Cambridgeshire & Peterborough Integrated Care System

NHS Cambridgeshire & Peterborough

Strategic Commissioning Plan 2025 - 28

cpics.org.uk

February 2025

Content

Executive Summary

The ICS Joint Forward Plan set out our ICS aims and priorities, building from our Health and Well-Being Integrated Care Strategy Ambitions, which in turn drive our ICS Outcomes Framework. Through local and region-wide work over the past 12 months we have developed a Health Utilisation Model (widely referred to as the 'New Care Model') as a cross-cutting approach to manage care, delivering better outcomes and financial sustainability.

The Strategic Commissioning Plan sets out how we will translate this model into reality over the next 3 years through four workstreams – Managed Care, Sustainable Primary Care, Elective Care, Digital and other enablers. The Plan is intentionally high-level and focused, and much of the content is applicable across all ages and care groups. It serves as our high-level commissioning intentions for 2025-28 and provides context for the 2025/26 Operational Plan.

The structure of this Strategic Commissioning Plan is:

- Strategic Context
- Health Utilisation Model
- Evidence Review
- Activity Model
- Main workstreams & programmes: Managed Care; Sustainable Primary Care; Elective Care
- Enablers
- Delivery Plan

Rationale and Key Features

By 2030-31 we would need the equivalent additional bed capacity of a new district general hospital to cope with the demand for beds, under our current care model. We have reviewed the evidence-base which shows that multi-morbidity is the primary driver of in-patient demand, especially among ageing and socio-economically disadvantaged groups. It also shows that integrated care models addressing multi-morbidity demonstrated sustained reductions in hospital utilisation, costs, and disparities.

Implementing the Health Utilisation model and completing the productivity work required to make us as efficient as possible will have a significant impact on activity across the ICS. Our strategy is to convert a proportion of the demand for acute beds into contacts with people and patients which take place outside a hospital setting, on the basis that such contacts are a more cost-effective way of meeting and reducing demand for services whilst still providing a quality experience for our citizens and staff. The shift in service provision will create a new demand challenge, away from the acute setting. This challenge will be met by:

1. The Managed Care Programme will drive better outcomes and effective use of resources. It will use predictive data modelling to identify reversible or mitigatable risk for cohorts and individuals in our population, overseen by the 'nerve centre' (described below) and delivered through local providers including the Integrated Neighbourhood Teams as a key change agent. Health optimisation will reverse risk in the population so that contacts are avoided. This reduces the forecast additional capacity we need by 2030/31 by c.78,000 non-elective bed-days.
2. Creating more capacity in Sustainable Primary Care and Integrated Neighbourhood Teams.
3. Being more efficient and delivering more care through Digital channels.
4. Using existing capacity more efficiently through our Elective Care Strategy, which will support recovery of elective care and diagnostic targets, reduce unnecessary out-patient follow up appointments, and see development of Community superhubs.

5. Delivering productivity gains (see Appendix C: Productivity Opportunities Summary) based on our analysis of benchmarking and opportunities as set out above, which will reduce the 2030/31 forecast Non-elective bed days by c.54,000.
6. The total forecast benefit is 142,000 non-elective bed days, leaving residual growth of 43,000 non-elective bed days by 2030/31 as set out in the Activity Model section.

Managed Care Hub (Nerve Centre)

At present our local health and care system can feel fragmented and difficult to navigate for patients and staff. Although there are huge amounts of data relating to patients and their care, they are often kept in silos which do not connect. This is not only frustrating for patients but also means treatment processes are not always joined up, and staff have to spend time piecing together information or duplicating tests which is not efficient. Serving the whole Cambridgeshire & Peterborough population, the Managed Care Hub or 'nerve centre' will bring together a number of managed care functions which support patients and healthcare professionals and drive better use of health and care resources (blue box in the diagram below).

