim review and evaluate outcomes  Complete the roll out of the health trainer scheme
<b>Health Promotion / Disease Prevention (£2,904k)</b>	Screening Programmes: continue to implement  NHS Health Checks: evaluate Phase 1 and plan for Phase 2  Increase the number of people who quit smoking	Screening Programmes: continue to implement  NHS Health Checks: implement Phase 2  Continue to increase the number of people who quit smoking	Screening Programmes: evaluate  NHS Health Checks: evaluate  Work with employers to take forward Staying Health in the Workplace (smoking cessation)

	<p>Sexual health: increase LARC * prescribing</p> <p>Adult obesity: develop peripatetic intensive service (NICE C.G.43)</p> <p>Alcohol Harm Reduction: implement new contract for community based services (July 2010)</p>	<p>Sexual health: increase LARC prescribing</p> <p>Adult obesity: complete development of peripatetic intensive service (NICE C.G.43)</p> <p>Alcohol Harm Reduction: increase number of Brief Interventions and work with hospitals to reduce alcohol related admissions</p>	<p>Adult obesity: review all weight management programmes</p> <p>Alcohol Harm Reduction: review capacity of services to meet demand</p>
<p><b>Older People</b> <b>(£1,490k)</b></p>	<p>Improve services for people with dual frailty</p> <p>Falls prevention project</p> <p>Improve mental health services for older people.</p> <p>Extra care sheltered housing</p> <p>Introduction of personal budgets (by April 2010)</p> <p>Complete reablement project</p>	<p>Continue to improve services for people with dual frailty</p> <p>Falls prevention project completed</p> <p>Continue to improve mental health services for older people.</p> <p>Extra care sheltered housing</p>	<p>Extra care sheltered housing (until 2016)</p>
<p><b>Mental Health</b> <b>(£2,020k)</b></p>	<p>Consolidate implementation of mental health promotion strategy; services to be more 'recovery focussed'</p>	<p>Roll out of the 'In Control' pilot of individual budgets.</p> <p>Reduce further waiting times for services, where possible</p>	<p>Review full range of services</p>
<p><b>Major Health Conditions</b> <b>(£371k)</b></p>	<p>Continue to improve uptake of cardiac rehabilitation and standards for heart failure services</p> <p>Continue to implement the Cancer Reform Strategy – improve access times for radiotherapy and chemotherapy</p> <p>Dermatology Service re-commissioned.</p> <p>Rolling review of other clinical pathways as</p>	<p>Consolidate stroke clinical network</p> <p>Commission stretch targets for brain scans and thrombolysis</p> <p>Continue to implement the Cancer Reform Strategy</p> <p>Evaluate new Dermatology Service</p> <p>Rolling review of other clinical pathways as indicated</p>	<p>Review full range of services</p> <p>Review full range of services</p> <p>Rolling review of other clinical pathways as</p>

	indicated by commissioning plans	by commissioning plans	indicated by commissioning plans
<b>Carers (£966k)</b>	Implement National Carer's Strategy. Review prescriptions for care project (pilot commenced 2009)	Complete implementation of National Carer's Strategy	Evaluate progress made
<b>End of Life Care (£1,600k)</b>	Implement End of Life Strategy – including ensuring that more people are able to choose to die at home	Complete implementation of End of Life Strategy	Evaluate progress made
<b>Developing the Infrastructure / Planning for new Communities (£3,540k)</b>	Produce an Estates Strategy to support our strategic priorities Draw up a Climate Change / Carbon Footprint Reduction Strategy Complete review of Doddington Hospital Plan for needs of new communities	Implement primary care service at CB1 Development (Cambridge) – subject to local authority planning Implement the agreed Climate Change / Carbon Footprint Reduction Strategy Plan for needs of new communities	Evaluate progress made Plan for needs of new communities

\* Long acting reversible contraceptive

The following set of initiatives will not be taken forward in this year's Strategic Plan because they were:

- deemed to be part of our core business and therefore not a time limited project
- or
- completed in the financial year 2009/10
- or
- better merged with other more major projects
- or
- assessed as a lower priority as other projects

