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Cambridge University Hospitals NHS
NHS Foundation Trust

Strategic Plan Document for 2014-19

Cambridge University Hospitals NHS Foundation Trust

1.1 Strategic Plan for y/e 31 March 2015 to 2019

This document completed by (and Monitor queries to be directed to):

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Date	**30 June 2014**

The attached Strategic Plan is intended to reflect the Trust's business plan over the next five years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

- **The Strategic Plan is an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views of the Council of Governors;**
- **The Strategic Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;**
- **The Strategic Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans;**
- **All plans discussed and any numbers quoted in the Strategic Plan directly relate to the Trust's financial template submission; and**
- **The 'declaration of sustainability' is true to the best of its knowledge.**

Approved on behalf of the Board of Directors by:

Name *(Chair)*	**Jane Ramsey**

Signature Jane Ramsey

Approved on behalf of the Board of Directors by:

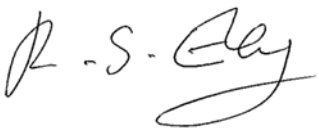
Name *(Chief Executive)*	**Keith McNeil**

Signature

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	**Richard Eley**

Signature



1.2 Executive summary (for publication)

This is a summary of the 5 year plan for Cambridge University Hospitals (CUH). It brings together the plans and aspirations of the Trust together with the emerging agenda to review and reform the health economy across Cambridgeshire and Peterborough. As such it reflects the initial phase of an emergent strategy between commissioners and providers to tackle the healthcare needs of our catchment populations within the resources available.

In the *Cambridgeshire and Peterborough health system Blueprint 2014/15 to 2018/19* the Clinical Commissioning Group (CCG) acknowledges that forming a plan to deliver better health outcomes and a more sustainable health system is a complex process which needs to reflect a number of key factors:

- The Cambridgeshire and Peterborough health system is not financially sustainable and faces a significant financial gap by 2018/19
- The population of Cambridgeshire and Peterborough is increasing and there will be a greater proportion of older people in 5 years' time
- Demand for mental health services continues to increase
- There are significant levels of deprivation and inequality that need to be addressed
- People are living longer and health outcomes are generally good but there are significant differences in people's health
- Our health system has multiple stakeholders

In addition there are a number of factors that could make this health system more complex than many others. These include:

- Hinchingbrooke Health Care NHS Trust: The first NHS trust to be operated by a private partner, Circle
- Peterborough and Stamford Hospitals NHS Foundation Trust: Currently supported by a contingency planning team to find a system-wide solution to the Trust's financial challenges
- Cambridge University Hospitals NHS Foundation Trust: A national centre for specialist treatment, and one of six academic health science centres in the UK
- Papworth NHS Foundation Trust: The UK's largest specialist cardiothoracic hospital, due to move to the Cambridge Biomedical Campus in 2017.

Analysis by PwC shows that Cambridgeshire and Peterborough CCG has a low market concentration for inpatient and outpatient providers. This indicates a greater level of competition between providers and greater patient choice for services. This also suggests duplication of services, and therefore costs, within the market.

Our experience however, is that the Trust's geographical position within the region (with hospitals spread out at a considerable distance) means that competition is constrained particularly for District General Hospital (DGH) type services. Patient choice does bring DGH patients from outside our immediate catchment population and this is an increasing trend. There is some competition in a limited number of clinical sub-specialist areas but this is largely dealt with through formal centralisation processes. (e.g. vascular surgery/surgical resection of liver metastases).

Over the life of this plan we currently expect the debate in relation to Peterborough and Hinchingbrooke Hospitals to continue.

We do not expect any significant changes in market share except as a result of planned regional collaboration and repatriation of patients, particularly of children's services, from London hospitals.

In this context, and specifically as a result of the financial challenges faced by the system, all partners recognise that fundamental changes are required to the organisation, provision, co-ordination and delivery of services across the health economy. The CCG has focused work in the following key areas:

- Elective care
- Non-elective care
- Women's and children's
- Prevention and self-care
- Older people and vulnerable adults
- Mental health

A number of transformation programmes are on-going in these areas already. For example the Older People's Procurement is an innovative way of commissioning for better outcomes, and the Better Care Fund provides an opportunity to commission with Local Authority partners.

A "Care Design Group" approach has been used for elective and non-elective care to identify schemes that have the potential to reduce our £250m gap by up to £80m. Further schemes and system changes need to be considered and worked up, and similar development work, led by our clinicians, will determine the way forward in each of the key areas above.

The Trust Board is committed to the principle of financial, operational and clinical sustainability. The Board has put in place a number of initiatives to promote sustainability including:

- eHospital - a world-class clinical information system driving new ways of working both within CUH and between CUH and our partners.
- Hosting the Pathology Partnership (tPP) a joint venture between six NHS Trusts in the East of England to provide both hospital and community pathology services across the tPP area.
- Partnership with Cambridgeshire and Peterborough NHS Trust and MITIE as a member of an NHS-led, limited liability partnership called the 'Uniting Care Partnership' in response to Cambridgeshire and Peterborough CCG's tender for a contract over five years for the design and delivery of improved integrated care for older people and adult community services, to achieve the overall ambition of improving outcomes and patient experience, and system wide sustainability.
- A Transformation Programme comprising 12 work streams to deliver a range of service and cost improvements (CIPs) which will then be embedded as part of normal business.
- Capital funding for two additional operating theatres. Approval to move to 24/7 consultant led services in the emergency department in response to rising ED demand and the Keogh safety and quality initiatives.

Our two year operating plan, published previously, also sets out a number of proposals to ensure sustainability over the 5 years of this plan and beyond:

- Children's Services- a dedicated service to meet projected demand, improve patient care and to enable the further repatriation of activity from London, and to establish a regional centre for specialist children's services in conjunction with regional partners.
- Oncology and Haematology Ambulatory Centre - the Centre will deliver transformed patient experience covering Day Chemotherapy (including haemato-oncology), Outpatient Clinics, Information and Support
- Neurosciences Facility - improved facilities to accommodate demand for Neurology activity (primarily the diagnosis of acute symptoms and the long-term management of chronic neurological conditions), and Neurosurgery infrastructure (operating theatres, intensive care and radiology with major specialised equipment).

These proposals are at the Strategic Outline Case stage and will be considered by the Board in July.

CUH's position will need to be reviewed in the light of changes across the local health economy including any options worked up for consideration across the local health economy(LHE) by the CCG and with other providers.

CUH is committed to working with the CCG and other partners to develop a workable solution across the LHE that meets the needs of patients within the resources available.

The financial outlook for the Trust is challenging. The Trust's overall financial objective remains to achieve a sustainable financial future demonstrated by a Continuity of Service Risk Rating of 3. This will be put under significant strain over the planning period particularly as The Trust is experiencing unprecedented growth in emergency work subject to the 70% tariff reduction.

The Trust however, is fully engaged in finding ways of resolving these issues, both internally and across the Cambridgeshire and Peterborough health economy. eHospital will go live in October 2014 and the financial position of the Trust reflects the ongoing costs and benefits of this project. Externally, the Trust is engaged with system partners in identifying structural solutions to the financial challenge.

1.3 Declaration of sustainability

The board declares that, on the basis of the plans as set out in this document, the Trust will be financially, operationally and clinically sustainable according to current regulatory standards in one, three and five years time.	***Confirmed***

This is the 5 year plan for Cambridge University Hospitals (CUH). It brings together the plans and aspirations of the Trust together with the emerging agenda to review and reform the health economy across Cambridgeshire and Peterborough. As such it reflects the initial phase of an emergent strategy between commissioners and providers to tackle the healthcare needs of our catchment populations within the resources available.

The Plan sets out the challenges we face as a Trust and as part of the local health economy (LHE), some firm plans to tackle these challenges and broader proposals to engage with our partners across the LHE to create a sustainable healthcare future. *It is a financially sustainable plan on an in-house basis based on current information at the date of Board approval (11.6.14) and pending further decisions across the LHE.*

The challenges that delivering this plan will pose should not be underestimated, particularly in terms of meeting performance requirements. In making decisions to implement this plan, the Board will not compromise patient care and patient safety where proposed changes engender risks to safety and quality that cannot be effectively mitigated.

The Plan has been prepared from the perspective of CUH and the LHE across Cambridgeshire and Peterborough. PwC has worked with commissioners and providers across the LHE to review unplanned and elective care. A shortlist of options from this work are set out in this Plan and linked to CUH's ambitions and intentions. It is expected that further work to create long and shortlist options for Older People and vulnerable adults, women's and children's services, mental health, prevention and specialist services will be undertaken this year.

In essence then this plan:

- Sets out CUH's view of the next 5 years
- Identifies options for meeting population health needs across the LHE and tackling the significant financial issues facing commissioners and providers over that period
- Expresses CUH's willingness to work as part of the health system in Cambridgeshire and Peterborough to devise a joint approach to meeting healthcare needs within the resources available
- Acknowledges that doing this will require significant change

The population of Cambridgeshire and Peterborough is increasing and growing older. The Clinical Commissioning Group (CCG) population is currently 883,000 and is predicted to increase between 2014 and 2019 by 5.3%. There are significant levels of deprivation and inequality. For example 14,400 children live in poverty; and life expectancy is 7.2 years lower for men and 5.3 years lower for women in the most deprived areas of Cambridgeshire than in the least deprived areas. People are living longer but there are significant differences in people's health.

The current system across the LHE is recognised as not being financially sustainable. One estimate is that by 2019 the CCG will have a deficit of £61.7m per annum. The shortlisted options for unplanned care and elective care across the LHE set out in this plan are expected to contribute to closing this gap.

The CCGs clinical priorities are

- Improving care for the frail and elderly through projects such as enhanced multi-disciplinary team working and a greater focus on improving provision of integrated care, known as the Older Peoples' Programme.
- Improving care for those with life-limiting disease in their last 6 to 12 months of life.
- Decreasing inequalities in health across our CCG, focussing on reducing the inequality in premature death from coronary heart disease.

Against this background the Trust faces an immediate shortfall of 30 adult beds and 1 theatre in 2014/15 and a projected shortfall of 255 beds and 10 theatres by 2018/19. This is based on activity projections for the period 2014/15 to 2018/19 as follows:

- Elective spell growth projected to be on average 5.4% per annum (Day Cases 5.6%, Inpatients

4.2%).

- Non-Elective spell growth projected to be on average 2.5% per annum.
- Total Spell growth therefore projected to be on average 4.6% per annum.
- Accident & Emergency growth projected to be on average 4.0% per annum.
- Outpatient Attendances projected average growth of 3.9%* per annum, made up of the following:
  – First Attendances growth of 5.2% per annum.
  – Follow-up Attendances growth of 3.2% per annum.
  – Outpatient Procedures growth of 4.3% per annum.

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These proposals are at the Strategic Outline Case stage and will be considered by the Board in July

CUH's position will need to be reviewed in the light of changes across the LHE. The short list of options worked up with the CCG and other providers and with support from PwC includes:

- Single point of access (SPA) for patients
- Single point of access (SPA) for professionals
- Front end A&E model
- Discharge planning, including early supported discharge
- Regarding of an A&E unit following reconfiguration of services
- Closer links between GPs and the ambulance service
- Primary Care Referral Management
- Patient Flow Optimisation
- Patients who should not be in an acute setting would not be there any longer
- Single provider for specific elective services
- Jointly owned, risk shared "cold site" for elective work

An indicative change in activity if they were all implemented has been modelled, and the indicative financial savings that would result is a saving of around £80m. This is substantially short of the estimated gap of £250m.

The Board also recognises that sustainability over the next five years is contingent on a number of significant factors outside the Board's control. These include the level of demand for services dictated by the growth and ageing of the population in this region; and the level of funding available to commissioners to meet this demand.

The Board also recognises that the period until 2019 will take us beyond the election of a new government and we stand ready to respond to any policy changes relating to health and social care that this brings about.

Our vision for and commitment to transformation is:

'Achieving sustainability across the local health economy and within the Trust will require collaboration, investment and innovation among all stakeholders. The scale of the challenge we face requires radical reforms across the system in the way health and social care is organised, delivered and paid for.