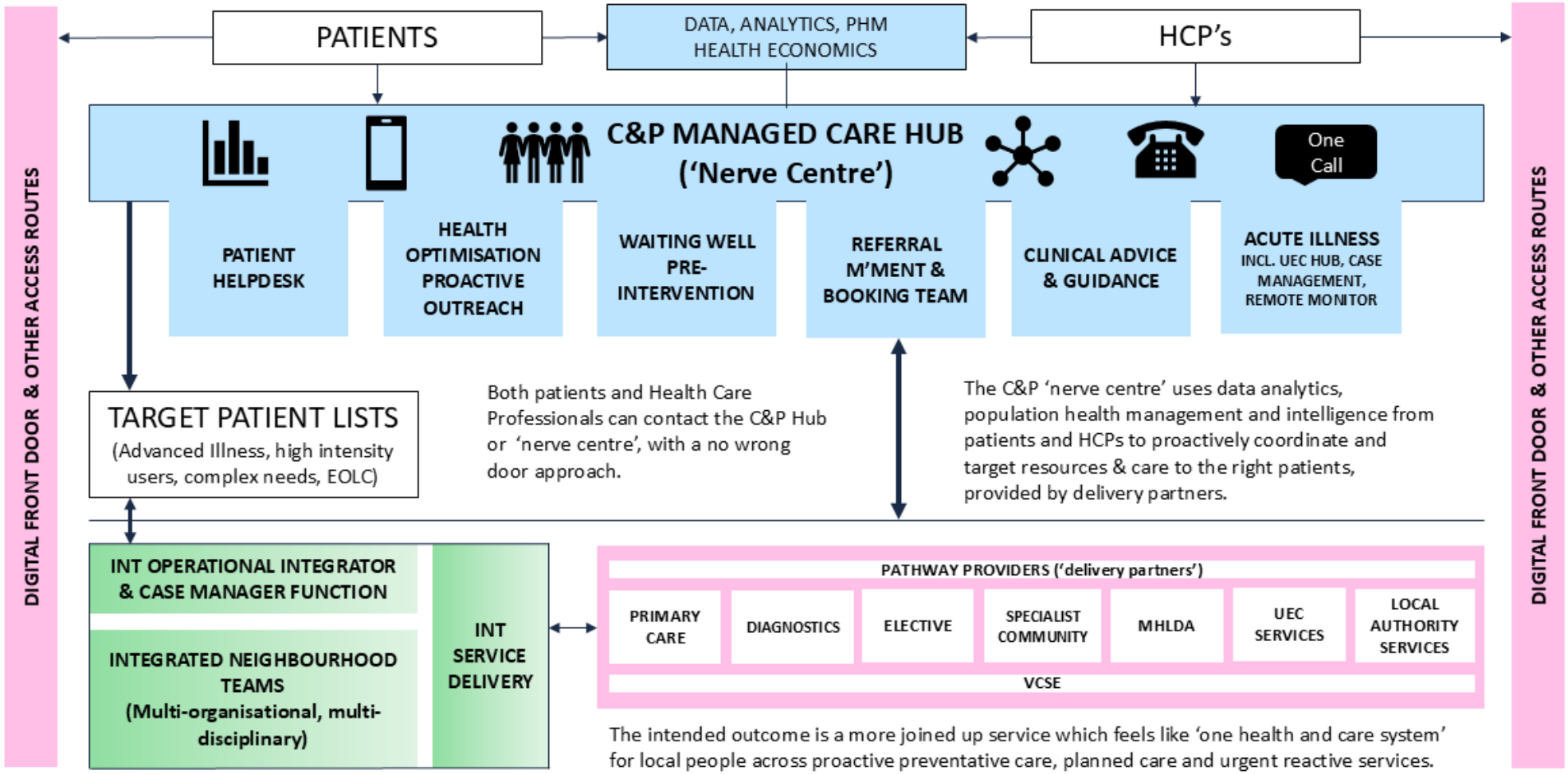
- Health Optimisation – targeted proactive prevention programmes.
- Acute Illness – UEC Hub, advice & guidance coordinating urgent care.
- Patient Helpdesk & Waiting Well support.
- Referral Management & Booking Team.
- Integrated Information, Data & Population Health Management Analytics.

