NHS Cumbria

North Cumbria University Hospitals NHS
NHS Trust

North Cumbria Health Economy Executive Summary

03 October 2011

Important Notice

Background

- These slides have been prepared by Cumbria Teaching Primary Care Trust and North Cumbria University Hospitals NHS Trust (together "the North Cumbria organisations") with assistance from Deloitte LLP ("Deloitte") and Finnamore Limited ("Finnamore").
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- Deloitte and Finnamore accept no duty of care to any party other than North Cumbria for their assistance in the preparation of this document.
- We have been asked to produce this summary document two months after the conclusion of our work. Please note that this document is in addition to the written outputs already delivered as part of this wider assignment.

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Post date events

- Our work was performed in the period 23 March 2011 to 15 July 2011. This document has not been updated to reflect any matters concerning the financial position of North Cumbria for events and circumstances occurring after the date of our assignment.

Glossary

07/08. 08/09 etc.	The financial year ending April 2008, 2009 etc.
A&E	Accident and emergency
C2H	Closer to Home
CIC	Cumberland Infirmary
CIP	Cost improvement programme
CPFT/Cumbria Partnership	Cumbria Partnership NHS Foundation Trust
CPCT/the PCT	Cumbria Teaching Primary Care trust
Cumbria CC	Cumbria County Council
GP	General Practitioner
the Health economy	The Health economy of Cumbria
LOS	Length of stay
NCUHT/the Trust	North Cumbria University Hospitals Trust
NHS	National Health Service
PbR	Payment by results
QIPP	The Quality, Innovation, Productivity and Prevention programme
SHA	Strategic health authority
UHMB	University Hospitals of Morecambe Bay NHS Foundation Trust
WCH	West Cumberland Hospital

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The national challenge of government spending constraints and demographic pressures will present a significant challenge for the Health economy

- NHS Cumbria commissions health care for the population of Cumbria of around half a million residents and in geographical terms is the second largest county in England. In the north of the County (covering around 60% of the population) acute hospital services are provided by North Cumbria University Hospitals NHS Trust.
- NHS Cumbria and North Cumbria University Hospitals NHS Trust have for many years faced a difficult service and financial position. There is also recognition that the national challenge of government spending constraints and demographic pressures (quantified as a savings target of £20 billion over the next four years for the NHS nationally) will present a significant challenge.
- A publically consulted strategy called "Closer to Home" has been pursued by NHS Cumbria over the past 3 years led by locality GPs who now are National Pathfinders for GP commissioning.
- The implementation of the strategy, combined with the organisational financial position of the acute secondary care provider, necessitates a system wide approach to the clinically led reconfiguration of patient services.
- Joint working between all partners is focused upon meeting the future activity and cost/cost reduction demands with regard to:

  The right service provision

  Provided within the right environments with the highest quality and lowest costs

  Long term sustainability

  Supporting the continued development and implementation of GP Commissioning

  Supporting the Trusts acquisition process
- In order to expedite this process, the Health economy jointly appointed Deloitte/Finnamore to support it in evaluating and assisting with key components of its turnaround plan. The work was grouped into four main areas**:**
  - Financial Summary – to provide a clear analysis of the drivers for the current financial position, and a forecast of the position anticipated to 2013/14.
  - Clinical Strategy – to provide an assessment of progress on Closer to Home, the feasibility and implications of delivering the strategy.
  - Clinical Workstream – to work with clinicians across the economy in developing defined plans to implement the strategy across five key areas.
  - Turnaround Workstream – to develop cost reduction plans focused upon delivering savings through better integration across primary and secondary care.
- Both NCUHT and the PCT have their own CIP schemes in place. The focus of our work was on the was on system-wide CIPS and not those of the individual organisations.
- The purpose of this document is to summarise the key activities and findings from the recent work in support of the North Cumbria System Turnaround. This document is intended to read as a stand alone summary of the numerous detailed documents and analyses produced as part of the written deliverables. These are referenced clearly to signpost to further detail as required.

There is insufficient understanding across the wider clinical and management team of the extent of problems faced by North Cumbria and hence the scale and pace of change required. Equally there is a lack of full consensus on the way forward between various parties

- The work was impacted by practical difficulties such as:
  - A relative lack of management capacity to provide fully dedicated resource to workstreams with a sufficient blend of seniority, relevant knowledge and availability away from other responsibilities in order to provide the required level of full time input and focus. This was particularly crucial to the success of the turnaround workstream and will be absolutely critical the implementation phase
  - Changes in leadership roles in certain workstreams and the wider management team which have led to continuity issues
  - Other significant demands on management time such as contract negotiations, existing Trust specific and PCT specific cost reduction and restructuring initiatives together with work in support of the Trust's priority to merge with another NHS body
  - Insufficient understanding across the wider clinical and management team of the extent of problems faced by North Cumbria and hence the scale and pace of change required.
  - Long standing and deep-rooted tensions between elements of the Trust and the PCT (for example over recent and current contract negotiations)
  - Lack of full consensus on the way forward between groups of management and clinicians
- Against this background the challenges faced by the senior management team and hence the turnaround process have been significant and impacted the pace, completeness and extent of the outputs.
- This document provides a high level summary of the output from our detailed work which covers the following areas:
  - Analysis of the historical and financial baseline of the Trust and PCT