Within CUH we will create innovative and entrepreneurial responses to these challenges and be open to and actively seek partnership opportunities across the management and delivery of services and organisation where they can be shown to improve care and deliver efficiencies.

We will offer system leadership where this is in the best interests of patient care. We expect this to include opportunities in clinical governance and staff training.

Our eHospital system offers a platform for further patient benefit and we will work openly with our partners to spread this benefit where possible.

We will review opportunities to deliver care in new settings wherever possible with our partners in primary and community healthcare and in other hospitals in our region. We expect this to involve identifying key patient groups whose care is best suited to particular healthcare settings in our region.

We value the support of our colleagues in social care and will continue to explore opportunities for improved integration of services.

We recognise that the type of structural change which will be required to ensure sustainable healthcare raises challenges and we will be truthful with patients, the public and staff about any proposed changes and their implications.

We recognise that healthcare in hospital is only a part of the patient's experience and will seek opportunities to consolidate and strengthen our partnership with families, carers and the third sector. '

We have set out a number of options towards delivering this vision below. In addition we have signed the Strategic Planning Concordat set out below.

Strategic Planning Concordat

All NHS organisations in the LHE have signed the following concordat:

Our commitments

As the leaders and regulators of the local health and care system, we commit to work together to develop and deliver a system-wide Strategic Plan in the interests of the people we service and the whole health and care system. This means:

- *For people in our local area*: we will create the experience of a health and care system that works in a joined up way, a system that focuses on the health and well-being of our local population
- *For our local system*: we will create a common vision where the needs of service users transcends the need to protect organisational form
- *For health and care professionals*: we will create a culture where a sense of collective responsibility exists, supported by appropriate structures and support
- *For our population now and in the future*: we will create a more productive and sustainable future for the health and care system in Cambridgeshire and Peterborough.

Our values

We will:

- Place people at the centre of everything we do
- Empower people to stay healthy
- Focus on improving quality and health and care outcomes
- Develop a financially sustainable health and care system

Core principles

To this end we individually and collectively commit to these practical working principles:

- We collectively own this Strategic Plan, for which we share responsibility to both champion and deliver
- We will each contribute resources to the design and implementation of this strategic plan
- We will prioritise changes that improve outcomes and quality, whilst delivering financial sustainability where changes:
  - Maintain, and where possible improve, health and care outcomes
  - Protect quality and patient safety;
  - Reduce overall system cost
- We will share data openly
- We will seek to integrate care and break down traditional barriers to people-centred care

We acknowledge that this may result in the following:

- Changes in how we commission and provide care, for example
  - Less acute activity – using only part of the current physical footprint
  - Community services and primary care being delivered in mixed-use settings
  - More integrated services – including social, primary, community and acute provision
  - Relocation of services
  - More Integrated urgent care provision
- Changes in how we fund and pay for care, to ensure that we align incentives with benefits for the whole system
- Changes in the focus of some organisations to ensure best fit with our overall system objectives

1.3 Market analysis and context

Forecasted activity in a 'do nothing' scenario

Distribution of activity within Cambridgeshire & Peterborough

The increasing demands on the health economy are driven by an increasing and aging population, reflected in the increased numbers of inpatient and outpatients in elective care, particularly in age groups 60-75 and 75+.

Current and projected breakdown of spells by age and type in C&P LHE

Current inpatient activity

Age group	Urgent Care	Elective Care	Maternity & Paediatrics
0 - 4	4,181	1,507	1,683
5 - 19	3,456	3,816	408
20 - 39	6,702	10,088	7,643
40 - 59	8,221	22,874	323
60 - 74	8,227	27,722	-
75+	13,059	20,776	-

Current AE activity

Age group	Urgent Care
0 - 4	9,119
5 - 19	25,214
20 - 39	38,297
40 - 59	29,084
60 - 74	19,227
75+	17,971

Current outpatient activity

Age group	Elective Care	Maternity & Paediatrics
0 - 4	22,224	-
5 - 19	70,879	852
20 - 39	155,776	12,323
40 - 59	182,680	636
60 - 74	183,015	-
75+	118,485	1

Future inpatient activity (2021)

Age group	Urgent Care	Elective Care	Maternity & Paediatrics
0 - 4	4,648	1,675	1,871
5 - 19	3,889	4,294	459
20 - 39	6,890	10,371	7,858
40 - 59	8,849	24,621	348
60 - 74	9,656	32,537	-
75+	17,448	27,759	-

Future AE activity (2021)

Age group	Urgent Care
0 - 4	10,138
5 - 19	28,374
20 - 39	39,372
40 - 59	31,306
60 - 74	22,566
75+	24,011

Future outpatient activity (2021)

Age group	Elective Care	Maternity & Paediatrics
0 - 4	24,708	-
5 - 19	79,763	959
20 - 39	160,148	12,669
40 - 59	196,634	685
60 - 74	214,802	-
75+	158,308	1

Source: Hospital Episode Statistics ("HES")
Movement in activity based on forecast population changes., scaling upwards the current model of care (Office of National Statistics (ONS))

PwC 10

Healthcare needs assessment : Key issues for Cambridgeshire and Peterborough

The Cambridgeshire and Peterborough CCG population is 883,000 and is predicted to increase between 2014 and 2019 by 5.3%. Several over-arching themes emerge from the available Joint Strategic Needs Assessments and Health needs profiles. The impact on activity across the LHE is set out in the table above.

The population of Cambridgeshire and Peterborough is increasing and there will be a greater proportion of older people in 5 years' time

Information from the Office of National Statistics shows that in Cambridgeshire the population is forecast to increase by 5.0 % between 2014 and 2019 (32,000 people in total) with most of the increase in Cambridge City and South Cambridgeshire. In Peterborough, the population is forecast to increase by 6.1% between 2014 and 2019 (11,600 people in total). In Cambridgeshire and Peterborough the population aged 75 years and over is set to increase by 24% between 2014 and 2019 (16,000 people).

There are significant levels of deprivation that need to be addressed

In Peterborough the city's deprived areas are those that are more densely populated and 26% of the population live in these areas. Some of the wards in Peterborough are rated amongst the highest areas for child poverty in England and 13 of the city's smaller neighbourhoods (lower super output areas) are amongst the most deprived 10% in the country. 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.

Lifestyle has an important bearing on the prevention of ill-health and premature mortality
Our population varies both in levels of experience of unhealthy lifestyles and their consequences, as well as in the take up of preventive services such as smoking cessation.

People are living longer but there are significant health inequalities
Average life expectancy in Cambridgeshire is 80 years for males and 84 years for females. In Peterborough, average life expectancy is 78 years for males and 82 years for females (2008-2010 ONS Life Expectancy). Life expectancy in both areas is increasing over time and death rates for the major causes of death are generally declining locally, as they are nationally. Death rates for diseases like circulatory diseases are falling more quickly than death rates for cancers. However, important differences remain between the life expectancy and mortality of our populations between local authority districts and between areas in both Cambridgeshire and Peterborough, for example in Peterborough the rate of coronary heart disease (CHD) mortality is not falling as fast as in Cambridgeshire, some districts in Cambridgeshire have higher death rates than the county average, e.g. in Fenland and there are important differentials in premature deaths from CHD.

Demand for mental health services continues to increase
Local mental health services face many of the same trends as identified in the preceding paragraphs, in particular the increase in overall population growth, but especially of older people. The demand for services continues to increase and especially the number of people presenting with dementia. The modern focus on community-based 'recovery' services places significant pressures on community services. Community Health Profiles also provide an overview of local mental health prevalence. The most significant risk-factors for poor mental health locally are deprivation, employment, limiting long-term illness, crime, substance misuse, physical health and being part of a 'marginalised' group such as an ethnic minority, homeless or people with a learning disability. There are pockets of deprivation throughout the CCG, but for most mental health risk factors Fenland, Peterborough and Cambridge City are above national averages, whilst Huntingdonshire, South Cambridgeshire and East Cambridgeshire are below national averages.

Deprivation:
Cambridgeshire is less deprived than Peterborough although there are significant areas of deprivation in Fenland, North East Cambridge and North Huntingdon.
Peterborough is predominantly urban with 26% of the population in Peterborough living in the most deprived areas in the country (Dogsthorpe and East Wards).

Life expectancy differs significantly across the CCG
77.7 for men in Peterborough (significantly below the national average)
80.6 for men in Cambridgeshire (significantly above the national average)
82.6 for women in Peterborough (statistically the same as the national average)
84.5 for women in Cambridgeshire (significantly above the national average)
Circulatory disease and cancer are the main causes of death.
For more information, see Peterborough JSNA at:
http://www.peterborough.gov.uk/health_and_social_care/joint_strategic_needs_assesmen.aspx

and Cambridgeshire's JSNA at
http://www.cambridgeshireinsight.org.uk/jsna

Healthcare needs assessment : Key issues for CUH

The Joint Strategic Needs Assessment (JSNA) also identifies key issues for CUH in a number of areas. In summary:

Children and Young People:

JSNA: A good start to life has a positive impact throughout the lifecourse. Need to identify and focus on vulnerable children

- As recommended in the Marmot Review, effective local delivery requires participatory decision making at the local level which can only happen by empowering individuals and local communities. 'ACTIVE' is CUH's Children and Young Person's Board to promote and engage in service evaluation and redesign. CUH has three dedicated websites for children and young people coming into hospital.
- CUH is committed to safeguarding and promoting the welfare of children and young people and expects all of its employees and contractors to share this commitment. All staff undertake mandatory safeguarding children training. The Trust complies with the requirements of Section 11 of The Children Act 2004.

Older People:

JSNA: Significant growth in numbers over the next 20 years

CUH recognises the changing demographic that will occur in the 65 years and older population and the significant issues it will pose. CUH has already responded to increasing numbers of older and frail patients that it is currently treating through:

- Continued focus on the integration of health and social care with well-developed communication between primary and secondary care as part of the CCG's older person's tender process. In primary care, higher continuity of care with a GP is associated with lower risk of admission.
- CUH has an active dementia working group and a developing dementia strategy as well as encouraging staff dementia training and champions. CUH employs dedicated clinical specialist nurses for dementia and mental health. The Trust also utilises the 'This is me' passport for patients with Alzheimers.
- CUH introduced the Dementia Assessment Tool (CQUIN) to all patients aged 75 and above admitted as an emergency (day cases, transfers and elective admissions are not included at present). Accurate information about a patient's cognitive state supports better patient management.
- All patients aged 75 years or over admitted to the Trust, via the emergency pathway, are to be screened for frailty using the clinical frailty scale (CFS) within 72 hours of admission.
- A number of initiatives have been rolled out to assist older patients in hospital including colour coded trays in wards to identify if patients need assistance at meal times and dance and movement sessions to aid in rehabilitation. A pictorial hospital communication book was introduced in 2010 to assist a range of patients in communicating their needs and for staff to help explain medical procedures.
- CUH has focused on development of the Ambulatory Care service where a significant proportion of emergency medical patients can be managed safely and appropriately outside of the Emergency Department (ED) setting without the need for admission to a hospital inpatient bed.
- CUH is reviewing plans for a Frail Elderly Unit to bypass ED and provide dedicated clinical geriatric assessment in an appropriate setting.
- Continued use of the Addenbrookes@Home service once patients are medically fit for discharge enables available capacity to be used more effectively.
- Reviews of care pathways and redesign in conjunction with local health economy partners.
- Continued promotion of education and self-management for Long Term Conditions (LTCs) especially for those patients with asthma and COPD through CUH's Centre for Self-Management.

Alcohol:

JSNA: Overall, Cambridgeshire as a county compares well to the national average on statistics for alcohol misuse and harm but Cambridge City is above the national average for a number of indicators including

hospital admissions specifically caused by alcohol, aspects of alcohol related crime and binge drinking

- CUH continues to work with partner agencies across the LHE to support alcohol-specific interventions for individuals during a hospital admission. This includes regular contact with the City and County Council, the police and local alcohol support charities.