Service Area	Project Title Summary	Reason(s)
<b>Children's Services</b>	Safeguarding Children	Core business
	Review paediatric physiotherapy	Merged with work on improving access to services
	Child health promotion programme	Project re-scoped and re-prioritised for breast feeding – original project brief stopped
<b>Dentistry</b>	Improving access and increasing coverage of dentistry in the County	Initial development completed – now core business – included in contract management
<b>Primary Care</b>	Equitable Access Centre at St Neots	Completed – centre opened Autumn 2009
	Improved access to GP services	Initial development completed – now part of our core business – included in contract management
<b>All Services</b>	Improve access generally	Core business – included in contract management
	Improve care and choice	Core business – included in contract management
<b>Major Health Conditions</b>	Cancer waiting time targets	Core business – included in contract management
	Preventing the risk of cancer	Core business – part of mainstream prevention work
	Cancer Pathway data management	Core business – included in contract management
	Timely access to cancer treatments	Core business – included in contract management
	Improving Outcomes Guidance Palliative Care	Part of our core business
	Service shift from acute hospitals	Original project terminated and re-focussed. Now part of Strategic Change Programme 4
	Mental Health Promotion Strategy	Project stopped due to delay in publication of external strategy report – project to be re-considered if necessary. Mental health promotion is still part of our core business
	Better user involvement for mental health services	Core business – included in contract management
<b>Safety</b>	Viable stroke network	Core business
	Implement a 5 year high level safety plan	Will be completed by end 2009/10
	Reduce health care acquired infections	Core business – included in contract management
	Identify the 'at risk' patient	Core business (safety improvement programme)
	Safe services in Primary Care	Core business – included in contract management
	Best practice for venous thrombo-embolism	Core business – included in contract management
	Implement East of England drug chart	Core business – included in contract management
<b>Other</b>	Input to the Growth Agenda	Core business
	Brookfields Hospital	Will be completed by end 2009/10
	Travellers health needs	Project phase completed, now core business
	Social marketing	Project stopped – may need a regional approach

**Our Commissioning Portfolio for the Financial Year 2009/10**

Area	Provider	Services	Total 09/10 budget (£m)	09/10 forecast outturn (£m)
Acute care	Addenbrookes	Elective inpatients, non-elective inpatients, outpatients, drugs, A&E, critical care, direct access, dialysis, chemo, radio-therapy, patient transport, other	£193.4m	£198.1m
	Hinchingsbrooke	Elective inpatients, non-elective inpatients, outpatients, drugs, A&E, critical care, direct access, chemo, patient transport, other	£78.6m	£82.5m
	King Lynn & Wisbech	Elective inpatients, non-elective inpatients, outpatients, drugs, A&E, critical care, direct access, chemo, patient transport, other	£24.9m	£25.4m
	Peterborough	Elective inpatients, non-elective inpatients, outpatients, drugs, A&E, critical care, direct access, chemo, patient transport, other	£28.0m	£29.9m
	Other acute		£27.5m	£27.0m
	E AAT	Emergency ambulance	£16.2m	£16.6m
Mental health	Mental health trust	Primary care - IAPT, Acute & PICU, Intake & treatment, Rehabilitation & recovery, Personality Disorders, Early Intervention, Substance Misuse, Inpatients, Dementia, Intermediate care, Functional community, Young Onset Dementia, Day hospital, Tier 2, Core, Neurodevelopmental, Children with LD, Tier 4, Adult Eating Disorders	£51.9m	£51.9m
	Other mental health		£10.6m	£10.8m
Specialist commissioning	Papworth	Elective inpatients, non-elective inpatients, outpatients, critical care, dialysis, other	£20.2m	£20.8m
	Other specialist commissioning	Elective inpatients, non-elective inpatients, outpatients, drugs, A&E, critical care, dialysis, chemo, patient transport, other	£16.1m	£14.5m
Out of hospital care	PCT provider services	Care at home, hospital care, clinic based, children, palliative care	£57.2m	£57.2m
	Other providers	Care at home, hospital care, clinic based, children, palliative care, GPSI, other individual placement, learning disability, other	£48.8m	£48.8m
Other	Other budgets	Other commissioning budgets, prescribing, GP primary care costs, dental	£206.3m	£196.1m
	Other support	PCT support costs, Anglia support partnership, National Programme for IT, Saving / Improving Lives, other commissioning budgets	£28m	£28.1m
<b>Total</b>			<b>£807.7m</b>	<b>£807.7m</b>