The nerve centre will offer a 'one call' service for busy clinicians navigating complex care pathways. It will create a 'no wrong door' patient (service user) helpdesk designed to help callers with a range of queries such as where they are in a referral process or waiting list, releasing time for GP practice staff who would otherwise deal with this. The helpdesk will be complemented by our waiting well pre-intervention information and related support services.

It will use population health management analytics combined with intelligence from patients and healthcare professionals to target health optimisation work, enable effective urgent care coordination and streamline referral management and booking. It will also use and support development of evidence-based interventions, based on health economics and qualitative – quantitative evaluation.

C&P 'NERVE CENTRE' & INTEGRATED NEIGHBOURHOOD TEAMS DELIVERY FUNCTIONS

The diagram below shows proposals for the C&P Managed Care Hub or 'nerve centre' and Integrated Neighbourhood Team functions.

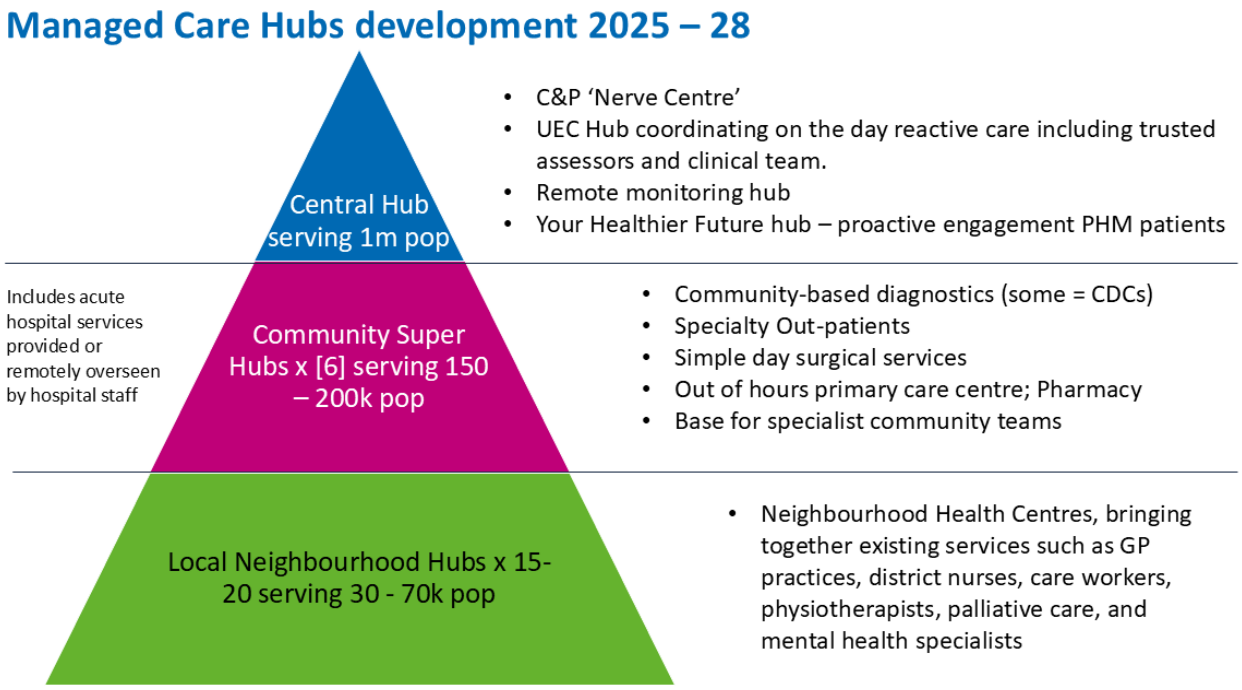


Integrated Neighbourhood Teams

Development of our Integrated Neighbourhood Teams is an essential component to provide seamless multi-agency community-based care. The INTs will hold accountability for their local population, focusing on priority population groups including adults who are frail or with advanced illness, often with multi-morbidity. The INTs will use population health data (target patient lists) and local professional insight to identify people who would benefit most from assessment and wrap around care, reducing the risk of crisis and use of emergency services.