Smoking:

*JSNA: Cambridgeshire smoking prevalence estimated at 11.5 % *(less than the English average) but 26.1 % in people in routine and manual occupations*

- CUH has become a no-smoking site as of January 2014 and continues to promote a smoking cessation service for both outpatients and inpatients.

Ethnic Minorities and Migrant workers (including Gypsies and Travellers):

JSNA: Foreign-born workers have traditionally formed an important sector of the seasonal labour force in Cambridgeshire; recently, migrant communities are becoming more established and less 'seasonal'. The distribution, hotels and restaurant industries are important employers for foreign born workers in Cambridge City. In other districts, the majority of migrant workers are employed in agriculture, manufacturing and construction industries.

Cambridge also attracts highly skilled migrants due to the presence of the University, a major teaching hospital and technology companies.

Gypsies and Travellers make up almost 1% of the population in Cambridgeshire representing the largest ethnic minority in the county. Gypsies and Travellers have:

- Significantly poorer health status (in Peterborough only 55% reported no health problems)

- More self-reported symptoms of ill-health than the rest of the population

- Reported health problems being between two and five times more prevalent.

- Poor mental health is a particular concern. Access also needs to be improved

- Low uptake of early intervention and prevention measures such as screening and immunisation

- Adverse rates of lifestyle risk factors such as rates of smoking and obesity

- CUH acknowledges the needs of a multi-ethnic urban population. We provide access to interpreter services for patients and encourage our staff to attend workshops to explore issues, processes and ways of communicating in order to improve access to local NHS services. We have specific staff training and awareness in diversity and mental health issues for minority ethnic groups.
- CUH works with Public Health's multi-agency team Traveller Health Team in health checks, reflecting cultural needs and promoting co-located services allowing multi-disciplinary assessment and treatment.

People with learning disabilities:

JSNA: As the population grows and ages, the number of people with disabilities is also expected to rise, leading to an increased proportion of people with a learning disability (LD) aged over 55 so that parents caring for them are likely to have died or become frail. Analysis demonstrates that:

- Social care requirements for people with learning disability in England are expected to increase by 14%, up to 2030

- The number of children with disabilities is predicted to increase

- The number of children with statements of special educational needs has increased in Cambridgeshire

Additionally, we know that people with learning disability in England are more likely to go into hospital for conditions that could have been treated in the community. People with learning disabilities in Cambridgeshire reported certain shortcomings in the provision of health care services (in 2007). This included:

- a lack of 'easy read' information

- poor attitudes from some health staff towards people with learning disabilities and their carers

- insufficient care available whilst person with learning disability is in hospital

- inadequate hospital facilities, including access and delays in referrals

Local surveys identified that people with autism have unmet needs, such as difficulties with identification and diagnosis and a lack of training amongst staff concerning people with autism with whom they came into contact.

- CUH hosts an LD training programme and an LD working group which service users and carers attend quarterly meetings. Relevant charities and voluntary organisations are also represented in this forum which encourages debate and collaboration in identifying staff training needs or facility requirements to improve the secondary care experiences for LD patients.
- Staff training programmes enable early identification and diagnosis of patients with LD, appropriate care at the front door and subsequent period in hospital. CUH also strives to ensure LD recording on patient hospital information (notes/system alerts) during hospital admission.
- CUH is working towards all services being fully accessible to those with LD with key information available in an accessible form. The hospital pictorial communication book supports these patients and a 'Patient Passport' for those with LDs (including children) is widely used.
- CUH will further the promotion of the LD specialist nurse role accessible to patients of all ages. The aim is to review every admitted LD patient within 24 hours; construct an individual care plan with the team managing the patient and formally liaise with the patients, carers or family.

Mental Health (MH):

- CUH continues to provide Liaison Psychiatry Services in conjunction with Cambridgeshire and Peterborough FT aiding in admission avoidance where appropriate. This works in a number of ways including direct intervention in A&E and the Clinical Decision Unit to prevent admissions and with wards and discharge planning teams to facilitate appropriate and timely discharges.
- CUH encourages staff training to better identify and manage MH needs amongst acute hospital patients. Dedicated specialist nurse roles provide support for patient management.
- CUH works with its LHE partners as well as the Richmond Fellowship and 'Shame No More' to promote initiatives such as Mental Health Awareness week and address the issue of Mental Health self-stigma.
- The Cambridge Dementia Biomedical Research Centre (BRC) has a pioneering experimental research programme in dementia and capitalises on translating research in the laboratory through to patient trials in clinics. This will significantly impact on the diagnosis, prevention and treatment of dementia for both the individual patient and the community.

Our Patients

We provide acute and specialist services to our local population and across the East of England. Our patients predominantly come from Cambridgeshire, Essex, Suffolk and Hertfordshire. CUH's strength lies in the combination of its different roles to catchment populations of between 500,000 and several million:

- As a local District General Hospital for the Cambridgeshire community;
- As a specialist hospital on a supra-regional and national basis;
- As a major academic and clinical research centre; and
- As a teaching hospital for the University of Cambridge

As well as providing clinical care, we have a significant focus on research and teaching. We are part of a successful Academic Health Science Network whose aim is to accelerate the translation of clinical research into healthcare practice as well as to develop and implement integrated services.

Patient safety, quality, patient experience and performance remain at the top of the Board's agenda. Our priority remains the care of our patients; we are treating more people than ever before and our health outcomes remain amongst the best in the country.

Against this background the Trust faces increasing demand based on population growth and advances in healthcare which means that our population is living longer. Rising activity over and above population growth result in increased use of a range of Trust services and particularly emergency care. Trust capacity to accommodate this rising activity is limited by physical space, ageing infrastructure and budgetary constraints.

Activity assumptions

Activity assumptions have been based on ONS growth adjusted for historical growth in excess of ONS projections, with further adjustments for known developments and anticipated changes.

The following table shows forecast activity compared to plans for 2013/14 and projections for the period 2014-15 to 2018-19 by activity type, including Monitor's reporting structure.

AP Narrative - Activity Sub Heading2	2013-14 Planned Activity	2013-14 Forecast - Activity	2013-14 Variance	2013-14 Variance %	Final 2014-15 Forecast - Activity	Final 2015-16 Forecast - Activity	Final 2016-17 Forecast - Activity	Final 2017-18 Forecast - Activity	Final 2018-19 Forecast - Activity	2014-15 Growth %	2015-16 Growth %	2016-17 Growth %	2017-18 Growth %	2018-19 Growth %
Admitted Patient Care														
Elective														
Day Cases (Includes Regular Day Attenders) *	109,935	115,423	5,488	5.0%	121,642	128,531	135,749	143,174	151,270	5.4%	5.7%	5.6%	5.5%	5.7%
Elective Inpatients	19,543	20,061	518	2.7%	19,391	21,453	22,444	23,458	24,547	(3.3%)	10.6%	4.6%	4.5%	4.6%
Elective Total	**129,478**	**135,484**	**6,006**	**4.6%**	**141,033**	**149,984**	**158,193**	**166,633**	**175,817**	**4.1%**	**6.3%**	**5.5%**	**5.3%**	**5.5%**
Non-Elective	53,517	54,143	626	1.2%	55,329	56,652	58,138	59,658	61,318	2.2%	2.4%	2.6%	2.6%	2.8%
Admitted Patient Care Total	**182,995**	**189,628**	**6,633**	**3.6%**	**196,362**	**206,635**	**216,330**	**226,290**	**237,135**	**3.6%**	**5.2%**	**4.7%**	**4.6%**	**4.8%**
Accident & Emergency	**99,577**	**102,092**	**2,515**	**2.5%**	**106,379**	**110,212**	**114,638**	**119,240**	**124,027**	**4.2%**	**3.6%**	**4.0%**	**4.0%**	**4.0%**
Outpatients														
First Attendance	136,006	140,752	4,746	3.5%	152,094	155,199	163,312	171,883	181,225	8.1%	2.0%	5.2%	5.2%	5.4%
Follow Up Attendance **	360,783	375,326	14,543	4.0%	389,693	398,020	411,276	424,615	439,033	3.8%	2.1%	3.3%	3.2%	3.4%
Outpatient Procedures **	105,084	98,851	(6,233)	(5.9%)	160,459	167,714	175,022	182,307	190,316	62.3%	4.5%	4.4%	4.2%	4.4%
Outpatients Total	**601,873**	**614,929**	**13,056**	**2.2%**	**702,245**	**720,933**	**749,609**	**778,805**	**810,575**	**14.2%**	**2.7%**	**4.0%**	**3.9%**	**4.1%**
Other NHS Activity														
Chemotherapy Delivery Event	16,614	17,974	1,360	8.2%	18,027	20,534	21,527	22,575	23,680	0.3%	13.9%	4.8%	4.9%	4.9%
Chemotherapy Procurement Event	15,314	16,597	1,283	8.4%	18,040	18,892	19,778	20,713	21,699	8.7%	4.7%	4.7%	4.7%	4.8%
CQUIN	0	0	0	0.0%	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0.0%
Critical Care Bed Days	37,785	36,728	(1,057)	(2.8%)	36,447	38,092	38,092	38,092	38,092	(0.8%)	4.5%	(0.0%)	0.0%	(0.0%)
Direct Access ***	2,361,511	2,483,658	122,147	5.2%	164,935	171,496	175,387	179,353	183,442	(93.4%)	4.0%	2.3%	2.3%	2.3%
Excess Bed Days	36,550	40,908	4,358	11.9%	36,259	37,615	39,193	40,758	42,488	(11.4%)	3.7%	4.2%	4.0%	4.2%
High Cost Drugs and Devices	0	0	0	0.0%	0	177	177	177	177	0.0%	0.0%	0.0%	0.0%	0.0%
Maternity Pathways	7,636	9,611	1,975	25.9%	8,623	10,250	10,250	10,250	10,250	(10.3%)	18.9%	0.0%	0.0%	0.0%
Other NHS Activity	315,153	318,362	3,209	1.0%	289,915	291,632	298,427	305,172	312,157	(8.9%)	0.6%	2.3%	2.3%	2.3%
Outpatients - Other (Includes Unbundled) **	198,643	190,723	(7,920)	(4.0%)	163,945	168,783	172,801	176,960	181,417	(14.0%)	3.0%	2.4%	2.4%	2.5%
Radiotherapy Fractions	49,481	47,669	(1,812)	(3.7%)	48,807	49,622	50,470	51,238	52,056	2.4%	1.7%	1.7%	1.5%	1.6%
Radiotherapy Planning	4,695	4,704	9	0.2%	4,795	4,891	4,983	5,069	5,163	1.9%	2.0%	1.9%	1.7%	1.8%
Rehabilitation Bed Days	10,186	10,556	370	3.6%	11,243	12,655	12,963	13,279	13,601	6.5%	12.6%	2.4%	2.4%	2.4%
Renal Dialysis	65,473	70,012	4,539	6.9%	75,698	80,728	86,802	92,800	99,112	8.1%	6.6%	7.5%	6.9%	6.8%
Other NHS Activity Total	**3,119,041**	**3,247,500**	**128,459**	**4.1%**	**876,734**	**905,368**	**930,850**	**956,436**	**983,336**	**(73.0%)**	**3.3%**	**2.8%**	**2.7%**	**2.8%**
Grand Total	**4,003,486**	**4,154,149**	**150,663**	**3.8%**	**1,881,720**	**1,943,149**	**2,011,428**	**2,080,772**	**2,155,072**	**(54.7%)**	**3.3%**	**3.5%**	**3.4%**	**3.6%**

* Now includes Renal Dialysis Regular Day Attender Spells in 2013-14 plan for consistency

** Plan movement due to Radiotherapy Clinic reporting change

*** TPP Impact

In headline terms activity projections for the period 2014/15 to 2018/19 are as follows:

- Elective spell growth projected to be on average 5.4% per annum (Day Cases 5.6%, Inpatients 4.2%).
- Non-Elective spell growth projected to be on average 2.5% per annum.
- Total Spell growth therefore projected to be on average 4.6% per annum.
- Accident & Emergency growth projected to be on average 4.0% per annum.
- Outpatient Attendances projected average growth of 3.9%* per annum, made up of the following:
  - – First Attendances growth of 5.2% per annum.
  - – Follow-up Attendances growth of 3.2% per annum.
  - – Outpatient Procedures* growth of 4.3% per annum.
  - – The above numbers* are affected by a change of reporting of outpatient procedures in relation Radiotherapy and so this has been adjusted for to provide like for like comparison.
- Other NHS activity is projected to grow on average by 1.9%** per annum. Given the various activity types included within this heading some of the main growth types are as follows:
  - – Chemotherapy Delivery and Procurement events are projected to grow on average by 5.7% and 5.5% per annum respectively.
  - – Radiotherapy Fraction and planning events are projected to grow on average by 1.8% and 1.9% per annum respectively.