Impact Assessment Criteria

Importance of criterion	Criterion (not in priority order within each category)	Red / Amber / Green status
<b>Necessary</b>	The initiative is safe for patients and in line with statutory duties and has been risk assessed	
<b>Necessary</b>	The financial cost/benefit of the initiative is clear and best value for money is demonstrated	
<b>Necessary</b>	The initiative is deliverable within the relevant timescale	
<b>Necessary</b>	The health needs of the population (e.g. from JSNA) have been considered, together with the impact of the proposal on health outcomes and on health inequalities	
<b>Necessary</b>	Effective evaluation measures are identified which will enable the project to be stopped if unsuccessful	
<b>High</b>	Results in financial savings to the health and social care system, in line with Quality, Innovation Productivity and Prevention principles.	
	Fits with one or more of the existing four local strategic priorities: <ul style="list-style-type: none"> <li>• Promoting health and preventing disease</li> <li>• Older people's Health and Health Care</li> <li>• Ensuring that Cambridgeshire has sustainable and affordable health services</li> <li>• Patient experience and customer care</li> </ul>	
<b>High</b>	National or regional 'Must Do', taking into account resources available	
<b>High</b>	Addresses an unacceptable risk to patient safety	
<b>Medium</b>	Contributes to World Class Commissioning and/or Care Quality Commission and/or CAA assessment	
<b>Medium</b>	Is supported by the views of the local public and patients	
<b>Medium</b>	Is supported by the views of clinicians	
<b>Medium</b>	Is an identified Practice Based Commissioning priority	
<b>Medium</b>	Is a Local Area Agreement or Vital Signs target	

**Health Outcome Metrics**

No	Outcome Description	Aspiration				
		2009/10	2010/11	2011/12	2012/13	2013/14
1a	Slope index of inequality for life expectancy at birth at Lower Layer Super Output Area. (Males)	6.14	6.08	6.02	5.96	5.90
1b	Slope index of inequality for life expectancy at birth at Lower Layer Super Output Area. (Females)	5.05	5.00	4.95	4.90	4.85
2a	Male life expectancy at time of birth, years	79.70	80.06	80.42	80.78	81.15
2b	Female life expectancy at time of birth, years	83.47	83.75	84.02	84.30	84.58
3	Clostridium Difficile: rate per 1,000 bed days in patients aged 2 years and over	294	256	229	205	184
4	Smoking quitters: rate per 100,000 population aged 16 years and over	650.6	692.1	779.1	789.3	800.2
5	Prevalence of obesity in Year 6 children as measured by the National Child Measurement Programme	15.70%	15.50%	15.40%	15.20%	15.10%
6	Achieving independence for older people through rehabilitation and care: the proportion of older people discharged from hospital to their own home or to a residential or extra care housing bed for rehabilitation with a clear intention that they will move on/back to their own home, who are at home 3 months after the date of discharge from hospital	78.0%	81.0%	82.0%	83.0%	84.0%
7	Percentage of people dying at home	25.8%	26.8%	30.0%	31.0%	33.0%
8	Chronic Obstructive Pulmonary Disease admissions per 100,000 population	154	149	145	141	137
9	Diabetes: the percentage of patients with diabetes who have an HbA1c of 7.5 or less	60.0%	62.0%	63.0%	65.0%	66.0%

**Explanation of Assumptions used to create the Base Case**

The inflation figures included in the assumptions are all net of efficiency requirements. The future years gross inflation figure for NHS providers is expected to be 2.5% across all scenarios and the level of efficiency required is adjusted for each scenario. The best and worst case inflation scenarios need to be considered along with the resource uplift to be understood, the table below shows this.