    Analysis and feasibility of the clinical strategy

    Plans for specific clinical pathways

    Turnaround plans for specific system wide workstreams

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Historically, the Trust's cost base has run above the level of income secured under a PbR contract. These costs have been met through significant non-recurrent funding support

Trust Financials 07/08 - 10/11

£m	07/08	08/09	09/10	10/11
Revenue from patient care activities	**(187.8)**	**(179.2)**	**(189.7)**	**(187.0)**
* Support/additional funding from PCT/SHA (Trust view)	-	(20.4)	(12.7)	(20.6)
Other operating revenue	(10.1)	(12.6)	(14.1)	(14.9)
Total revenue	**(197.8)**	**(212.2)**	**(216.5)**	**(222.5)**
Total expenditure	**197.8**	**211.3**	**214.3**	**221.4**
(Surplus)/Deficit	**(0.1)**	**(1.0)**	**(2.2)**	**(1.1)**

Source: Management information

* The amount of transitional support provided over the years differs in the PCT and Trust 's interpretation. The difference totals £23.4m over the period and is largely due to a differing opinion on overpayment above PbR tariff

PCT Financials 07/08 - 10/11

£m	07/08	08/09	09/10	10/11
Revenue funding available	**(720.8)**	**(759.5)**	**(827.3)**	**(871.1)**
NCUHT expenditure	162.2	157.9	171.3	169.6
* Non-recurrent transitional support to NCUHT (PCT view)	8.2	25.8	19.3	23.8
Other expenditure	549.8	575.6	636.5	683.7
Total expenditure	**720.2**	**759.3**	**827.1**	**877.1**
(Surplus)/Deficit	**(0.5)**	**(0.2)**	**(0.2)**	**6.0**

Source: Management information

Note: PCT financials relate to the entire county rather than just North Cumbria

The Closer to Home Strategy has shown a decrease of circa 8% in non elective activity, with activity broadly constant in most other areas, which although below the expected overall decrease has to be seen in the context of rapidly rising activity in the Acute sector across the rest of the UK

Historical financial position – PCT and Trust

- In 2007, the PCT commenced the Closer to Home strategy. This was introduced to provide more services in primary care and the community, and aimed to reduce the number and length of hospital stays for those with long term conditions. The aim was to change patient pathways and treatment in line with evidence based best practice and was to be a system-wide solution to sustainable healthcare in Cumbria.
- Although it was expected that Cumbria would therefore see lower activity levels in its acute hospitals, both UMHB and NCUHT, activity levels in most areas have remained broadly flat with a c.8% decline seen in non-elective. Key points to note are:
  - The original strategy document stated that £10m was to be invested in community services in the three years 07/08 to 09/10 with additional £9.2m available for investment in 10/11 to 11/12. Actual investment in closer to home is more in the region of £6.1m in the period to 10/11.
  - The document indicated that proposed changes to bed numbers and services at the Trust would deliver £15m of savings per annum. The Trust now believes that its own assumptions were not robust enough to underpin the savings envisaged. In addition, in order to assist the Trust in the cost of these proposed changes, the PCT was going to offer non-recurrent transitional funding of £4m in 08/09, £5m in 09/10 and £5m in 10/11. Neither the savings nor the predicted activity levels were achieved to the extent assumed, and transitional funding has been required. The PCT have calculated that £64.9m of transitional funding has been provided to the Trust over these three years with £20.6m of this amount from the SHA in 10/11. Both parties agree that the amount of money paid. However, the PCT contends that their figures represented the non-recurrent support to the Trust although the Trust argues that some of the difference relates to direct patient activity.
  - The expected reductions in activity due to Closer to Home have not materialised to the levels in the original plan but, based on benchmarking data for the North West, appear to have stemmed the level of growth of activity in the system that would otherwise have occurred, although this cannot be fully quantified. Had activity fallen further then the PbR gap with NCUHT would have been larger than it currently is and therefore NCUHT would have required further funding.
  - The Trust has not reduced costs in accordance with the original planning assumptions, in particular the CIPs instigated by the Trust have not impacted its overall cost base to the levels envisaged. This has contributed to the funding gap discussed below. For example, in 10/11, whilst the Trust achieved financial balance following transitional support from the SHA, it reported £12.1m of CIP but only £3.7m of this was cash-releasing. The trust is unable to provide evidence to support the level of cash releasing savings that have actually been achieved prior to this year.

The Trust has not reduced costs in accordance with the original planning assumptions

Historical financial position – PCT and Trust (cont.)

- The PCT has experienced average recurrent revenue growth of 5.4% for the period 07/08 to 10/11 with a corresponding increase in expenditure. The Trust's cost base has grown by an average of 3% per annum over the same period but its financial position has been maintained by additional funding in excess of a PbR contract from either the PCT or the SHA over the past four years as the level of real cost savings required in order to achieve a break-even position have not been delivered. There has been a 13.5% growth in income from the PCT/SHA to NCUHT over the three years, including transitional support.
- In 09/10 and 10/11 the two organisations could not agree on the contract values and so the decision went to mediation and arbitration respectively. In 10/11 the additional amounts deemed to be payable from the PCT resulted in the PCT reporting a deficit of £6.0m in that year. In addition, the Trust received £20.6m of support funding from the SHA in 10/11 as the existing cost base of the Trust as currently configured, is too high to work on a purely tariff based system without continuing additional funding.
- The Trust's cost base has been examined through comparison with other Trusts in the North West that are delivering similar activity from volume/ specialty/ age of admission perspectives. At a high level the cost comparator analysis has identified a number of areas that indicate levels of expenditure at NCUHT that are higher than expected. These include PFI financing costs; drug spend; medical and nursing pay costs.