Community Superhubs

There is an overall deficit of fit for purpose physical space to provide primary and community care to our current and forecast future population, whilst accommodating and increasing services traditionally delivered in main acute hospital sites. By strategically placing community superhubs in the right locations, the NHS and wider care partners can enhance health and care accessibility, address health inequalities, and provide comprehensive services tailored to the needs of the local populations.



Sustainable Primary Care

Proposed key ambitions for sustainable general practice include equity in access and patient experience, a sustainable workforce model, a financial model incentivising the right care, preventative activity supported at scale is the norm for the main areas of disease experienced by our population, and digital innovation.

Our ambition is to align community pharmacy services with wider health system priorities, focusing on improved access to primary care, management of long-term conditions, and reduction of health inequalities.

Elective Care

Our planned care strategy encompasses elective care, diagnostics, out-patients, waiting well and cancer. The key features are firstly end-to-end pathway redesign to ensure they are technology and digitally enabled, diagnostic led, flexible to meet patient needs. Secondly, to support service redesign, we will also look at how and where we deliver treatment, adopting a closer to home model where this works best but scaling up to hubs or elective centres where this generates the best outcomes. Moving to an elective hub model is one part of this. This is about productivity, efficiency, maximising our current resources. Thirdly, our ambition is to move to shared waiting lists across Cambridgeshire and Peterborough, enabling timely treatment and choice to patients.

Digital Enablers

Our ambition is to offer consistently excellent online services where local people can easily find reliable health-related information, select service options, manage their health care appointments, and self-refer where the option exists. We have heard how frustrating our current fragmented online tools and apps can be for local people and healthcare professionals – we want to improve interoperability across providers so everyone can more easily navigate their way through their health care journey. We also want to use online apps to drive health optimisation programmes which will help us achieve a move from treatment to prevention, supporting the long-term sustainability of NHS services.

Engagement

Engaging with our stakeholders is a vital part of the development of our planning process. We will continue to build on the two Let's Talk engagement campaigns, engagement in the JFP, Outcomes Framework and Health Utilisation Model. We will engage on specific programmes as appropriate, for example the Citizen Panels, Healthwatch-led survey and stakeholder event for digital enablers, and use co-production approaches where appropriate. We will also build on the strong existing partnership working with health and wider partners.

Delivery

The approach will be incremental, leveraging existing opportunities for gradual transformation while maintaining operational stability. We will continue our engagement with partners and wider stakeholders to develop the detail on how we work together to deliver this ambitious set of transformation and enabling programmes.

Introduction

Purpose & Scope

The ICS Joint Forward Plan set out our ICS aims and priorities, building from our Health and Well-Being Integrated Care Strategy Ambitions, which in turn drive our ICS Outcomes Framework. Through local and region-wide work over the past 12 months we have developed a Health Utilisation Model as a cross-cutting approach to manage care, delivering better outcomes and financial sustainability.

The Strategic Commissioning Plan sets out how we will translate this model into reality over the next three years through four workstreams – Managed Care, Sustainable Primary Care, Elective Care, Digital and other enablers. The Plan is intentionally high-level and focused, and much of the content is applicable across all ages and care groups. It does not duplicate existing strategies including those for children, maternity, mental health, learning disability and autism, but where relevant it refers to supporting documents for more detailed information. The Plan serves as our high-level commissioning intentions for 2025-28 and provides context for the 2025/26 Operational Plan.

Strategic Commissioning Plan Structure

The structure of this Strategic Commissioning Plan is set out below:

Section	Headlines
Strategic Context	Outcomes Framework, Joint Forward Plan, partner and national reference points; Engagement
Health Utilisation Model, Ethos & Principles	Local & regional blueprint for sustainability addressing current and future challenges including health inequalities
Evidence Review	Headline summary of supporting evidence, full report available on request
Activity model	Headline outputs from baseline, forecast and mitigators analysis
Main Workstreams & Programmes	• Managed Care • Sustainable Primary Care • Elective Care
Enablement Programme	Supporting strategies for digital, data, workforce, financial, estates, VCSE, engagement & delivery
Delivery Plan	High-level delivery over 2025-28

Why do we need a Strategic Commissioning Plan now?

Nationally and locally the health and care system is facing significant pressure today. The challenges and problems were set out in Lord Darzi's ' diagnostic' report Independent Investigation of the NHS in England in September 2024.