<b>Provider inflation uplift</b>	<b>Base Case %</b>	<b>Scenario 1 (Worst) %</b>	<b>Scenario 2 (Best) %</b>
<b>Resource Uplift</b>	<b>0.0</b>	<b>0.0</b>	<b>2.5</b>
<b>Provider Inflation</b>			
Inflation	2.5	2.5	2.5
Efficiency Savings	(4.5)	(4.0)	(3.5)
<b>Net Provider Inflation / (Deflation)</b>	<b>(2.0)</b>	<b>(1.5)</b>	<b>(1.0)</b>
<b>Net Increase / (Decrease) Against Resources</b>	<b>(2.0)</b>	<b>(1.5)</b>	<b>1.5</b>

The efficiency figures in future years are significantly higher than in recent years i.e. 4.5% compared with 2.5%, and this will be a challenge for provider units to manage.

The GP prescribing uplift at 5% is higher than the other uplifts because it includes activity growth as well as inflation.

The activity increases included in the assumptions are for acute activity growth. Activity is expected to increase for population growth at 1.4% per annum and this has been built into the financial model. In addition, previous years' trends have shown that activity has always increased at a higher rate than the population growth. The base case growth assumption reflects the actual trend in growth over the last three years; this has been adjusted by plus and minus 2% for the worst and best cases. Previous years' trends have not only shown an increase in activity but an increase in the cost of that activity as the complexity of care and treatments available increases. We have built in a 1% increase in cost per annum for this "case mix / acuity" change; this has been adjusted by plus and minus 1% for the worst and best cases.

**NHS CAMBRIDGESHIRE**  
**FIVE YEAR FINANCIAL PLANNING SCENARIOS**  
**04/01/2010**

Base Case	2009/10	2009/10	2009/10	2010/11	2010/11	2010/11	2011/12	2011/12	2011/12	2012/13	2012/13	2012/13	2013/14	2013/14
	Rec £'000	Non Rec £'000	Total £'000	Rec £'000	Non Rec £'000	Total £'000	Rec £'000	Non Rec £'000	Total £'000	Rec £'000	Non Rec £'000	Total £'000	Rec £'000	Non Rec £'000
Baseline Expenditure	754,571	0	754,571	817,528	0	817,528	877,693	0	877,693	900,270	0	900,270	924,210	0
Inflation	14,127	0	14,127	10,418	0	10,418	(6,652)	0	(6,652)	(6,047)	0	(6,047)	(5,928)	0
Investments	45,330	(10,140)	35,190	45,747	0	45,747	25,229	0	25,229	25,987	0	25,987	31,298	0
Strategic Initiatives	3,500		3,500	4,000		4,000	4,000		4,000	4,000		4,000	4,000	
<b>Total Expenditure</b>	<b>817,528</b>	<b>(10,140)</b>	<b>807,388</b>	<b>877,693</b>	<b>0</b>	<b>877,693</b>	<b>900,270</b>	<b>0</b>	<b>900,270</b>	<b>924,210</b>	<b>0</b>	<b>924,210</b>	<b>953,580</b>	<b>0</b>
<b>Loan Repayment</b>	<b>0</b>	<b>9,000</b>	<b>9,000</b>	<b>0</b>	<b>9,000</b>	<b>9,000</b>	<b>0</b>	<b>9,000</b>	<b>9,000</b>	<b>0</b>	<b>8,000</b>	<b>8,000</b>	<b>0</b>	<b>0</b>
<b>Resources</b>	<b>806,276</b>	<b>10,112</b>	<b>816,388</b>	<b>856,461</b>	<b>0</b>	<b>856,461</b>	<b>856,461</b>	<b>0</b>	<b>856,461</b>	<b>856,461</b>	<b>0</b>	<b>856,461</b>	<b>856,461</b>	<b>0</b>
<b>Gap</b>	<b>(11,252)</b>	<b>11,252</b>	<b>0</b>	<b>(21,232)</b>	<b>(9,000)</b>	<b>(30,232)</b>	<b>(43,809)</b>	<b>(9,000)</b>	<b>(52,809)</b>	<b>(67,749)</b>	<b>(8,000)</b>	<b>(75,749)</b>	<b>(97,119)</b>	<b>0</b>