The PCT and the Trust have prepared baseline forecasts out to 13/14. These include significant levels of projected cost savings for which the majority of plans are not fully developed although the savings from the current turnaround engagement workstreams of £7.7m will be need to be reflected

PCT baseline financial forecasts

£m	10/11	11/12	12/13	13/14
Revenue funding available	**(871.1)**	**(863.5)**	**(877.5)**	**(870.8)**
NCUHT expenditure	169.6	155.4	147.0	139.4
Non-recurent transitional support to NCUHT (PCT view)	23.8	-	-	-
Other expenditure	683.7	699.9	722.3	723.3
Total expenditure	**877.1**	**855.3**	**869.3**	**862.7**
(Surplus)/Deficit	**6.0**	**(8.2)**	**(8.2)**	**(8.1)**

Source: Management information

PCT baseline financial forecast

- The PCT forecasts are based on NW NHS guidance and their interpretation of the operating framework. There are some points of interpretation on which the PCT and Trust disagree. Notable assumptions over the three year period are:
  - no real growth in recurrent revenue as any growth will be offset by National Initiatives and targets and local system QIPP;
  - reductions in the values of the acute contracts with NCUHT (£30.2m)and UHMB (£17.1m) as a result of reversal of non-recurrent spend, demand management schemes, pricing changes and service transfers;
  - growth in non-acute spend such as packages of care stemmed through cost saving programmes;
  - CIP of £62.4m achieved over the three years; and
  - surplus of £8m pa targeted with £8m pa contingency in both 12/13 and 13/14 and the 2% top slice continues.
- The contract reduction targets that the PCT is forecasting to achieve are challenging and, for the most part, require clinical buy-in from both organisations. Should the management schemes comprising demand management and pricing variations which have not yet been agreed by the PCT and the Trust (£28.9m in NHUCT and £15.5m in UHMB) fail to deliver the extent of volume reductions expected, the payments to NCUHT will increase although it will still need to address its cost base and the PCT will need to manage these additional costs through its other budget lines or contingencies (i.e. through reduced investments).
- The CIP programme in the PCT is currently being developed. It is made up of 28% demand reduction management and 72% productivity/deflation assumption for providers. There may be further risk relating to delivery of PCT CIPs which are as yet unquantified, as detailed plans are not yet available to support target savings.

If the Trust receives the level of income projected by the PCT it has built in an assumption that it will still require additional support of £27.3m per annum assuming full delivery of its CIP initiatives. However, the Trust has not agreed to the amount of contract income forecast by the PCT under the contract under discussion

Trust baseline financial forecast

£m	10/11	11/12	12/13	131/4
Revenue from patient care activities	**(187.0)**	**(166.8)**	**(162.7)**	**(159.6)**
Support/additional funding (Trust view)*	(20.6)	(27.3)	(27.3)	(27.3)
Other operating revenue	(14.9)	(14.7)	(14.9)	(15.1)
Total revenue	**(222.5)**	**(208.8)**	**(204.9)**	**(202.0)**
Operating expenses (exc impairments)	207.1	192.3	188.4	185.5
Other costs	14.3	15.4	15.4	15.4
Total expenditure	**221.4**	**207.7**	**203.8**	**200.9**
Surplus/(Deficit)	**1.1**	**1.0**	**1.1**	**1.1**

Source: Management information

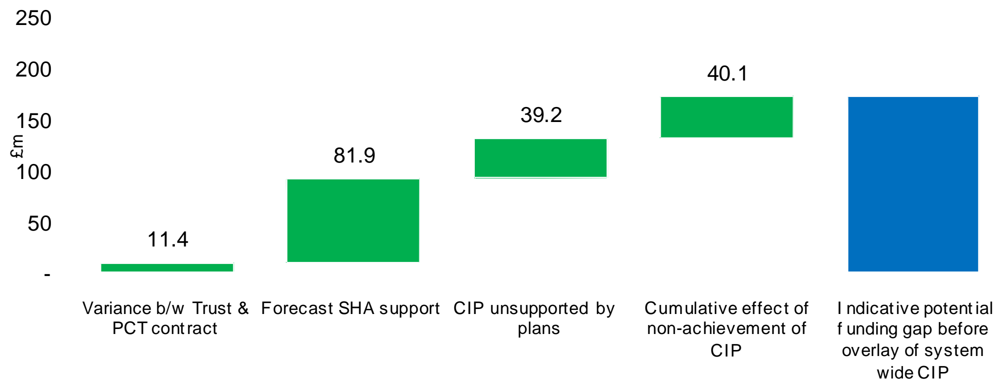
* Note: before consideration of currently unsupported CIP (see following page)

Trust baseline financial forecast

- The Trust forecasts are based on a roll-forward of the 10/11 baseline and have the following key assumptions:
  - The forecast includes an estimate of the reduced income from CPCT (but varies by £11.4m) and assumes other income remains flat;
  - The forecast also assumes the Trust will receive additional SHA support of £81.9m which has not been confirmed;
  - The operating cost base is forecast to reduce by 10.4% (£21.6m) over the three years by implementing annual CIP targets of c.4% in line with National targets to mitigate the growth expected through inflationary pressures. The main area where operating expenditure is forecast to reduce is pay with a 13% reduction in costs projected over the three years. The Trust forecast does not include direct cost adjustments from the planned activity reductions detailed in the PCT's commissioning intentions; and
  - In addition, annual CIP targets total £42.7m over the three years although the Trust does not have detailed plans for much of this and hence some of these savings are at risk of not being delivered although the impact of current turnaround workstreams will need to be reflected, although these only total £7.7m.
- After making these assumptions, the Trust is forecasting to deliver a surplus of c.£1m per annum in the years to 13/14. However, the Trust has assumed broadly flat contract income made up of PCT income or external support. Neither PCT contract income nor the balance of support is yet agreed.