Locally, demographic and non-demographic growth projections for Cambridgeshire & Peterborough indicate a deficit of over 350 acute hospital beds by 2030, escalating to between 650-900 beds by

2040, if we do nothing differently. Current analysis shows that 93% of acute bed utilisation is from unplanned admissions. Although these forecast shortfalls are expressed in terms of hospital beds, they will also apply more widely across primary and community care, mental health services and other types of treatment such as diagnostics.

We used data, evidence and stakeholder engagement to develop the draft Health Utilisation model, which we believe will help significantly in addressing these challenges and ensure that we have a local NHS which is sustainable. In short, it is essential that we make progress in delivering the vision and route map set out in this Strategic Commissioning Plan for 2025-28.

Strategic Context

The Strategic Commissioning Plan takes into account and builds on the wider strategic context including:

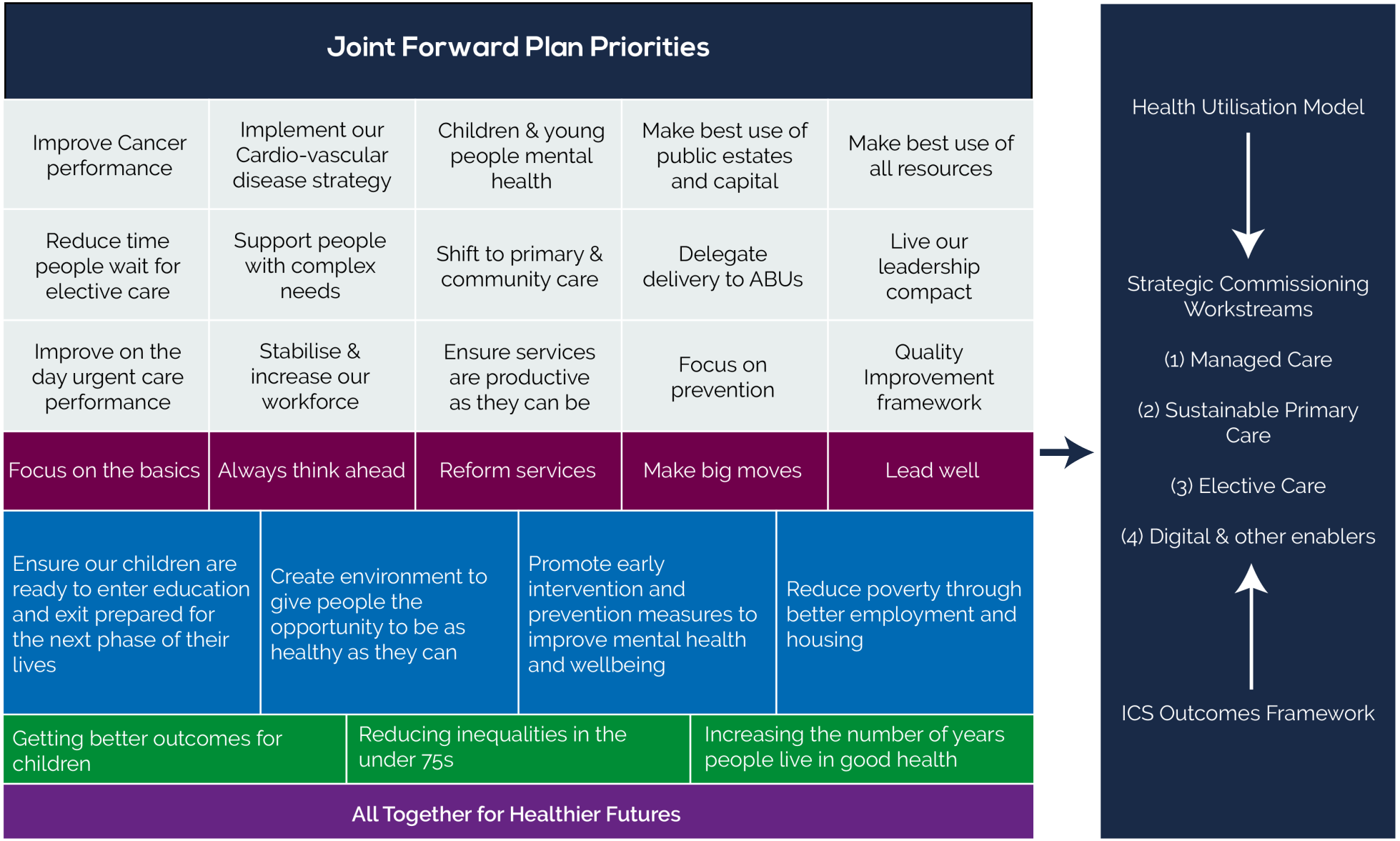
- The Cambridgeshire & Peterborough ICS Outcomes Framework.
- Our Health& Well-Being Integrated Care Strategy, and our Joint Forward Plan which set out our broader strategic aims and major programmes of work.
- Health Utilisation Model: local and regional work to develop a common approach to tackling the current and future challenges we face.
- Our approach to tackling Health Inequalities.
- Work which our partners are developing such as the CUHFT Acute Clinical Strategy and NWAFT's Clinical Strategy, the recent Place-based Joint Strategic Needs Assessments and the Cambridgeshire & Peterborough Combined Authority State of the Region.
- National policy including Lord Darzi's Independent Investigation of the NHS in England, and early indications of the Governments intentions for its 10 Year Plan – from hospital to community services, from analogue to digital, and from treating sickness to preventing it. We see our Care Model as closely aligned to these themes but will review our Strategic Commissioning Plan when the national 10-year plan is published.