– Driven by spell projections, Rehabilitation bed days are projected to grow on average by 5.3% per annum.

– Renal Dialysis sessions growth projected to be on average 7.2% per annum.

– The above numbers** are affected by the TPP transfer and the change in reporting of outpatient procedures in relation to Radiotherapy and so these have been adjusted to provide like for like comparison.

Implications for bed pools / other physical capacity

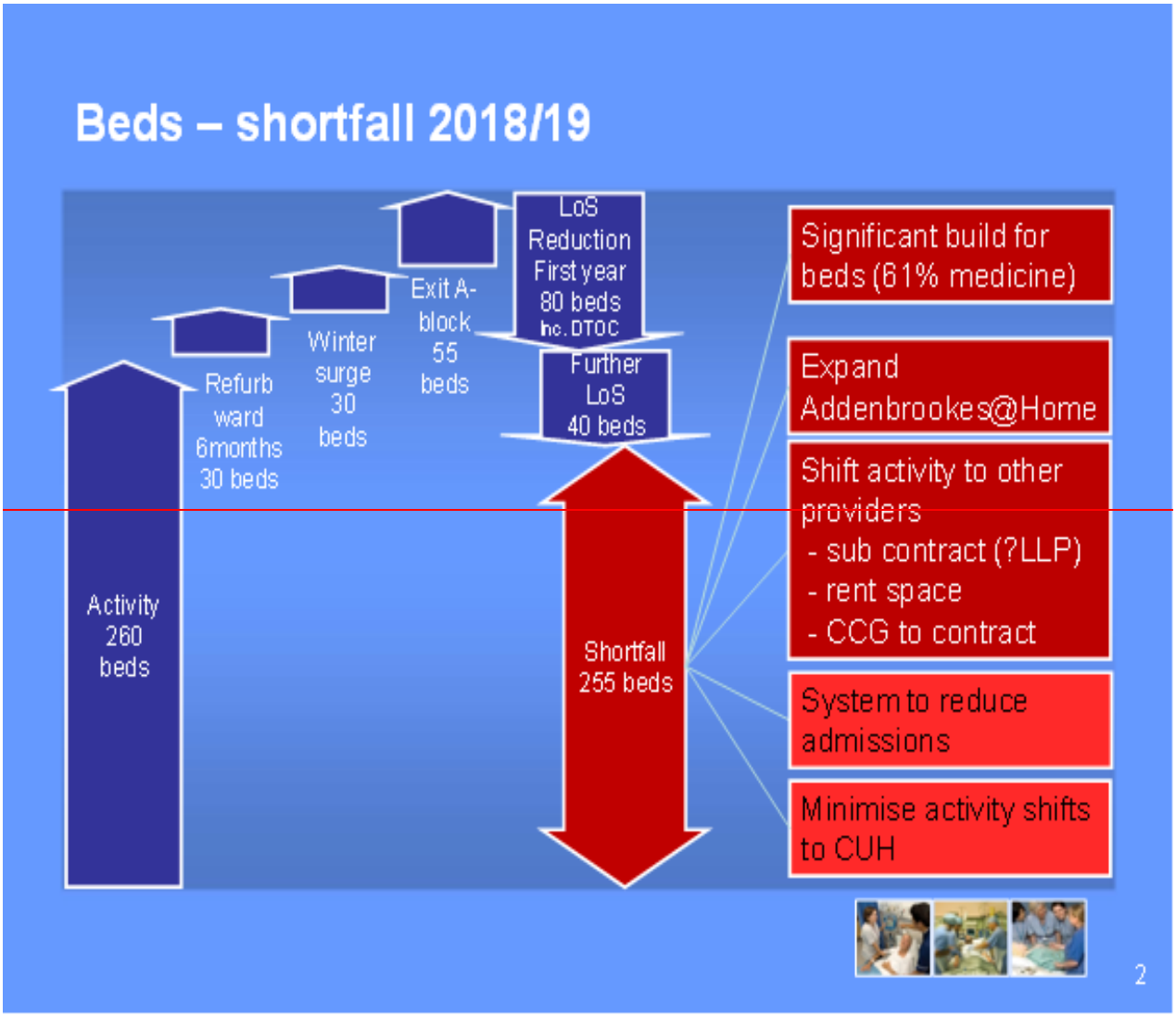
We have identified target bed savings based on upper decile performance from a group of 30 peer hospitals across our 5 Divisions. Target bed savings have been derived using a volume adjusted approach, calculated at procedure or diagnosis for elective and non-elective activity respectively. The savings focus has been on inpatients with a historical average length of stay between 1 and 27 days. The overall target bed saving, if the upper decile benchmark is achieved is 79.6 beds.

Activity projections, taking into account demographic factors such as increased pressure on length of stay due to the ageing population and increasingly complex co-morbidity patterns, will require an extra 38 general acute beds to deliver plans for 2014/15, prior to any identified length of stay savings. Additionally activity projections for 2015/16 and 2016/17 would require a further 46 and 48 beds respectively. This would take the total general acute bed requirement for additional activity during the period April 2014 to March 2017 to 134 beds, prior to any identified length of stay savings.

Furthermore, the longer term picture to March 2019 would add a further requirement for 2017/18 and 2018/19 of 102 beds, taking the five year bed requirement for growth to 236 beds, prior to any identified length of stay savings.

The Trust is also looking to provide additional headroom in terms of general bed capacity and is therefore looking to reduce bed occupancy from 92% to 90%. This is equivalent to an additional 22 general acute beds. This would take the overall acute general bed requirement for the period April 2014 to March 2017 to 156 beds, prior to any identified length of stay savings and to 258 beds for the 5 year period to March 2019.

Clearly, a number of additional risks still exist to projections. It is felt the risk of over-performance should be mitigated due to the basis of the plan's construction, through the use of ONS growth and recognition of historical growth in excess of historical ONS projections. However, there is the risk that the planned number of patients whose transfer of care is delayed is substantially exceeded. To this extent, overall demographic modeling has sought to ensure appropriate allowances have been made for the ageing population. Additionally, the risk exists that services at other providers may shift in an unplanned manner, putting significant pressure on general acute bed and target achievements.



Based upon current Theatre utilisation and projected activity levels the Trust has an additional 0.9 Theatre requirement for 2014/15, rising to 6.7 theatres by 2018/19. In addition to this the Trust recognises the need to exit and re-provide three theatres in the A-block due to fire risks and the need to exit two theatres within Main Theatres for four years to enable the refurbishment of air cleaning and cooling plant. Through the Theatres Workstream of the Transformation programme the Trust anticipates gains of around 1.2 theatres in efficiency. This gives a shortfall of 10.5 theatres by 2018/19. To bridge the short term deficit the Trust intends to build a theatre pair within Main Theatres in 2014/15 and utilize other providers both through sub-contracting and with commissioners re-directing GP referrals. To bridge the longer term deficit the Trust will need to consider a combination of normalising elective weekend operating and additional capacity created by strategic outline cases being worked up for Children, Neuroscience and Cancer patients.

Based on current length of stay and projected activity levels the Trust has an additional 38 bed requirement in 2014/15, rising to 260 beds in 2018/19. This is based on demographic growth split into 5 year age bands plus historic increases seen above this demographic growth. In addition the Trust recognises the need to exit 55 beds in the A-block due to identified risks, to reduce the occupancy in the Trust to 90% to improve patient safety and to release a ward each summer for six months to enable ward refurbishments for patient safety reasons. Through the capacity workstream of the Transformation Programme the Trust is targeting 122 beds of capacity creation in 2014/15, driven by length of stay and local health and social care system reductions in Delayed Transfers of Care. There are also smaller targets for increasing ambulatory alternatives to emergency admission and in use of the patient hostel. To bridge the short term deficit the Trust intends to use the Capacity workstream as described. To bridge the

longer term deficit the Trust will need to consider additional capacity created by strategic outline cases being worked up for Children, Neurosciences and Cancer patients and steps that could be taken through the integrated care procurement being run by Cambridgeshire & Peterborough CCG, to reduce non-elective admissions.

In terms of Endoscopy rooms, activity projections show that based upon current working practices the Trust would require an additional 0.4 rooms for 2014/15, rising to 1.1 rooms by March 2017 and finally 1.9 rooms by March 2019. Moving all 6 Endoscopy rooms to 6 day working (currently only 3 routinely work Saturdays) would mitigate the projected growth to March 2017. After this the Trust will need to consider either routine 7 day working or additional physical Endoscopy room capacity to mitigate growth to March 2019.

Capacity Development: Theatres

A scheme to develop two new theatres within the existing Trust theatre area has been approved by the Board of Directors.

With a highly utilised and ageing plant, options for building a new theatre in this financial year to accommodate additional surgical activity have been developed and reviewed to address the 2014/15 shortfall in theatre capacity. In-list utilisation is now at a maximum level resulting in no regular fixed session availability, affecting our ability to deliver RTT and cancer targets.

The Trust is planning to develop two additional theatres (incorporating EVAR) with recovery and re-located support facilities. Providing an additional six recovery spaces, they will be co-located in an ideal position within the Trust's main theatre suite, next to Emergency/Transplant/Recovery/Overnight Intensive Recovery. This new development will also provide greater flexibility and supervision of junior theatre, anaesthetic and surgical staff, particularly out of hours. The programme of design and construction should take nine months from approval.

Capacity Development: Options for major infrastructure development

The Trust faces urgent requirements for further capital investment in clinical facilities. In addition to a general capacity shortfall, there are specific issues in a number of key service areas that can only be resolved through further investment. The key drivers for this investment in buildings to meet this capacity shortfall are:

- Rising demand caused by demographic change
- An immediate shortfall of 30 adult beds and 1 theatre in 2014/15 and a projected shortfall of 255 beds and 10 theatres by 2018/19
- Long-standing and increasingly critical issues in paediatric services:
  - insufficient capacity (30 beds now rising to 60 beds in 2018/19)
  - dispersed services (14 locations across the hospital)
  - functional unsuitability, especially as regards segregation from adults
  - vulnerable children's services in neighbouring District General Hospitals
  - continuing pressure for centralisation of specialist work at Addenbrooke's
  - plans for academic development that would bring additional specialist activity
- Critical infrastructure issues in the neurosciences block (built c1960)
- Capacity requirements in the Oncology and Haematology Day Units, where activity is growing at 7% to 8% per annum. These units are already operating at a level of utilisation where patient dignity and privacy are compromised and will soon be faced with a level of demand that cannot be met within existing facilities
- Substantial backlog maintenance requirements

It is highly unlikely that the Trust will have the necessary borrowing capacity to resolve all of these issues in the next five years. The challenge therefore, is in identifying a deliverable development that will optimise the response to capacity, safety and functional suitability challenges in a context of severe resource constraints. In response to this challenge, the Trust has initiated work to develop business cases as follows:

- Children's Services - a dedicatedservice to meet projected demand, improve patient care and to

enable the further repatriation of activity from London and to establish a regional centre for specialist children's services in conjunction with regional partners.