The PCT and the Trust's forecast contract values differ by an amount of £11.4m over the three years. In addition, by assuming no SHA support and removing the impact of CIP, the resultant funding gap increases to £172.6m over the period to 13/14 (before system wide CIP, M&A impact or support funding)

Potential forecast funding gap



Source: Management information

Projected financial gap between organisations

- The base case forecasts show a difference in income/cost expectations from the trust and the PCT respectively of £11.4m over the three years to 13/14. The Trust's forecast contract values differ from the PCT's which are based on their commissioning intentions.
- In addition, the Trust's forecast includes an annual amount of £27.3m of support from the SHA. As there is no confirmation that this will be provided we have excluded this when illustrating the potential gap in funding over the period.
- The Trust's forecasts include achievement of £42.7m CIP in the period. Of this amount, we have seen plans for schemes totalling £7.2m and estimate that up to 50% of this amount may be achievable in 11/12.
- The Trust is still developing and progressing work on its own Trust specific turnaround plans and the plans for 12/13 and 13/14 that are fully costed and close to finalisation incorporate up to £1.0 and £2.4m respectively of potential savings. Further plans are being costed and developed by the Trust. These have not been adjusted in the table and graph as the plans are subject to review, risk adjustment and finalisation and do not materially alter the indicative magnitude of the overall gap. The graph therefore assumes that the recurrent non-achievement rolls forward into future periods.

- Taking all this into account, the total gap between the PCT and the Trust forecasts could increase to £172.6m in the period to 13/14 if no mitigating actions were taken. This does not factor in any variations to the activity projected in the forecasts which may occur and could reduce or increase the funding gap between the organisations (but would put pressure on other areas of the PCT budget).
- The level of the system-wide gap is planned to reduce by the following actions which are as yet unquantified:
  - additional achievement of CIP from the Trust following cost baselining exercise
  - additional CIP from the PCT or reduction in planned investments
  - whole health economy CIP workstreams (£7.7m identified to date) currently in progress some of which will lead to activity reductions and further funding pressure
  - impact of M&A proposals
  - additional transitional support funding from the SHA or PCT
- The earlier the financial gap can be addressed, the greater the overall effect as non-achieved CIPs would not accumulate over the period. Given the extent of the gap, it is likely that significant transitional support will continue to be required.

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Analysis of the commissioning plan that underpins C2H demonstrates a cost challenge of c.£17m to the acute trust, in addition to the existing recurrent cost challenge of c.£25m. The strategy also defines that emergency cover based services should be provided from the two acute sites

Overview Summary

- The purpose of the Clinical Strategy analysis was to provide an assessment of progress to date on Closer to Home, and to describe the feasibility and implications of continuing to deliver the strategy.
- Closer to Home describes how health services will be transformed to improve the health outcomes for the people of Cumbria. In essence, it is about providing health care in more effective and efficient ways - providing the right care at the right time in the right setting and managing demand for acute care in a different way. Central to this is continuing to provide emergency cover based services from two acute sites (CIC and WCH) and commissioning intentions to reduce activity delivered in an acute setting.
- The following summary describes the current situation, the increased and ongoing challenge presented by the strategy, and the implications both for managing demand and aligning acute capacity. It also outlines what will be required for it to be feasible to deliver the strategy.
- The process used to develop our findings was:
  - Discussion with key stakeholders including clinical leaders, executives and managers from across the health economy.
  - Analysis of the original Closer to Home plans, current Commissioning Plans and related information.
  - Detailed income and cost analysis on the implications of the Commissioning plans that underpin Closer to Home.
  - Development within the wider Turnaround programme.

Current Situation

1) Acute costs are not aligned to income

- NCUHT has endured over a decade of historical debt and required significant non-recurrent support over a prolonged period. Its current cost base is significantly higher than income (estimated at c.£25m and projected to increase). Note – in the absence of any agreed position between the Trust and the PCT as to the true level of support and hence the variance in the cost base, this figure is an average of the PCT's perceived level of support (£23m) and the Trust's projection of required support in 11/12 (£27m). This figure will be used in the analysis in the remainder of the clinical strategy section.
- The Trust operates from two small sites which are located a significant distance apart (approximately 1 hour travelling time). Each site provides emergency services including A&E, obstetrics, critical care and paediatrics. The additional costs associated with the provision of these services are largely driven by medical cover requirements.

2) The clinical strategy will reduce activity delivered in an acute setting – reducing income and increasing the cost challenge for the acute trust.

- The clinical strategy states that emergency services will continue to be provided from two sites.
- The Commissioning Plan that represents the Closer to Home strategy identifies significant reduction of activity to be delivered in an acute setting.
- The implications for NCUHT is the need to find ways of delivering services for North Cumbria from its two sites, whilst scaling its cost base to align to a loss of income from the PCT/SHA.