Scenario 2 (Best)	2009/10	2009/10	2009/10	2010/11	2010/11	2010/11	2011/12	2011/12	2011/12	2012/13	2012/13	2012/13	2013/14	2013/14
	Rec £'000	Non Rec £'000	Total £'000	Rec £'000	Non Rec £'000	Total £'000	Rec £'000	Non Rec £'000	Total £'000	Rec £'000	Non Rec £'000	Total £'000	Rec £'000	Non Rec £'000
Baseline Expenditure	754,571	0	754,571	817,528		817,528	857,380		857,380	870,828		870,828	885,111	
Inflation	14,127	0	14,127	4,712		4,712	(724)		(724)	(460)		(460)	(278)	
Unavoidable Investments	45,330	(10,140)	35,190	31,141		31,141	10,172		10,172	10,744		10,744	11,311	
Strategic Initiatives	3,500		3,500	4,000		4,000	4,000		4,000	4,000		4,000	4,000	
<b>Total Expenditure</b>	<b>817,528</b>	<b>(10,140)</b>	<b>807,388</b>	<b>857,380</b>	<b>0</b>	<b>857,380</b>	<b>870,828</b>	<b>0</b>	<b>870,828</b>	<b>885,111</b>	<b>0</b>	<b>885,111</b>	<b>900,144</b>	<b>0</b>
<b>Loan Repayment</b>	<b>0</b>	<b>9,000</b>	<b>9,000</b>	<b>0</b>	<b>9,000</b>	<b>9,000</b>	<b>0</b>	<b>9,000</b>	<b>9,000</b>	<b>0</b>	<b>8,000</b>	<b>8,000</b>	<b>0</b>	<b>0</b>
<b>Resources</b>	<b>806,276</b>	<b>10,112</b>	<b>816,388</b>	<b>856,461</b>	<b>0</b>	<b>856,461</b>	<b>877,873</b>	<b>0</b>	<b>877,873</b>	<b>899,819</b>	<b>0</b>	<b>899,819</b>	<b>922,315</b>	<b>0</b>
<b>Gap / (Surplus)</b>	<b>(11,252)</b>	<b>11,252</b>	<b>0</b>	<b>(919)</b>	<b>(9,000)</b>	<b>(9,919)</b>	<b>7,045</b>	<b>(9,000)</b>	<b>(1,955)</b>	<b>14,708</b>	<b>(8,000)</b>	<b>6,708</b>	<b>22,171</b>	<b>0</b>

SHA Scenario 1 (Worst)	2009/10	2009/10	2009/10	2010/11	2010/11	2010/11	2011/12	2011/12	2011/12	2012/13	2012/13	2012/13	2013/14	2013/14
	Rec £'000	Non Rec £'000	Total £'000	Rec £'000	Non Rec £'000	Total £'000	Rec £'000	Non Rec £'000	Total £'000	Rec £'000	Non Rec £'000	Total £'000	Rec £'000	Non Rec £'000
Baseline Expenditure	754,571	0	754,571	817,528		817,528	888,830		888,830	927,163		927,163	967,038	
Inflation	14,127	0	14,127	4,712		4,712	(3,182)		(3,182)	(3,029)		(3,029)	(3,006)	
Unavoidable Investments	45,330	(10,140)	35,190	62,590		62,590	37,515		37,515	38,904		38,904	44,772	
Strategic Initiatives	3,500		3,500	4,000		4,000	4,000		4,000	4,000		4,000	4,000	
<b>Total Expenditure</b>	<b>817,528</b>	<b>(10,140)</b>	<b>807,388</b>	<b>888,830</b>	<b>0</b>	<b>888,830</b>	<b>927,163</b>	<b>0</b>	<b>927,163</b>	<b>967,038</b>	<b>0</b>	<b>967,038</b>	<b>1,012,804</b>	<b>0</b>
<b>Loan Repayment</b>	<b>0</b>	<b>9,000</b>	<b>9,000</b>	<b>0</b>	<b>9,000</b>	<b>9,000</b>	<b>0</b>	<b>9,000</b>	<b>9,000</b>	<b>0</b>	<b>8,000</b>	<b>8,000</b>	<b>0</b>	<b>0</b>
<b>Resources</b>	<b>806,276</b>	<b>10,112</b>	<b>816,388</b>	<b>856,461</b>	<b>0</b>	<b>856,461</b>	<b>856,461</b>	<b>0</b>	<b>856,461</b>	<b>856,461</b>	<b>0</b>	<b>856,461</b>	<b>856,461</b>	<b>0</b>
<b>Gap</b>	<b>(11,252)</b>	<b>11,252</b>	<b>0</b>	<b>(32,369)</b>	<b>(9,000)</b>	<b>(41,369)</b>	<b>(70,702)</b>	<b>(9,000)</b>	<b>(79,702)</b>	<b>(110,577)</b>	<b>(8,000)</b>	<b>(118,577)</b>	<b>(156,343)</b>	<b>0</b>