- Oncology and Haematology Ambulatory Centre - the Centre will deliver transformed patient experience covering Day Chemotherapy (including haemato-oncology), Outpatient Clinics, Information and Support
- Neurosciences Facility - improved facilities to accommodate demand for Neurology activity (primarily the diagnosis of acute symptoms and the long-term management of chronic neurological conditions) and Neurosurgery infrastructure (operating theatres, intensive care and radiology with major specialised equipment)

The initial timescale for reporting this first phase of the proposed development programme to the Board is June/July 2014

Local health economy context: Cambridgeshire and Peterborough CCG Outline Strategic 5 Year Plan 2014/15 to 2018/19

The CCG's key areas for transforming the health and social care system are:-

- Maximise areas of joint commissioning between the Clinical Commissioning Group (CCG), the Local Authorities (Cambridgeshire County Council and Peterborough City Council) and NHS England whilst moving our contracting towards outcome based measurement and rewards.
- Effectively manage the local health and social care markets together as commissioners working with providers to achieve the safest, highest quality health and social care services with the best clinical and experience outcome for patients. Key areas for market transformation are:-
  - More preventative services especially in the community, schools and out of hospitals for the young and frail elderly. Supporting self-care, patient empowerment and personalisation.
  - More integrated continuity of care out of hospital for people with long term care conditions
  - Delivering more capacity in primary care at scale and collaboratively across social and community services
  - Delivering the safest, clinical service for emergency and urgent care needs within all national and local standards of access
  - Achieving a step change in productivity and equity of access to clinically effective planned and elective care meeting NHS Constitution Standards at all times.

To achieve true transformational change across our health and social system all LHE partners will need to fully engage patients, the public, local professionals and politicians to help achieve a radical change in the range and location of services over the next 5 years. If we are to achieve our ambitions for sustaining high quality, safe and easily accessible services by 2020 for our growing population, we will need our full fair funding allocation in order to meet our statutory duties and deliver for patients and our population.

This involves short term opportunities in:

- Clinical engagement
- Older People's Procurement
- Multidisciplinary Team working piloting across the CCG
- Closer work with Local Authorities through the Health and Wellbeing Boards and Better Care Fund
- Motivation across all providers to improve outcomes and have a financially stable system

and long term opportunities in

- Sustained demand reduction and improve wellbeing through maximisation of patient engagement and prevention
- Alignment of the provider landscape with available financial resources.
  This will involve consideration of the services provided and configuration of acute hospitals, community care and primary care i.e. a managed re-set of the provider market
- Continued integration at the operational and organisational level that moves to a seamless service for patients
- Step change in clinician involvement

The clinical areas for strategic pathway change over the 5 years of the Plan are:

- Older Peoples Services
- End of Life Services
- Coronary Heart Disease - tackling inequalities in outcomes
- Children and Young People Services
- Emergency and Urgent Care Services
- Mental Health Services
- Long Term Care Condition Services
- Planned and Elective Care Services
- Cancer Services

In addition, operational improvements will be sought in

- Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.
- Increasing the proportion of older people living independently at home following discharge from hospital.
- Increasing the number of people having a positive experience of hospital care.
- Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

Market analysis

The financial position across the health economy and in social care will remain challenging into 2014/16 and beyond.

PWC's analysis shows that Cambridgeshire and Peterborough CCG has a low Herfindahl measure of market concentration for inpatient and outpatient providers. This indicates a greater level of competition between providers and greater patient choice for services. This also suggests duplication of services, and therefore costs, within the market.

However, our experience is that the Trust's geographical position within the region (with hospitals spread out at a considerable distance) means that competition is constrained particularly for District General Hospital (DGH) type services. Patient choice does bring some DGH patients from outside our immediate catchment population but this is limited. There is some competition in a limited number of clinical sub-specialist areas but this is largely dealt with through formal centralisation processes. (e.g. vascular surgery/surgical resection of liver metastases).

Over the life of this plan we currently expect the debate in relation to Peterborough and Hinchingbrooke Hospitals to continue.

We do not expect any significant changes in market share except as a result of planned regional collaboration and repatriation of patients, particularly of children's services, from London hospitals.

CUH SWOT Analysis

Strengths	**Issues**
Leading edge services/developments	• Significant strengths in numerous clinical disciplines • eHospital • Pathology Partnership • Major Trauma Centre
Reputation	• Based on 'quality', specialisation, research and development and education and training • Government-designated Biomedical Research Centre • The 'Cambridge' brand i.e. partnership working with the University and other partners • Strong across the tripartite mission – patient care, clinical research and medical education
Locality	• No major restrictions on physical space around campus • Community orientated to bio-pharmaceutical science and technology with eighteen science parks
Health and social care economy	• Good local GPs • Committed Local Authority
Staff	• High commitment and good quality reputation • Strong Board of Directors and Council of Governors
Partners	• University of Cambridge • Shelford Group • Campus partners (MRC/LMB, CRUK, GSK etc) • Cambridge University Health Partners • Academic Health Science Network (AHSN)
Weaknesses	**Issues**
Capacity	• Growth in demand typically 3% above that expected from population growth • Need to ensure we secure workforce supply to meet demand
Financial constraints	• Success of previous years CIP Programme will be increasingly difficult to repeat without impacting on patient care • Local health economy nationally recognised as financially challenged
Demographics	• Growing and ageing population • High consumers of healthcare – patients are assertive and demanding • Expensive area to live
Infrastructure	• F & G block and A block need replacement • A&E capacity is limited • Lack of capital for new equipment and buildings
Opportunities	**Issues**
Leadership roles in the Local Health	• Opportunity to work collaboratively with commissioners and providers to create an integrated

Economy	health and care system across Cambridgeshire and Peterborough • Potential to extend our service portfolio/governance into primary and community care
eHospital	• Potential to extend benefits across the health economy
Integrated Care	• New models of care arising from the Integrated Care tender
Forum	• High level educational and conferencing opportunities • Commercial opportunities
Campus Development	• Papworth relocation • SOCs for Cancer, Children and Neuroscience under consideration
Threats	**Issues**
Demand continues to grow above levels expected from population growth	• Lack of capacity/ funding/capital Role of Hinchingbrooke and Peterborough hospitals still to be clarified
Economy	• Deflating tariff over a prolonged period • Insufficient local infrastructure

1.4 Risk to sustainability and strategic options

Service line sustainability: Identified external challenges on each key CUH service line and the resulting sustainability risk

The table below is an initial assessment of the challenges facing each of our major service lines. It is set in the context of our portfolio management framework.

Portfolio Management Framework

Quadrant 1 – Invest and Grow

Cancer, neurosciences, transplant (With with Papworth) zoned for infrastructure development

Other BRC themed services: presumption in favour of growth based on affordable service development opportunities

Quadrant 2 – Right-size

Children's services zoned for infrastructure development to become the hub for the Eastern Region Child Health Service

Services for older people: presumption in favour of service development outside the hospital

Quadrant 3 – Transition

Presumption in favour of restructuring elective care services (and how they are paid for) across the LHE while retaining a sufficient platform for education and training

Quadrant 4 – Exit

Reduce interventions which result in little or no clinical benefits to patients

Assessment of the challenges facing each of our major service lines

	Risk to sustainability	**Options: Grow, right size, shrink, merge, collaborate or transform**	**Impact (CUH)**	**Impact(LHE)**	**LHE support required and alignment**
Digestive Diseases	Lack of capacity/increasing demand Lack of sufficient funding via NHSE Additional demand from national screening programmes (match in resources and capacity required)	Grow/collaborate	Pathway redesign – Digestive Diseases to embark on redesign of services. Moving to symptom based clinics and straight to test procedures where appropriate to release capacity. OP CQUIN for gastroenterology will affect LHE	Potential collaboration with local DGH's in a hub and spoke model for some routine procedures	Support for specialist regional services
ICU/Perioperative Care	Demand/Lack of capacity	Right size	Capital /revenue cost		Support for agreed focus
Musculoskeletal T&O	Ward/Theatre/Clinic capacity for increasing demand Manpower to support predicted demand and developments (Major Trauma Centre Ageing capital equipment/reduced budget	Potential to increase market share of DGH type activity with appropriate capacity and infrastructure (LLP) Development of regional paediatric network Metastatic bone disease/ Bone infection services growth Specialist orthopaedic unit status aim	Support services (AHP/therapies) also require matched investment to support growth	Change of focus in other LHE hospitals	Support for agreed focus

Cancer	Increasing demand/ CUH needs to be able to do more to help prevent cancer and to enable earlier detection, applying the principles of high throughput genomic screening to different disease sites. TYA funding mechanism yet to be agreed	Grow/collaborate	Capital /revenue cost Non-IOG compliant service, under discussion at national level	Continuing collaboration with local DGH's in a hub and spoke model	Support for agreed focus
Imaging	Increasing demand Diagnostic equipment budget to support implementation of new technology Demand related to increased cancer diagnostic, particularly prostate CCS' Medical Devices tender	Right size/collaborate	Capital /revenue cost £33m of Trust wide medical devices greater than their recognised life. MTC and perinatal equipment now out of warranty. Direct impact on radiology (CT, MRI, Bone scan) and pathology services as well as potentially oncology (MDT discussions), clinical activity and theatres CUH could increase its medical device services to CCS	Potential for a 'Transforming Imaging Partnership' type approach	Potential scope/scale and implications to be assessed
Labs	Increasing demand Number of NHS Regional Genetics laboratories will be rationalised in 2014	Right size	Capital /revenue cost Potential loss of funding	Part of Transforming Pathology Partnership	Support for agreed focus
Acute Medicine		Right size/collaborate			Support for agreed focus
DME	Increasing ageing population and changing demographics Reputational impact if we	Integrated elderly care plans will transform services internally	Outcome of contract implications has the potential to impact the services we provide and the way	Potential for better system-wide approach to managing	

	do not meet future demands	and externally	in which they are delivered Reduce length of stay Improve outcomes Improved patient experience	elderly patients	
Acute Medicine	The ability to appoint to medical workforce is a challenge nation-wide Increase in demand Reduction in junior doctors	Ambulatory care pathways need to be developed and expanded Opportunity to develop short stay working to stream patient from the emergency department early	Reduce length of stay Improve outcomes Improved patient experience	Improved access to services that avoid and reduce hospital admission	
Clinical Pharmacology	Sustaining the junior doctor workforce	Research and associated commercial opportunity with drug and medical science partners	Increased income	Research based care for the local health system	
Palliative Care	The ability to appoint to medical workforce	Need to expand palliative care beyond cancer to a great extent as there is many other specialities that could benefit from the service	Improved patient care and end of life patient experience	Greater support for family and relatives of dying patients	
Emergency Medicine	The ability to appoint to medical workforce is a challenge nation-wide Reduction in junior doctors Significant increase in activity (ambulance arrivals, care of the elderly, mental health, etc.)	The implementation of the recommendations outlined in the 'Transforming urgent and emergency care services in England'	Further increase in activity	Increased centre of excellence	Negotiate the expansion of remote medical advice and guidance services

Inflammation / Infection	BRC research themed clinical area Physical Capacity across directorate Shift from : Emergency to elective Elective to daycase Daycase to ambulatory	Growth based on research potential Collaborate with Papworth thereby optimising patient pathways and care delivery models Collaborate with other trusts via Networks and SLAs Growth through specialist commissioning Growth through private specialist delivery e.g. Nutlife	Do nothing will produce negative impact on LoS/beddays/finance Develop patient pathway models will increase usage of BPH Increased specialist activity OP/elective Re-design of CUH/PAPH in order to provide innovate collaborative pathways (e.g. Bone Spec Service)	Streamlined and further enhancing patient pathways to avoid consultant duplication and enabling greater research opportunities Network SLAs would offer greater efficiencies for the LHE. Collaboration with other specialties (multi skilled teams)	Support for agreed focus Clear referral pathways for patients. Greater care in the community Care closer to home. Support for specialist regional services
Infectious Diseases	Physical Capacity Manpower Shift from : Daycase to ambulatory (OPAT) Payment Mechanisms (e.g. via Networks c) NHS commissioning GUM move to non-NHS providers (notice served)	No merge options Growth through transformation	Do nothing will produce negative impact. Knock on effect from commissioning and wider trust impact through non-NHSE commissioning for wider services Develop patient pathway models will increase income and activity Re-design of CUH pathways (Network SLAs) will produce wider trust benefit (e.g. Bone Spec Service)	Streamlined and further enhancing patient pathways to avoid consultant duplication and enabling greater research opportunities	Clear referral pathways for patients. Greater care in the community Care closer to home. SLA Support
HPB surgery	BRC research themed clinical area	Grow: Centralisation of liver mets surgery will bring in additional activity.	Already negotiated	Already negotiated	Support for agreed focus
Transplant	BRC research themed clinical area	Grow and collaborate – Papworth service	Capital/revenue investment Requires investment	None	Support for agreed focus