C2H requires patient demand to be managed differently, as a consequence acute capacity needs to be aligned and reduced

Implications in terms of demand:

1) To deliver the clinical strategy, demand must be managed effectively by the whole system

- GPs, acute clinicians and community services need to manage patients to avoid attendances and admissions to acute care. This requires:
  - (i) The localities to ensure services are available and effective to avoid the need for acute care.
  - (ii) Emergency services provided at the 'front door' of acute care are provided in an integrated way to avoid or minimise the need for acute care.

  The North Cumbria Clinical Leaders Forum identified key workstreams related to providing more effective emergency services. These workstreams have further defined the clinical model and considered options for how they can be delivered. In the main, the preferred options continue to provide A&E, obstetrics, critical care and paediatric services at both sites; options to transfer patients from WCH to CIC could present significant in terms of quality of care and the cost of transfer. The costs of the preferred options are broadly cost neutral but provide improved and more integrated services to enable the delivery of the strategy.

2) Commissioning intentions define a plan to reduce acute activity

- Acute non-elective, elective and outpatient activity is planned to reduce. The activity changes described represent a potential reduction in Trust income of c £11m

3) Commissioning intentions define a plan to reduce the price paid for some activity

- This includes a reduced tariff for 'zero day LoS' and avoiding charges for 'readmissions'. In total, price/ contract changes represent c. £6m of income reduction.

4) The combined effect is a significant reduction in Trust income.

- The combination of activity and price changes from the Commissioning Plan represent a potential reduction in Trust income of c £17m

Implications in terms of capacity:

5) 'Cost down' analysis demonstrates that only some acute costs (£5m) are directly variable with reduced activity

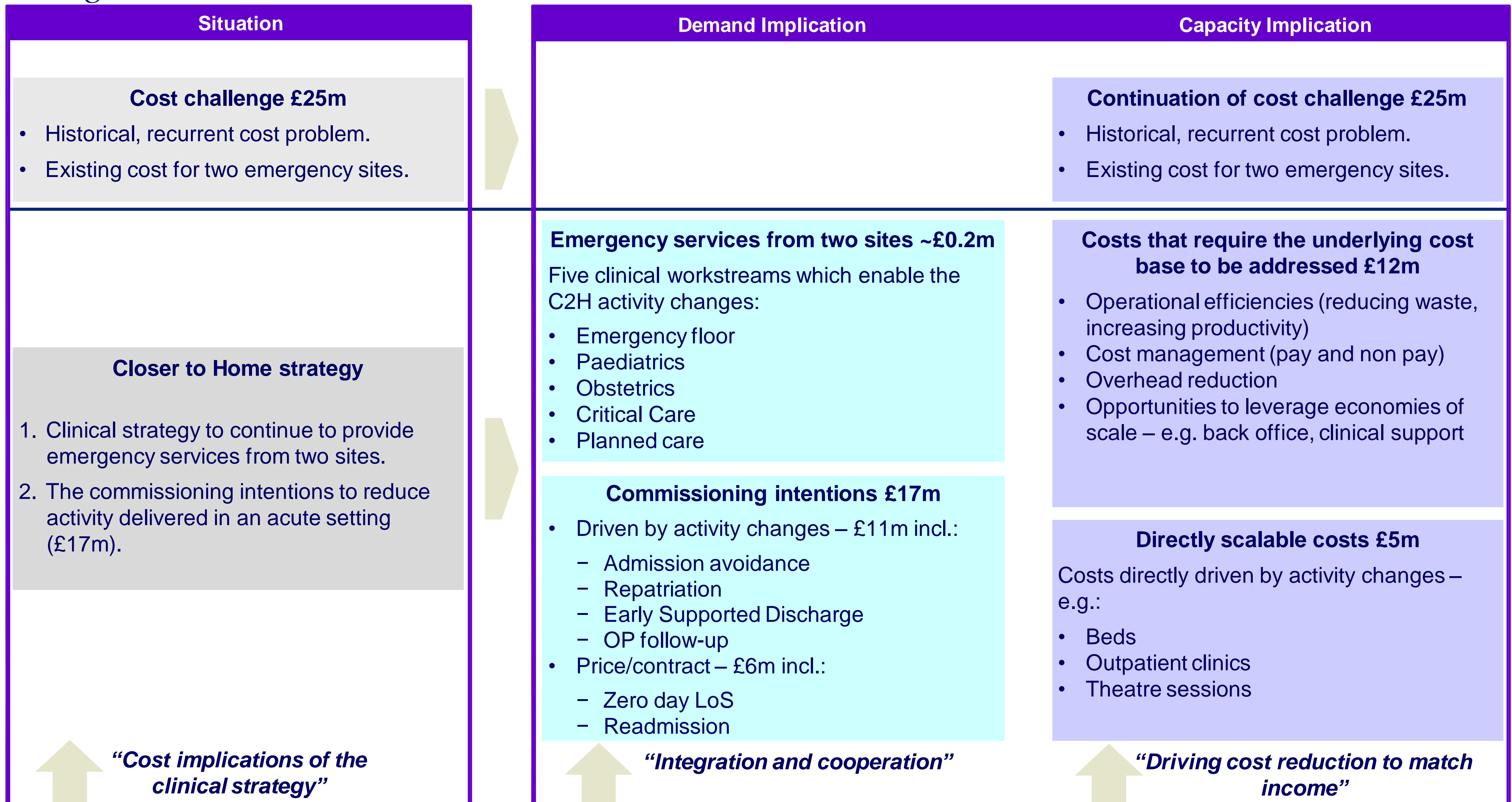
- There is potential net cost reduction from activity of £5m of directly scale-able costs (theatres, beds, clinics), assuming successful repatriation of elective activity.