ICS Outcomes Framework

Our Outcomes Framework sets out the longer-term outcomes we want to achieve, and the proxy measures which will help us understand if we are on track in the shorter term. The Cambridgeshire & Peterborough ICS Outcomes Framework covers a wide range of domains from Wider Determinants and Behavioural Factors through major conditions such as coronary heart disease and Respiratory Illness, and care groups (Children, Mental Health, Learning Disabilities) to Healthy Ageing. We also want to deliver against a set of outcomes expressed as 'I statements' from the perspective of local people using services. For example, "I have options and choices in my healthcare, ensuring that my preferences and needs are respected." The 'I statements' are set out in Appendix A.

Building on the Joint Forward Plan

The ICS Joint Forward Plan sets out our ICS priorities, summarised in the diagram below: building from our shared mission statement 'All Together for Healthier Futures', and our Health and Well-Being Integrated Care Strategy Ambitions (green, blue layers), which in turn drive our ICS Outcomes Framework. The Health Utilisation Model is a cross-cutting approach to manage care, delivering better outcomes and financial sustainability. The Strategic Commissioning Plan sets out how we will translate this model into reality over the next 3 years through four workstreams – (1) Managed Care Service (2) Sustainable Primary Care (3) Elective Care (4) Digital and other enablers. The JFP priorities as shown in the following diagram drive the four Strategic Commissioning Plan workstreams, also complementing wider strategies led by system partners.


Joint Forward Plan Priorities
Improve Cancer performance
Implement our Cardio-vascular disease strategy
Children & young people mental health
Make best use of public estates and capital
Make best use of all resources
Reduce time people wait for elective care
Support people with complex needs
Shift to primary & community care
Delegate delivery to ABUs
Live our leadership compact
Improve on the day urgent care performance
Stabilise & increase our workforce
Ensure services are productive as they can be
Focus on prevention
Quality Improvement framework
Focus on the basics
Always think ahead
Reform services
Make big moves
Lead well
Ensure our children are ready to enter education and exit prepared for the next phase of their lives
Create environment to give people the opportunity to be as healthy as they can
Promote early intervention and prevention measures to improve mental health and wellbeing
Reduce poverty through better employment and housing
Getting better outcomes for children
Reducing inequalities in the under 75s
Increasing the number of years people live in good health
All Together for Healthier Futures
Health Utilisation Model
Strategic Commissioning Workstreams
(1) Managed Care
(2) Sustainable Primary Care
(3) Elective Care
(4) Digital & other enablers
ICS Outcomes Framework

Engagement

Engaging with our stakeholders is a vital part of the development of our planning process. Throughout the continuing development process, we have been working with partners across the system to test, challenge and refine the model further. Bringing different perspectives and experiences into the process to progress our thinking through shared endeavour.