	Increasing demand	integration	in manpower/capacity and associated services - ITU/HDU beds resource/capacity to support activity		
Hepatology	Increasing demand	Grow	Investment required	None	Support for agreed focus
Nephrology	1-2 % increase in dialysis activity expected each year	Review options re satellite dialysis services at Bedford and Harlow hospitals	Capital/revenue investment	TBD	Support for agreed focus
Cardiovascular	Growth linked to move of Papworth to Cambridge	Right size relevant CUH services		None	Support for agreed focus
Metabolic	BRC research themed clinical area	Growth based on research potential	Capital/revenue investment	None	
Dermatology	Plan to serve notice at Hinchingbrooke – increased activity to CUH Exponential Outpatient demand not matched by increase in clinic space or medical manpower	Right size	Capital/revenue investment	For discussion	Support for agreed focus
ENT	Increase in demand/lack of capacity	Right size	Capital/revenue investment Increased demand	For discussion	Support for agreed focus
Oral/MaxFax	Increase in demand/lack of capacity Increased case complexity with MTC status Increased screening for Head and Neck cancer patients	Right size	Capital/revenue investment Additional and replacement medical manpower, theatres and clinic capacity Requires additional support services - treatment and rehabilitation. Additional MaxFax laboratory space will	For discussion	Support for agreed focus

			be required with additional manpower.		
Plastics	Not enough elective capacity –risk to targets/interdependencies with other specialties Sentinel Node Service and lymphadenectomy delivered by single consultant. Commissioning changes for cosmetic/aesthetic surgery mean thresholds reduction Bariatric surgery impact on plastics/cosmetic plastic surgery– resource implications with manpower, theatre and clinic capacity. National and regional centralisation process with potential to affect case complexity. H&N/Breast cancer reconstruction activity could reduce due to peripheral hospitals appointing local onco-plastic surgeons and the withdrawal of CUH surgeons from peripheral hospitals.	Right size	Capital/revenue investment Investment required in service/review of roles across department and regionally. Risks increase in referrals		Support for specialist regional services
Neuroscience	Increase in demand: the catchment area for neurosurgical cases has grown from 3.5 million to 4.8 million as the Trust's catchment extends down the A1 corridor. Clinical Reference Group expectation that demand for complex spinal surgery will increase The stroke service in East Anglia is very likely to be rationalised and	Grow	Capital/revenue investment Already the major centre for spinal surgery. Recognised regionally and nationally insufficient capacity for spinal injuries and complex surgery.	Network arrangements TBD	Support for specialist regional services

	Addenbrooke's is almost certain to be a key hub for treatment of this condition.				
Ophthalmology	Further centralisation of emergency and out of hour's services to a smaller number of units across the region anticipated. Increasing demand	Grow	Manpower investment needed to ensure increases in activity and greater community links are well managed to control demand Additional capacity investment – theatres and clinics at capacity Ophthalmology cannot increase private activity without additional theatre capacity	Network arrangements TBD	Support for agreed focus
Medical Paediatrics **Obstetrics & Gynae** **Paeds Critical Care** **Surgery Paeds**	Capacity – 51 beds, static against backdrop of rising activity - SOC in train to address this PICU growing into paediatric bed compliment - repatriating more patients into a static envelope – redirect around 100 PICU patients per year Regional issues - Bedford's unsustainable 24/7 service Hinchingbrooke: 25 beds shrunk to 19 because of staffing Workforce/staffing issues re nursing staff DGH vs. tertiary service - decision to be made. Development of a paediatric network across the region reflecting the decline in paediatric provision in peripheral	Right size	Capital/revenue investment	Network arrangements TBD	Support for agreed focus

	hospitals NHS England considering the designation of specialist paediatric ophthalmology centres. Reducing the number of units offering paediatric services from 40 to 20. Community Gynaecology clinics closure				

The ability to recruit sufficient quantity of suitably skilled and experienced staff remains a significant risk in all areas of service.

While this is our initial assessment of CUH's position, we will retain a flexible position in discussing and negotiating options with our colleagues in the LHE in order to deliver a sustainable service.

Meeting the challenge across the Cambridgeshire and Peterborough Local Health Economy

The content of this plan has been informed by three distinct but related strands of cross-system joint working.

- A Joint Strategic Planning Stakeholder Group has met since December 2013. This is chaired by the CCG Director of Commissioning and has on its membership Directors from across the Health and Social Care system and Healthwatch. In May 2014 the group held a 'system summit' which considered the different plans from the organisations in the system. Outputs from this work include agreement on the demographic projections and the risk log.
- PwC were appointed by NHS England to work across Cambridgeshire and Peterborough. They commenced this role in April 2014 and their work has been overseen by a local steering group chaired by the Director of the NHS England Norfolk, Suffolk and Cambridgeshire Area Team. This process has produced an overview of healthcare, and a system-wide estimate of the financial challenge. PwC have facilitated two Care Design Groups that have taken a clinically focussed approach to identify changes that could improve outcomes and the financial sustainability of the health system. Their estimation of the financial impact of these changes is shown below.
- The Cambridgeshire and Peterborough Chief Executives Group are working to agree the governance and delivery arrangements for this strategic planning work. Proposals on a delivery structure and resourcing for the next phase of this process are in preparation.

Possible interventions for change: the Care Design Group process to date

The Care Design Group process aims to identify options for change within a health system, confirm and challenge those options, determine which options could be taken forward and how this would be done and consider further options for development. It is a clinically driven process and works with representatives from across the whole health system.

PwC ran two Care Design Groups, on elective and non-elective care, in May 2014. Organisations were asked to nominate clinicians to be invited to the events. Clinicians and managers attended from the CCG, Hinchingbrooke Health Care NHS Trust, Cambridgeshire and Peterborough Foundation Trust, East of England Ambulance Service, Peterborough and Stamford Hospitals NHS Foundation Trust, Papworth Hospital NHS Foundation Trust, Cambridge University Hospital NHS Foundation Trust, Cambridgeshire County Council, Peterborough City Council, Urgent Care Cambridge and Herts Urgent Care. Patients representatives were also involved.

Design principles for the Care Design Group process

The following design principles were agreed as part of the Care Design Group process:

- Care is provided in the best setting (not necessarily the closest). Where patients must travel greater distances, issues with accessibility and transport are considered
- Care is patient centred, evidence based and does not compromise on quality
- Identify rules that are prohibiting efficient care, and flex them locally
- Set aside organisational boundaries, work for the benefit of the health system and the patients that we act for
- Be mindful of the impact we have on other health systems
- Manage patient expectations, work within financial limits (rights, entitlement, responsibility and education)
- The workloads of professional groups should be dictated by their skills, not their organisation
- Any future model of care should address the health inequalities across the health system
- Options for change must remain outcome focused
- Pathways must be designed to meet the needs of the most vulnerable

The result of the Care Design Group process was a set of proposals that could be used to improve outcomes and financial sustainability, as set out above.

The CCG is leading an approach similar to Care Design Groups to develop models of care in other areas including the following:

- Older People and Vulnerable Adults
- Women's and Children's
- Mental health
- Prevention

Financial impact of possible changes generate by the elective and non- elective Care Design Group process

The possible interventions that came out of the Elective and Non- Elective Care Design Group process have been assessed by PwC. An indicative change in activity if they were all implemented has been modelled, and the indicative financial savings that would result is a saving of around £80m. This is substantially short of the estimated gap of £250m.

Many of these possible interventions identified in the non-elective and elective CDG process increase the efficiency of the current health system, rather than create changes that will transform areas of health service delivery or reduce demand. To develop plans for a sustainable health system further consideration is needed of changes that will

- Deliver health services differently i.e. transform areas of the health system
- Reduce the demand for healthcare

1.5 Strategic plans

CUH Transformation

The Pathology Partnership

1st May 2014 saw the establishment of the Pathology Partnership (formerly known as the Transforming Pathology Partnership) as a contractual joint venture to deliver community and acute pathology services. The joint venture is owned by six trusts:

- Cambridge University Hospitals NHS Foundation Trust (CUH);
- Colchester Hospital University NHS Foundation Trust;
- East & North Herts NHS Trust;
- Hinchingbrooke Health Care NHS Trust,
- The Ipswich Hospital NHS Trust; and
- West Suffolk NHS Foundation Trust.

The joint venture was originally put together to bid to retain community pathology services under a competitive process initiated by the East of England SHA in 2011. The Partnership follows the recommendations of the Carter Review of Pathology Services in 2008, which advocated the development of shared service provision through a hub and spoke model. Under the Partnership's model there will be hubs at Ipswich and Cambridge which will deliver all the community (GP) and cold acute testing, whilst each partner trust will retain a satellite laboratory for urgent acute work.

CUH is the initial host to the joint venture for up to 3 years and will employ staff on behalf of the joint venture during that period. Public Health England will provide microbiology services on behalf of the Partnership and employ microbiology staff. Consultants will remain employees of partner trusts.

The Pathology Partnership objectives

The key objectives for the Partnership set out in the joint venture agreement can be summarised as:

- to deliver a transformed, high quality, cost effective and customer focused pathology services and to deliver improved health care in the health economy;
- to guarantee a safe and effective 24/7 core hospital pathology service for each Partner in order to meet the full requirements of each Partner for on-site pathology support;
- the provision of pathology services across as wide a UK territory as possible;
- not adversely affecting Partners' established clinical services and existing relationships or changing patient pathways without the agreement of the pertinent Partner;
- maintaining the principle of patient care "closer to home".

Key actions for Joint Venture

Years 1-2

- to move to a transformed 'hub and satellite' model of pathology through implementing centralised pathology systems and logistics and workforce transformation;
- standardisation of processes and procedures and driving 'lean', process improvement and skills throughout the organisation to drive down costs; and support building a reputation as an innovative provider and a leading organisation in pathology provision;
- development of new business and rolling other pathology services such as phlebotomy and point of care testing into the core five year blood sciences and microbiology contract with CCGs ;
- Planning and potentially moving to a new NHS owned legal structure

Years 3-5

- completing move to new legal entity
- securing a renewal for the core contract with CCGs at year five;
- continuing to develop service model and propositions including use of new technology and point of care testing
- deliver the cost reductions in the business plan and break even in year three and on track to deliver a

cumulative profit over the 8 operational years of £35 million as set out in the update to the joint venture's Investment Plan dated 24th January 2014.

- further consolidation of blood sciences and centralisation of histology processing
- growing the core business by adding partners into the consortium
- increasingly providing information to on-line requesting clinicians on the appropriate testing protocols
- actively looking at ways to exploit the organisation's single, standardised test database covering 3 million population to the growth in personalised medicine and the use of genetic testing
- providing active support to CUH becoming a national diagnostic and genetics hub

eHospital

eHospital is the largest ever investment in improving healthcare quality made by Cambridge University Hospitals, circa £200m over ten years. eHospital will deliver two strategic technology elements during 2014/15.

- Firstly the Trust will deploy a fully managed desktop service during 2014 providing flexible and truly mobile services, taking advantage of all the new technologies including providing nurses and doctors with clinical apps than can be accessed from their own iPhones and iPads (or equivalent Android). In all over 7,000 new devices will be rolled out across the Trust.
- Secondly the Epic electronic patient record (EPR) goes live in October 2014 providing all clinicians with a single robust, resilient and intelligent context specific integrated view of the patient's record. In the following optimisation phase we will develop more sophisticated pathways and work flows in the Epic application so that at every point in the care process, clinical decision support will work to protect patient safety and encourage compliance with organisational best practices.