6) The remaining £12m income reduction will therefore have to be mitigated through other cost reduction opportunities

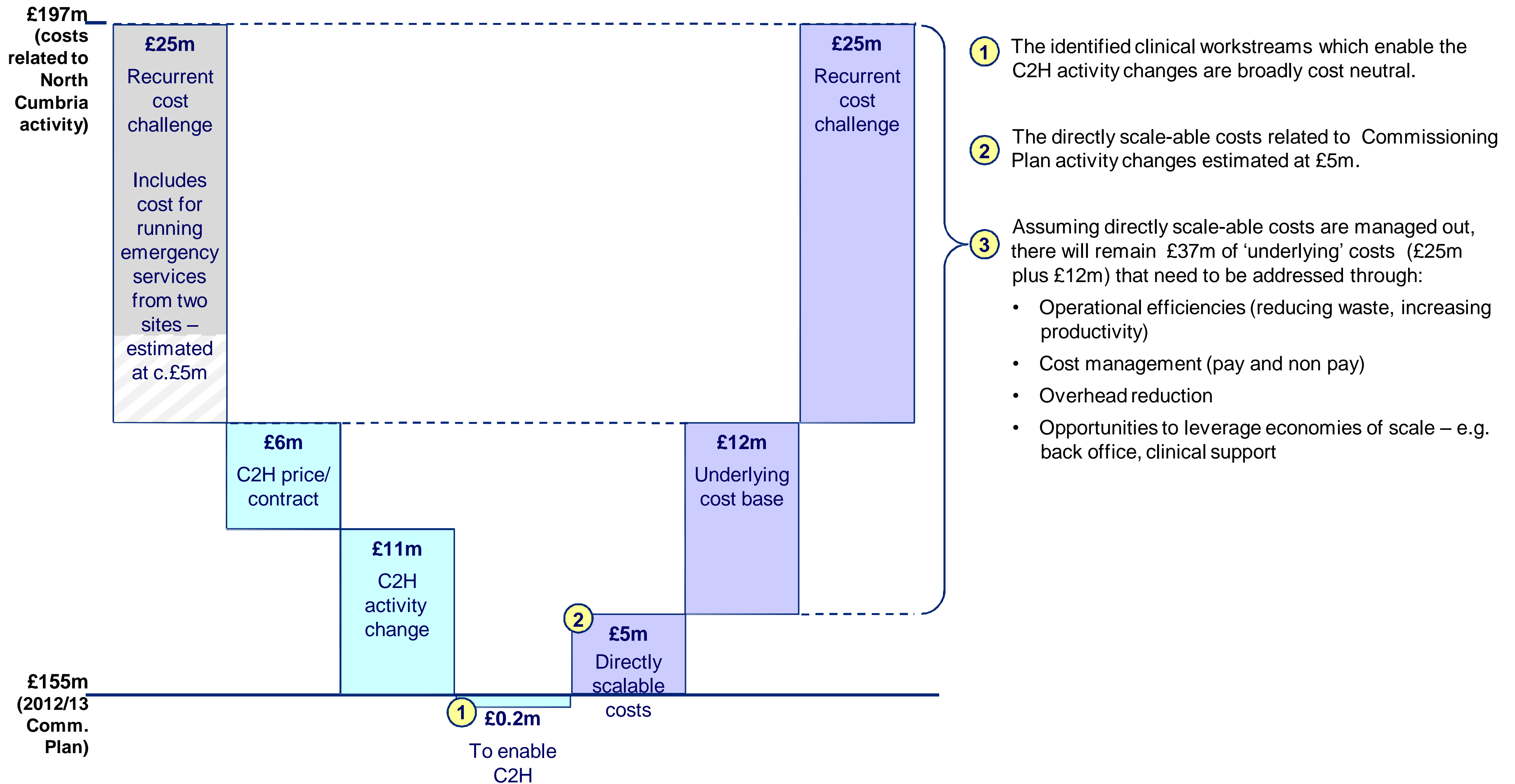
- These include operational efficiencies (reducing waste, increasing productivity), cost management (pay and non-pay) and overhead reduction.
- Opportunities to leverage economies of scale (through merger) will be an important enabler for both clinical support and corporate support functions.

Therefore the total financial pressures acting upon the Trust are to manage down the historic £25m cost base gap, plus mitigate for the loss of income from the Commissioning Plan driven by C2H by reducing non scale-able costs by a further £12m. In total this represents a total challenge of £37m – assuming that the directly scale-able costs of £5m are managed out.