Before starting the work, we reviewed engagement and consultation work we had recently undertaken to capture the views of local people about our services and strategic approach. For example, we ran two Let's Talk (engagement) campaigns with local people across our area to gather information for our Joint Forward Plan which provides a rich baseline of insights.

We have also focused in on our digital work, having held two rounds of focus groups and an engagement survey, led by Healthwatch, that has heard from over 1,300 local people. Alongside this we undertaken intensive stakeholder engagement, including a Market Engagement Event, to expand our reach further. All of these insights have been fed into the procurement specification process, shaping what we will go to market with. By bringing in local voices at such an early stage, we have enhanced and shaped the product that we go to market for.

This is not the end of our engagement work. We are committed to:

- Embedding effective stakeholder engagement, and management, into our programmes to ensure we continue to have the right conversations, with the right people at the right time
- Gathering views of our local people and communities to better understand how they want to access services and what it feels like to be on the receiving end of local NHS services
- Creating space for frontline workers to share their unique experiences and knowledge about how process and pathways are currently functioning, and how they could be improved
- To have these conversations when people's voices and views can have an impact on outcomes and sharing how they have shaped our thinking and the end results.

Health Utilisation Model

We have worked locally and across the East of England to develop the Health Utilisation (New Care Model) as a common approach to tackling our current and future challenges and deliver a sustainable health and care system. The vision is set out below:

> The vision for healthcare is one that is readily accessible, seamlessly integrated, and inclusive to all members of our community. We envision an NHS that is simple to use, with services available whenever they are needed. Our priority is to empower individuals by placing access to care directly in their hands, offering user-friendly digital platforms and personalised support to navigate their healthcare journey with ease. Moreover, we are committed to creating an environment where our workforce finds joy and fulfilment in their work, with opportunities for professional growth, meaningful collaboration, and a shared sense of purpose in delivering high-quality care. By prioritising accessibility, inclusivity, and workforce satisfaction, we aim to create a healthcare system that not only meets the needs of our community but also enriches the lives of those who serve within it.

Ethos

The ethos for the whole 'Health Utilisation Model' is about using the most innovative data analytics and digital tools to coordinate and target effective care, but first and foremost enabling **Personalised Care for local people:**

- Providing time and attention to understand what matters to individual patients, with staff trained in engaging patients in an empathetic way so patients feel respected and safe.
- No wrong door, taking ownership to find information and sort out queries with clear explanations and timelines.
- Provide options and control of options.
- Ability to communicate when and how patient wants to, recognising diversity and being mindful of inequalities.

Managed Care

The approach is based on ICBs taking accountability for the management of care and the overall optimisation of its population health to mitigate clinical and financial risk. To do this the model is based on the following essential elements of managed care and the outcomes they should achieve:

Patient-Centred Care

By promoting patient engagement, shared decision-making, and care coordination, managed care models prioritise the needs and preferences of patients, leading to a more personalised and effective healthcare experience.

Efficiency and Resource Optimisation

Through data-driven decision-making and continuous monitoring, managed care can identify inefficiencies and areas for improvement, leading to better allocation of resources and improved operational efficiency.

Improved Quality of Care

By emphasising preventative services, care coordination, and evidence-based practices, managed care can enhance quality and patient outcomes.

Enhanced Access to Care

Focus on improving access to healthcare services by streamlining processes, reducing wait times, and optimising resource allocation.

Population Health Management

Managed care models facilitate population health management by targeting interventions and resources to specific populations, addressing their unique health needs, and reducing health inequalities.

Cost Control

Managed care can help control healthcare costs through various mechanisms such as contracts, utilisation management, and preventative care.