By 2015 patients and GPs will have dedicated and secure access to our Epic EPR improving communication and efficiency and helping to drive up the quality of our care.

We will have comprehensive, structured clinical data which will support both Commissioning and research.

eHospital is part of our overall transformation agenda. It will ensure that any savings already achieved by service improvement and transformation will be sustainable into the future.

Over the life of this Plan eHospital will secure the following objectives:

- Ensure a single robust, resilient and intelligent context specific integrated view of the patient's record available to all clinical staff
- Deploy a fully managed desktop service which has the flexibility to make software available to all staff on a variety of technology platforms – in particular to take advantage of mobile devices with apps for iPhone and iPad (or equivalent android) technology.
- Optimise the base Epic implementation through development of more sophisticated pathways and work flows in the Epic application so that at every point in the care process, clinical decision support will work to protect patient safety and encourage compliance with organisational best practices.
- Develop staff skills to enable clinicians to build, customise and configure local specialty specific pathways, work flows, order sets and clinical decision support systems in the Epic EPR.
- Use the structured clinical and activity data to support commissioning and research and deliver more innovative and efficient models of care.
- Provide patient access to MyChart to encourage patients to improve their own health and reduce the cost of service provision.
- Use EpiCare Link to provide direct access into the EPR for GPs and other health and social care providers improving communication and relationships with other providers.
- Support the sustainability of the Trust's transformation agenda.

Integrated care

Future scenarios for integrated care depend on the outcome of the bid process. The Trust is preparing its position based on its own bid and the possibility of other entrants into the market.

Better Care Fund (BCF)

The overall vision for health and social care services in Cambridgeshire is: 'Our long-term shared vision is to bring together all of the public agencies that provide health and social care support, especially for older people, to co-ordinate services such as health, social care and housing, to maximise individuals' access to information, advice and support in their communities, helping them to live as independently as possible in the most appropriate setting.'

The whole health and social care system in the county has a shared ambition to improve health and wellbeing for local people, but is faced with the twin challenges of rising demand and reducing budgets. Furthermore, Cambridgeshire remains the fastest growing county in the country and, without change, our services will be unsustainable in the very near future. Consequently, the Health and Wellbeing Board, local authority and the CCG have already been planning to shift resources to invest in joined-up services that are focused on preventing deterioration and which support people to be independent, healthy and well in all aspects of their lives, thereby reducing demand for higher cost, more intensive services.

Focusing on preventative community support, wherever possible, means a shift away from acute health services, typically provided in hospital, and from emergency social care services. This is an ambitious and risky strategy – such services are usually funded on a demand-led basis and provided as they are needed in order to avoid people being left untreated or unsupported when they have had a crisis. Therefore, reducing spending is only possible if fewer people have crises: something which experience suggests has never happened before. Nevertheless, collectively the organisations in Cambridgeshire are committed to achieving this, because the alternative is unsustainable services. In addition, preventing people from going into crisis is better for them and their families. This approach will also be supported by a clear focus on improving access to timely information, advice and guidance

The £37.7m allocated by Government to the BCF offers an opportunity to improve the co-ordination and delivery of health and social care services in Cambridgeshire to support this goal. The BCF is an enabler to help organisations work together, but not as a panacea for health and social care in itself. We recognise that this is not new money – all of the money allocated to the BCF is already spent on health and social care services in Cambridgeshire. Secondly, compared to the overall spend on the system (more than £1bn per year in Cambridgeshire), it is a relatively small amount and therefore it must be a lever for much bigger change in the mainstream of health, social care and community services, including housing. We recognise that the development of preventative community based services (as an alternative to reactive, crisis based services) requires significant changes to our thinking and arrangements about how best to support the health and wellbeing of Cambridgeshire residents. There has to be a fundamental shift in emphasis in the system – instead of needing to support people when they are in crisis with hospital or long-term social care support, personalised services provided in the community will wherever possible prevent crisis in the first place. Our collective ambition is to achieve this big change.

Planning for BCF has been organised into three areas:

- Things that we are statutorily obliged to do. For example, meeting the requirements of the new Care and Support Bill by changing the way Social Services carry out social care assessments and by supporting the introduction of the cap on social care spending
- Transformation of existing services. For example, CCC and the CCG already fund services to support carers. One of the requirements of the Care and Support Bill is to change the way that carers are assessed. We will use the opportunity of the new Bill, and the thinking prompted by the BCF, to consider more radically how our collective support to carers is provided and not just 'bolt on' an extension to existing services funded by the BCF. This will maximise the opportunity afforded by the BCF to undertake better and more joined-up planning and commissioning.
- Stimulating innovation. Some of the ideas we have received from a wide range of organisations are genuinely new and offer a lot of promise.

(A) Support for people at home – to help people to live independently at home, either preventing them needing acute or long-term health and social care or minimising their needs

- Integrating carers' services and meeting the requirements of the Care and Support Bill, so carer breakdown is avoided
- Integrating Disabled Facilities Grant, occupational therapy, home improvement, advice and guidance in order to provide a comprehensive housing service for vulnerable groups, possibly countywide, so that housing is safe

- Developing community-based services providing relatively informal support for people with low-level conditions or who are coping with changes in circumstances – for example, peer-coaching for people with disabilities – so low-level conditions do not deteriorate
- Extending community medicine by, for example, supporting community pharmacies to do more medication management, developing occupational therapy and physiotherapy to be more accessible and to support people to be more independent, so long-term support services are minimised
- Creating a small grants pot to provide broader primary prevention activities or other patient-group specific interventions, so people are more resilient and can cope independently.

(B) Support for people in need of help – to help people who have had a crisis (or who are at the most risk of crisis) to get back to living independently so they don't need long-term or acute health and social care services

- Development of support or recovery programmes for people with long-term conditions, at a variety of levels of need – for example a support service for people with mental health issues who are very vulnerable and for whom a further crisis would result in breakdown, or telehealth remote monitoring for people at risk of hospital admission, so long-term support services are minimised
- Develop a common risk stratification tool and scale up multi-disciplinary teams (MDTs) across the county to respond to the results; develop a shared health and social care database, so we can identify people most at risk of crisis and respond with a joined-up proactive package of support to prevent crisis
- Develop and extend integrated intermediate care and rapid response services across the county for hospital and social care admission avoidance, including developing community step-up beds for use by GPs / MDTs and for hospital discharge, so we can avoid wherever possible someone in crisis being admitted to hospital.

(C) Support for people to leave hospital – to help people be discharged from hospital as quickly as is safe so they can recover at home (or another appropriate place)

- Expand teams to provide 7 day discharge planning and discharge so that at the weekends people do not have to wait for staff to become available to be discharged
- Develop more comprehensive 'return home' support, delivered by voluntary or private sector provider(s), to help people to be discharged from hospital safely and speedily and with support to help them back to independence.

(D) Investment in infrastructure to support integration – to work between organisations to develop common approaches to assessment, treatment and support

- Establish a joint team to oversee integration activity, so that there is capacity to do the development work necessary for common assessments, joint services, and joined-up packages of care and support
- Ensure organisations have the necessary frameworks to enable comprehensive data sharing and fully accessible databases.

CUH capacity

	Key milestones, resourcing requirements, dependencies and risk mitigations	**Communication plan for key stakeholders, including staff and the LHE**	**Monitoring arrangements and how plans will be adapted and amended for unexpected future challenges.**
Length of stay	Agreement of annual length of stay targets with clinical service divisions. Transformation capacity plans updated annually.	Widely publicised and discussed. Featured in 2 year Operational Plan which has been provided to CCG.	Routine and regular review by Executive Directors /Board of Directors.
General bed capacity	Integrated care provider appointed/starts operation 2015.Imapct on length of stay /general bed capacity to be routinely monitored. Impact of move of Papworth Hospital to Cambridge to be evaluated. Opening of The Forum private hospital on site in 2016 – potential medium term use of beds.	Widely publicised and discussed. Featured in 2 year Operational Plan which has been provided to CCG	Routine and regular review by Executive Directors /Board of Directors
Delayed transfers of care	Under constant review Long term assessment of regional patients care needs to be undertaken outside hospital by 2015	Widely publicised and discussed. Continuous focus with key stakeholders	Routine and regular review by Executive Directors /Board of Directors
Two new theatres 2014-16	Work has commenced to delivery two new theatres and 6 additional recovery beds within the existing main theatre block. The EVAR equipment will be provided within one of the theatres. The work will be completed during Q1 2015	Widely publicised and discussed. Featured in 2 year Operational Plan which has been provided to CCG	Routine and regular review by Executive Directors /Board of Directors
Theatre requirement for 2018/19 (6.7 theatres)	Through the Theatres Workstream of the Transformation programme the Trust anticipates gains of around 1.2 theatres in efficiency. This gives a	Widely discussed internally Featured in 2 year Operational Plan which has been	Routine and regular review by Executive Directors /Board of Directors

	shortfall of 10.5 theatres by 2018/19. To bridge the short term deficit the Trust intends to build a theatre pair within Main Theatres in 2014/15 and utilize other providers both through sub-contracting and with commissioners re-directing GP referrals. To bridge the longer term deficit the Trust will need to consider a combination of normalising elective weekend operating and additional capacity created by strategic outline cases being worked up for Children, Neuroscience and Cancer patients.	provided to CCG	
Exit and re-provide three theatres in the A-block	Following a review into fire compliance during 2013/14, the A block built in the 1960's has been found to be unsuitable to accommodate dependant patients. This is due to an inability to evacuate patients horizontally to an adjacent fire compartment, place of safety. The current fire escape at one end of the A block involves external vertical evacuation for neurological patients including theatres on level 6. A feasibility study is underway to explore whether a fire evacuation lift could be installed. In the event this is not possible, inpatients and theatres will need to be reprovided in alternative accommodation.	Widely publicised and discussed. Featured in 2 year Operational Plan which has been provided to CCG	Routine and regular review by Executive Directors /Board of Directors
Exit two theatres within Main Theatres for four years to enable the refurbishment of air cleaning and cooling plant	Major plant refurbishment is required to 8 theatres built in the 1970's. This will require the closure of a pair of theatres due to the shared ventilation plant for a period of 6 months. There is insufficient theatre capacity to enable this to occur until additional theatre capacity can be provided.	Featured in 2 year Operational Plan which has been provided to CCG	Routine and regular review by Executive Directors /Board of Directors

Exit 55 beds in the A-block due to identified risks, to reduce the occupancy in the Trust to 90% to improve patient safety and to release a ward each summer for six months to enable ward refurbishments for patient safety reasons.	The fire compliance review undertaken during 2013/14 has identified the accommodation is unsuitable for dependent patients. This is due to an inability to evacuate patients horizontally to an adjacent fire compartment, place of safety. The current fire escape at one end of the A block involves external vertical evacuation for neurological patients including theatres on level 6. A feasibility study is underway to explore whether a fire evacuation lift could be installed. In the event this is not possible, inpatients and theatres will need to be reprovided in alternative accommodation.	Featured in 2 year Operational Plan which has been provided to CCG	Routine and regular review by Executive Directors /Board of Directors
Endoscopy rooms: additional 0.4 rooms for 2014/15, rising to 1.1 rooms by March 2017 and finally 1.9 rooms by March 2019	Moving all 6 Endoscopy rooms to 6 day working (currently only 3 routinely work Saturdays) would mitigate the projected growth to March 2017. After this the Trust will need to consider either routine 7 day working or additional physical Endoscopy room capacity to mitigate growth to March 2019.	Featured in 2 year Operational Plan which has been provided to CCG	Routine and regular review by Executive Directors /Board of Directors
Capacity Development: Options for major infrastructure development	Board of Directors to decide on options to progress to OBC stage in July 2014. OBC expected early 2015. OBC will include proposed timescale for implementation	Featured in 2 year Operational Plan which has been provided to CCG	Routine and regular review by Executive Directors /Board of Directors

Papworth move to Cambridge: collaboration between Papworth Hospital and Cambridge University Hospitals

The approval by HM Treasury in May 2014 of Papworth's Business Case to relocate Papworth Hospital to the Cambridge Biomedical Campus has given further impetus to collaborative working between Papworth Hospital and Cambridge University Hospitals (CUH). There are many benefits for patients that will result from the co-location of the hospitals particularly through access to a full range of specialties for patients of both CUH and Papworth Hospitals. Research and Education will also be strengthened. The two Trusts will develop and implement a programme of work encompassing clinical and support services (some of which is already underway) which will result in improved services to patients and greater economy and efficiency. The following is a summary of the main areas which will be included in these reviews.