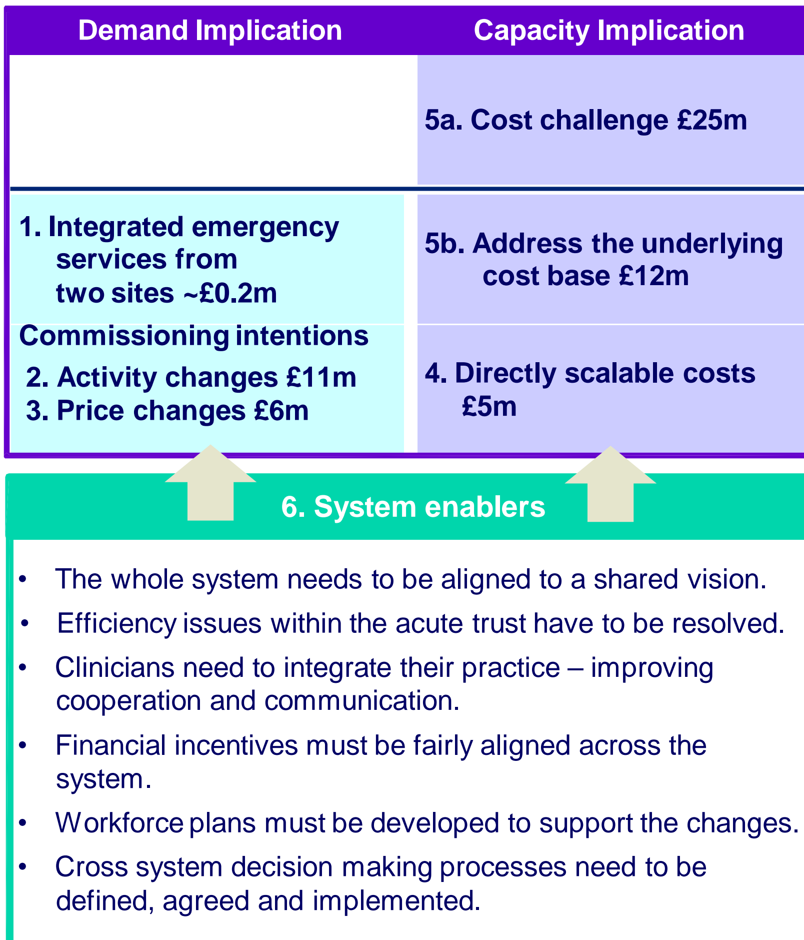
In summary, the clinical strategy will increase the existing recurrent cost challenge faced by the acute trust. It will only be deliverable if (i) demand is managed effectively through cross system cooperation and integration and (ii) cost reduction in the acute trust is driven to align to income



The cost implications of the Closer to Home strategy present an additional cost reduction challenge of £17m for the acute trust - making a total £42m. £5m of these costs are directly scale-able, leaving an overall requirement for £37m of 'underlying' cost base improvements



The clinical strategy for the North Cumbria health system is only feasible if the overall set of challenges are addressed in an integrated way



The North Cumbria health system needs an integrated plan to deliver:

1. **Integrated emergency services from 2 sites:**
   - Build on the plans from the clinical workstreams, agree the preferred options and ensure clinicians lead the implementation.
2. **Activity changes:**
   - Ensure locality plans to manage demand are robust and monitor through existing performance mechanisms.
   - Agree implementation plans for changes that are reliant on cooperation/ integration (ESD, outpatient follow-ups, repatriation, etc.)
3. **Price /contract changes:**
   - Agree principles for price changes cross organisations (fair incentives that match agreed clinical practice), understand implications for income and implement.
4. **Directly scalable costs:**
   - Agree capacity plans to match planned demand changes.
   - Define cost reduction plans (incl. workforce plans) to reduce acute capacity in line with reducing demand.
5. **Address the cost base challenge (£37m)**
   - Produce overall plan to identify how the underlying cost base will be reduced (operational efficiencies, cost management, overheads);,including plans to leverage economies of scale.
6. **System enablers**
   - Agree processes by which the whole system will be aligned to a shared plan and agree decision-making forums (clinical, operational and financial).

The health system faces a major challenge (consistent with the rest of the NHS) to transform the health system and address costs.

These challenges will take significant time and associated transition costs to be delivered.

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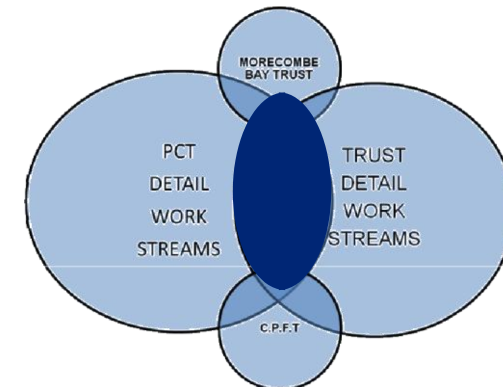
Four workstreams with personnel from both the Trust and the PCT were established to work collaboratively to produce turnaround plans which could benefit the health economy as a whole and deliver annualised savings of £7.7m