## Getting more for every Pound spent

## Appendix 6

Area	Name of Initiative	Base Case				Minimum Saving				Maximum Saving			
		2010/11 Total £'000	2011/12 Total £'000	2012/13 Total £'000	2013/14 Total £'000	2010/11 Total £'000	2011/12 Total £'000	2012/13 Total £'000	2013/14 Total £'000	2010/11 Total £'000	2011/12 Total £'000	2012/13 Total £'000	2013/14 Total £'000
Acute Services - all	Reduce Up-Coding	375	750	1,125	1,725	375	750	1,125	1,500	1,500	3,000	4,500	6,000
Acute Services - all	Reduce variation across three types of diagnostics - CT scans, MRI scans, and ultrasounds	400	400	400	400	133	133	133	133	667	667	667	667
Acute Services - Planned	Reduce First to Follow-up ratio of referrals	900	900	900	900	300	300	300	300	1,500	1,500	1,500	1,500
Acute Services - Planned	Reduce Consultant to Consultant Referrals	140	140	140	140	50	50	50	50	200	200	200	200
Acute Services - Planned	Decommission interventions of marginal benefit through rigorous use of individual prior approval and clinical thresholds	1,000	2,000	2,000	2,480	700	1,400	1,400	1,400	2,050	4,100	4,100	4,100
Acute Services - Planned	Cap the level of Excess Bed Days to be Funded	1,477	1,477	1,477	1,477	1,000	1,000	1,000	1,000	2,000	2,000	2,000	2,000
Acute Services - Planned	Pay No More For Activity Currently Received	2,400	2,400	2,400	2,400	2,000	2,000	2,000	2,000	5,000	5,000	5,000	5,000
	<b>Acute Sub Total</b>	<b>6,692</b>	<b>8,067</b>	<b>8,442</b>	<b>9,522</b>	<b>4,558</b>	<b>5,633</b>	<b>6,008</b>	<b>6,383</b>	<b>12,917</b>	<b>16,467</b>	<b>17,967</b>	<b>19,467</b>
Prescribing	Reduce variability in prescribing practices - move to benchmark volume and unit cost	3,500	7,000	7,000	7,000	2,000	4,000	4,000	4,000	4,500	9,000	9,000	9,000
Prescribing	Rigorous approach to high cost drugs	1,000	2,000	3,000	4,000	500	1,000	1,500	2,000	1,500	3,000	4,500	6,000
Prescribing	Medicine use reviews												
	<b>Prescribing Sub Total</b>	<b>4,500</b>	<b>9,000</b>	<b>10,000</b>	<b>11,000</b>	<b>2,500</b>	<b>5,000</b>	<b>5,500</b>	<b>6,000</b>	<b>6,000</b>	<b>12,000</b>	<b>13,500</b>	<b>15,000</b>
Primary Care	Better VFM on GMS PMS spend	-	933	1,566	2,800	-	667	1,333	2,000	-	1,333	2,667	4,000
Primary Care	Review of prescribing practices	600	600	600	600	500	500	500	500	1,000	1,000	1,000	1,000
Primary Care	Review of GPSIs	450	900	900	900	250	500	500	500	500	1,000	1,000	1,000
Primary Care	Review Extended Hours	600	600	600	600	500	500	500	500	1,000	1,000	1,000	1,000
	<b>Primary Care Sub Total</b>	<b>1,650</b>	<b>3,033</b>	<b>3,666</b>	<b>4,900</b>	<b>1,250</b>	<b>2,167</b>	<b>2,833</b>	<b>3,500</b>	<b>2,500</b>	<b>4,333</b>	<b>5,667</b>	<b>7,000</b>
	<b>Mental Health</b>												