Clinical Services

- Joint working groups have already been established between the two Trusts in respect of cardiology and respiratory services. Their remit is to determine how the services can be better integrated and to agree how patient pathways need to be changed to optimise clinical service. A similar working group will be established for transplant services.
- A further programme of work will be established to consider how diagnostic services and other clinical services such as radiography, physiotherapy, speech and language, dietetics and occupational therapy can be better integrated in areas such as management, learning and development and out of hours cover.
- The new Papworth Hospital does not have pathology, sterile services or mortuary provision. These services will be provided by CUH. A range of pathology services have already transferred from Papworth Hospital to CUH and the remainder will transfer on relocation. Technical support services will be integrated with the clinical physics service at CUH. The detail of how the remaining pathology services, sterile services, mortuary services and technical support services will operate will be established during the construction phase of Papworth Hospital.

Back Office Functions / Support Services

- Papworth Hospital and CUH intend to share back office functions. Services include HR and recruitment, training and development, finance, procurement, ICT infrastructure, systems development and support and occupational health. The two Trusts are currently considering the best means to progress this in advance of the relocation of Papworth to Cambridge. Consideration will also be given to sharing services with other similar organisations as part of a Cambridge University Health Partners initiative.
- There is agreement in principle between the two Trusts to have joint service provision for energy, laundry and linen, waste disposal, car parking, switchboard and security. A new Multi Storey Car Park to serve both hospitals has already been built. Detailed arrangements for the provision of energy services will be confirmed during the final procurement stage of the new Papworth Hospital PFI contract. The operational arrangements for the other services will be established following Financial Close on the PFI contract.

1.6 Appendices (including commercial or other confidential matters)

Financial Plan Summary

The Trust's overall financial objective remains to achieve a sustainable financial future demonstrated by a CoSRR of 3. This will be put under significant strain over the planning period

The Financial outlook for the Trust is challenging. The capacity constraints outlined in the plan put pressure on the Trusts ability to continue to achieve the requisite amount of financial savings. The Trust is experiencing unprecedented growth in emergency work which materially affects the ability of the organisation to effectively plan for efficiencies across pathways. This also has a knock-on effect on the Trusts ability to deliver tertiary, specialist care at high margin. For standard elective activity, the use of the private sector results in no margin or ability to deliver efficiencies. The increase in non-elective income is typically reimbursed at 30% marginal rate, which effectively means the trust loses income on this activity. It is clear that the original intention of this tariff reduction scheme (system wide reinvestment to reduce non-elective activity) has been largely ineffective.

This situation is further constrained by increased use of financial fines and penalties by commissioners, and education funding reform which significantly reduces income to the Trust. In particular, the £2bn perceived planning deficit for NHS England, and the linking of QUIPP payments to activity put additional strain on the ability of the Trust to achieve a surplus position. The Trust is within a challenged health economy, and further instability in commissioners would have a negative impact on the plan.

The Trust is however, fully engaged with finding ways of resolving these issues, both internally and throughout the LHE. eHospital will go live in October 2014 and the financial position of the Trust reflects the ongoing costs and benefits of this project. The benefits delivered by eHospital continue to contribute to the rising CIP challenge over the period of the plan with anticipated additional savings from eHospital of £11m, £5m and £2m in the years 2016-17 to 2018-19. eHospital will also ensure that the Trust has access to robust and detailed data on which to build future CIP programmes. Externally, the Trust is engaged with system partners in identifying structural solutions to the financial challenge.

Financial Plan

The Table below summarises the Trust Income & Expenditure position for the 5 years of the Strategic Plan:

Trust I&E	As submitted in Operational Plan				
	Plan 2014-15 £m	Plan 2015-16 £m	Plan 2016-17 £m	Plan 2017-18 £m	Plan 2018-19 £m
Income					
NHS Clinical revenue	557.1	581.5	602.6	622.7	642.8
Other Income	212.7	216.9	217.6	220.8	224.3
Total Income	**769.8**	**798.4**	**820.2**	**843.5**	**867.1**
Expenditure					
Pay	(402.9)	(404.3)	(410.4)	(417.3)	(426.0)
Non Pay	(342.1)	(352.8)	(366.9)	(383.3)	(400.4)
Total expenditure	**(745.0)**	**(757.1)**	**(777.3)**	**(800.6)**	**(826.4)**
EBITDA	24.7	41.3	42.9	42.9	40.7
Depreciation & Financing	(34.8)	(36.3)	(34.7)	(34.9)	(34.9)
Net surplus/ (deficit)	(10.1)	5.0	8.2	8.0	5.8

With the exception of two additional theatres at the end of 2014-15, the plan does not include capital investment in additional capacity. This will be determined by the outcome of the SOC evaluation process and is unlikely to be operational within the 5 years of the plan.

The plan reflects the transition arrangements to tariff based funding for education and training. This results in a reduction in income of £1.5m in each year for 2016-17 and 2017-18 followed by a small increase in 2018-19 due to the anticipated increase in the number of undergraduate medical placements.

The plan includes a contingency of £4m in each of the plan years.

In order to achieve recurrent surplus by 2015-16 the Trust has a CIP challenge of £41m. In order to maintain efficiency and sustainability thereafter the CIP challenge reduces to £27m in 2016-17, £26m in 2017-18 and £22m in 2018-19.

The main movements in Income & Expenditure between years are summarised in the table below:

Summary of Movements by year	2016-17		2017-18		2018-19	
	£m		£m		£m	
Previous year plan		5.0		8.2		8.0
Less Non recurrent CIP in previous year		(1.4)				
Tariff deflator/ pricing benefits/ expenditure inflation		(23.0)		(24.1)		(25.1)
Clinical Income growth	18.9		18.9		19.9	
Cost of growth	(16.2)	2.6	(16.3)	2.6	(17.1)	2.8
Education & Training revenue reduction		(1.5)		(1.5)		0.5
CNST		(1.7)		(1.8)		(1.9)
Other changes		4.9		2.5		3.5
Contingency		(4.0)		(4.0)		(4.0)
Budget proposal before CIP		(19.3)		(18.0)		(16.2)
CIP		27.5		26.0		22.0
Surplus / (deficit)		8.2		8.0		5.8

Downside Risk and Mitigation

Previous submissions outlined downside risks and mitigations for the first two years of the plan. This centred on the risks to the Trust of capacity constraints taken from the Board assurance framework. Mitigations included significant levels of staff reductions, which would be extremely challenging to the organisations continued ability to deliver the required services. In the final three years of the current planning template, further similar downsides have been modelled, however further mitigations beyond those identified previously would present an unacceptable level of risk to patient care. In the plan therefore, any additional downside remains unmitigated.

Pay costs and WTEs

Pay costs are expected to rise due to inflation. The plan does not reflect proposed changes due to revaluation of public sector pension contributions (2015-16) or reforms to state pension (2016-17) as the extent to which these will translate into cost pressures for providers has not been determined.

WTEs shows minimal changes over the final 3 years of the plan as increases expected by changes in activity are mitigated by greater efficiencies delivered by the CIP programmes.

	2016-17	2017-18	2018-19
	£m	£m	£m
Pay costs	410.4	417.3	426.0

	WTE	WTE	WTE
Opening average	8,747	8,691	8,663
Activity changes	178	176	182
CIP	(234)	(203)	(170)
Closing average	8,691	8,663	8,676

Cost improvement

CIP delivery for the final 3 years of the plan is underpinned by the benefits anticipated from eHospital.

CIP	2016-17	2017-18	2018-19
eHospital benefits	11.3	5.4	2.4
Other CIP schemes	16.2	20.6	19.6
Total	27.5	26.0	22.0

Cost improvement targets are outlined in detail for the first two years of the plan. There are three key themes which will continue to be developed for the final three years of the planning period. In summary these are:

1) Continued transformational efficiency: The Trust has a well established PMO, with clear processes and defined work streams. Whilst facing diminishing returns, it is expected that this process will continue to achieve savings of circa 2% per annum, in accordance with the guidance. Particular emphasis will continue to be placed on drugs, procurement and workforce planning along with length of stay and capacity reorganisation.
2) eHospital benefits. The Trust is expecting to accrue significant efficiencies through the implementation and subsequent optimisation of the EPIC eHospital system. Delivery increases significantly in 2015/16, and continues to increase in 2016/17 and beyond as the system is fully utilised. The benefits include both direct and indirect savings.
3) System wide efficiency work. As part of a challenged health economy, the Trust has engaged with preliminary system-wide work to identify structural solutions to the financial problems. Initial work suggests that this will lead to re-allocation of elective activity, and includes the proposed Integrated care for Older people procurement, which the Trust sees as integral to unlocking the efficiency and capacity requirements for the Trust.

Balance Sheet, Cashflow and CoSRR

The Trust plan is to maintain both a Liquidity Rating of 3 and an overall Continuity of Service Risk Rating of 3.

Satement of Financial Position	2014-15	2015-16	2016-17	2017-18	2018-19
	£m	£m	£m	£m	£m
Non Current Assets					
Intangible Assets	29.6	33.9	36.7	39.6	40.7
Property Plant and Equipment	280.9	276.0	273.8	271.3	268.4
PFI Assets	53.6	52.1	50.6	49.1	47.6
Total Non Current Assets	364.2	362.0	361.2	360.0	356.8
Current Assets					
Inventories	10.2	10.2	10.2	10.2	10.2
Receivable	60.3	60.3	60.3	60.3	60.3
Cash	39.9	37.8	37.5	37.3	37.0
Total Current Assets	110.4	108.3	108.0	107.8	107.5
Current Liabilities	(112.6)	(112.6)	(112.6)	(112.6)	(112.6)
Net Current Assets (Liabilities)	(2.3)	(4.3)	(4.7)	(4.9)	(5.2)
Non Current Liabilities	(154.0)	(144.7)	(135.4)	(126.0)	(116.6)
TOTAL ASSETS EMPLOYED	**207.9**	**212.9**	**221.1**	**229.1**	**235.0**
Taxpayers Equity					
Public Dividend Capital	124.8	124.8	124.8	124.8	124.8
Retained Earnings	25.9	30.9	39.1	47.1	52.9
Revaluation Reserve	57.2	57.2	57.2	57.2	57.2
TOTAL TAXPAYERS EQUITY	**207.9**	**212.9**	**221.1**	**229.1**	**235.0**

Cash Flow Statement	2014-15	2015-16	2016-17	2017-18	2018-19
	£m	£m	£m	£m	£m
Surplus / (deficit) after tax	**(10.1)**	**5.0**	**8.2**	**8.0**	**5.8**
Non-cash flows in operating surplus / (deficit)	34.8	36.3	34.7	34.9	34.9
Operating Cash flows before movements in working capital	**24.7**	**41.3**	**42.9**	**42.9**	**40.7**
Increase / (decrease) in working capital	0.0	0.0	0.0	0.0	0.0
Net cash inflow from operating activities	**24.7**	**41.3**	**42.9**	**42.9**	**40.7**
Net cash inflow / (outflow) from investing activities	(30.7)	(19.8)	(20.9)	(20.9)	(19.1)
Net cash inflow / (outflow) before financing	**(5.9)**	**21.5**	**22.1**	**22.0**	**21.6**
Net cash inflow / (outflow) from financing activities	(6.1)	(23.6)	(22.4)	(22.2)	(21.9)
Net increase / (decrease) in cash	**(12.1)**	**(2.1)**	**(0.3)**	**(0.2)**	**(0.3)**
Opening cash balance	**51.9**	**39.9**	**37.8**	**37.5**	**37.3**
Closing cash balance	**39.9**	**37.8**	**37.5**	**37.3**	**37.0**