Health economy turnaround plans



- The Trust and the PCT have identified their own CIP within their organisations which they require to achieve financial balance. In addition the System Turnaround Board agreed on the development of economy-wide workstreams.
- These were established to devise saving plans which would benefit the region as a whole.
- The scope for developing the workstreams was specified by the System Board as the intersection between the Trust and the PCT as shown in the diagram opposite.
- The logic was to seek benefits from greater cooperation and integration across primary and secondary care.
- The System Board agreed four key turnaround workstreams as follows:
  - **Unplanned Care** – This workstream focuses on the development of a work programme that will respond to the rising demand on unplanned care services in North Cumbria and subsequently resolve the current financial gap within the North Cumbria health economy. North Cumbria University Hospitals Trust (NCUHT), Cumbria PCT, Cumbria Health on Call ("CHOC"), and Cumbria Partnership NHS Foundation Trust have worked jointly (supported by Deloitte and Finnamore), to develop a sustainable whole system turnaround plan in line with the clinical strategy that will deliver high quality unplanned care at lowest total cost to the overall economy. This workstream has identified initiatives that if implemented systematically will reduce admissions to hospital and facilitate discharge as soon as clinically appropriate.
  - **Planned Care** - The overall objective of this plan, when implemented, is to deliver high quality planned care services at lower overall cost to the whole health economy. This will require an understanding of the demand and capacity required to deliver the planned care activity in the best care setting, in terms of both patient experience as well as overall cost to the health economy.
  - **Repatriation** - The Repatriation work stream aims to identify and repatriate procedures that are currently carried out "out of county" i.e. not within Cumbria and therefore maximise the income into the County, by performing these procedures at CIC, WCH or primary care facilities (where appropriate).
  - **Diagnostics** – Focussing on potential reconfiguration of services, in particular blood sciences.
- Based on the initial work by the workstreams, annualised target savings of £7.7m were identified. There may be scope for further savings once the plans are initiated.

In addition five clinical workstreams were established to work closely with clinicians from across the economy to define in greater detail what the clinical strategy means in practice

Clinical redesign workstreams

- Five key clinical strategy workstreams (chosen by the North Clinical Leaders Forum and endorsed by Medical Directors at NCUHT and the PCT) were focused on services that are 'based on cover' to define what the clinical strategy will look like in practice, i.e. the clinical innovation and integration required across the system.

1. ***Emergency floor:*** Develop an 'integrated emergency floor' to enable the reduction in non-elective acute admissions.
2. ***Paediatrics:*** Provide children-centred services which minimise acute care through integrated cross-system/community working.
3. ***Planned care:*** Develop West as a site to provide sophisticated operating for relatively fit patients requiring brief admissions. Reduce elective limited referrals of clinical value and 'repatriate' work.
4. ***Anaesthetics:*** Provide critical care services for planned and unplanned care to support other elements of the strategy.
5. ***Obstetrics:*** Deliver obstetric services on both sites.

Aligning clinical pathways to turnaround workstreams

- The relationship between the clinical pathways and the overarching turnaround workstreams was defined as follows:

  Turnaround:

  - A transactional element to ensure that the current delivery is as efficient and effective as it may be, this will be driven by an assessment of current delivery against benchmarked improvement in current delivery.

  Clinical redesign:

  - A transformational element to consider what the alternative methods for future delivery of outputs may be. This will be driven by the clinical pathway discussions.
  - Both the transactional and transformational aspects would be drawn together by the nominated economy workstream lead.

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Achievement of both the Closer to Home strategy for North Cumbria and sustainable financial balance will require significant action and increased cooperation between the PCT and NCUHT. Both organisations will need to overcome long standing and deep rooted tensions in order to deliver a more viable health economy otherwise significant external funding will continue to be required

Key conclusions

- The expected reductions in activity due to Closer to Home have not materialised to the levels set out in the original plan in 2007. Equally, NCUHT has not reduced costs in accordance with the original C2H planning assumptions. In particular the CIPs instigated by the Trust have not delivered material recurrent savings to its overall cost base and consequently, c£65m of transitional funding has been provided to the Trust over the last 3 years.
- The PCT and Trust have developed base line forecasts out to FY13/14 but achieving these plans will be challenging for both organisations.
  - The PCT's ability to deliver an annual forecast surplus of c£8m is dependent on achieving contract reductions totalling c£47m with the Trust. This will require clinical buy in from both organisations which is currently not there. Additionally, £62m of CIPs are to be delivered over three years, although detailed plans to support this level of savings have yet to be developed.
  - For the Trust to deliver an annual surplus of c£1m requires £82m of additional support from the SHA in addition to achieving annual CIP targets of £43m. Again, detailed plans are not yet in place to support this level of savings. However, there appear to be a number of key areas where NCUHT's cost base does not compare favourably with similar Trusts delivering comparable activity. These include PFI financing, nursing and medical costs, drug costs which suggests there are opportunities to reduce its cost base.
  - There are detailed plans in place to support system wide CIPs totalling £7.7m which reduce the financial gap, however non achievement of individual CIP targets will significantly increase the level of external support needed by the economy which could be as high as c£172m .
- The continuing impact of the PCT's commissioning plan based upon the delivery of the C2H strategy has significant implications for NCUHT. NCUHT has endured over a decade of historical debt and required significant non-recurrent support over a prolonged period. Its current cost base is c£25m higher than income and projected to increase.
- The PCT's plan will potentially reduce Trust income by £17m over the period 10/11 to 11/12. Only £5m of this income reduction would be easily scalable in terms of direct cost reduction. Accordingly, the total financial pressures acting upon the Trust are to manage down the historic £25m cost base gap, plus mitigate for the loss of income from the Commissioning Plan driven by C2H by reducing non scale-able costs by a further £12m. This represents a total challenge of £37m.
- Cumbria faces a major challenge to transform the health system and reduce costs. There is further work to be done to fully integrate the system so that benefits can be derived. This will require both organisations to work effectively and openly together in a way that has to date not been achieved. However, absent a shared vision and buy in from both organisations, NCUHT will continue to remain unviable.