Mental Health	Reduce Average Length of Stay to benchmark and share productivity gain	600	2,400	2,400	2,400	150	600	600	600	750	3,000	3,000	3,000
	<b>Mental Health Sub Total</b>	<b>600</b>	<b>2,400</b>	<b>2,400</b>	<b>2,400</b>	<b>150</b>	<b>600</b>	<b>600</b>	<b>600</b>	<b>750</b>	<b>3,000</b>	<b>3,000</b>	<b>3,000</b>
Community	Improve productivity across all services by 8 - 13%	1,500	3,000	4,500	5,760	1,533	3,067	4,600	4,600	2,500	5,000	7,500	7,500
	<b>Community Sub Total</b>	<b>1,500</b>	<b>3,000</b>	<b>4,500</b>	<b>5,760</b>	<b>1,533</b>	<b>3,067</b>	<b>4,600</b>	<b>4,600</b>	<b>2,500</b>	<b>5,000</b>	<b>7,500</b>	<b>7,500</b>
Dentistry	Increase check up interval and reduce UDA cost to benchmark	475	950	950	950	250	500	500	500	625	1,250	1,250	1,250
	<b>Dentistry Sub Total</b>	<b>475</b>	<b>950</b>	<b>950</b>	<b>950</b>	<b>250</b>	<b>500</b>	<b>500</b>	<b>500</b>	<b>625</b>	<b>1,250</b>	<b>1,250</b>	<b>1,250</b>
High Cost Placements	Negotiate lower contracts with the private sector and review criteria / threshold for funding place of care	860	1,790	1,790	1,984	400	800	800	800	1,500	3,000	3,000	3,000
	<b>High Cost Placements Sub Total</b>	<b>860</b>	<b>1,790</b>	<b>1,790</b>	<b>1,984</b>	<b>400</b>	<b>800</b>	<b>800</b>	<b>800</b>	<b>1,500</b>	<b>3,000</b>	<b>3,000</b>	<b>3,000</b>
Back Office	Review scope for increased integration with CCC	-	750	750	750	-	500	500	500	-	1,000	1,000	1,000
	<b>Back Office Sub Total</b>	<b>-</b>	<b>750</b>	<b>750</b>	<b>750</b>	<b>-</b>	<b>500</b>	<b>500</b>	<b>500</b>	<b>-</b>	<b>1,000</b>	<b>1,000</b>	<b>1,000</b>
	<b>Recommissioning</b>												
Recommissioning	Tender Patient transport services county wide	50	150	250	350	25	75	125	175	100	300	500	700
Recommissioning	Tender audiology direct access county wide	41	122	204	286	21	61	102	143	82	245	408	572
Recommissioning	Tender Wheelchair / DSC county wide	64	193	321	449	32	96	160	225	128	385	642	898
Recommissioning	Removal of Hinchingsbrooke Premium	1,179	1,179	1,179	1,179	-	-	-	-	1,000	1,000	1,000	1,000
Recommissioning	Small Items in QEII block	292	292	292	292	-	-	-	-	292	292	292	292
Recommissioning	Clinical academic reserve	-	426	426	426	-	-	-	-	-	426	426	426
Recommissioning	PBC incentive scheme (PACE)	-	-	1,000	1,000	-	-	-	-	-	-	1,000	1,000
	<b>Recommissioning Sub Total</b>	<b>1,626</b>	<b>2,362</b>	<b>3,672</b>	<b>3,982</b>	<b>78</b>	<b>233</b>	<b>388</b>	<b>543</b>	<b>1,602</b>	<b>2,648</b>	<b>4,268</b>	<b>4,888</b>
	<b>Total Pure Efficiency Initiatives</b>	<b>17,903</b>	<b>31,352</b>	<b>36,170</b>	<b>41,248</b>	<b>10,719</b>	<b>18,499</b>	<b>21,729</b>	<b>23,426</b>	<b>28,394</b>	<b>48,698</b>	<b>57,151</b>	<b>62,105</b>

**This page left blank intentionally**