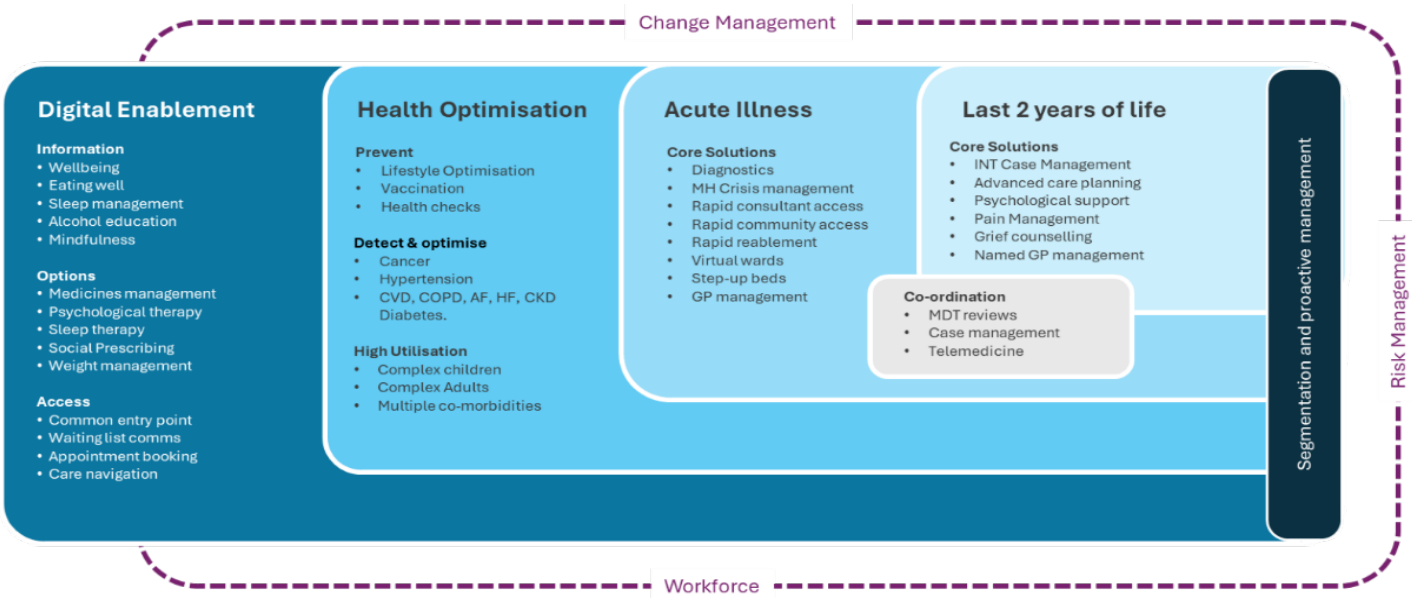
Sustainability of Healthcare Systems

Given the increasing demands on healthcare systems and finite resources, implementing managed care can help ensure the long-term sustainability of healthcare systems by balancing cost containment with quality of care.

Model 'Pillars'

The Health Utilisation model is based on four 'pillars' as shown in the diagram and described briefly below.

1. **Digital Enablement**: Utilises electronic health records (EHRs) and telemedicine to enhance patient care, streamline data sharing, and reduce costs. Digital tools will improve efficiency, accessibility, personalised care, and patient outcomes, while also allowing patients to manage appointments and access health records online.
2. **Health Optimisation**: Focuses on prevention, early detection, and management of chronic conditions. It targets high-risk populations with personalised interventions to improve health outcomes and reduce healthcare utilisation.
3. **Acute Illness Management**: Integrates multi-disciplinary teams (MDTs), case managers, and a virtual hospital infrastructure to streamline patient care, reduce delays, and ensure seamless transitions. This model emphasises community-based acute care and reduces unnecessary hospital admissions.
4. **Advanced Illness Care**: Enhances quality of life for individuals in their last two years by providing personalised support, managing end-of-life care, and reducing hospital admissions through better community care.



Health Inequalities Strategy

The aims set out in this Strategic Commissioning Plan will help our ICS to address health inequalities. We know that significant healthcare inequalities exist across Cambridgeshire, Peterborough & Royston. For example, female and male life expectancy in Cambridgeshire is persistently higher than in Peterborough, while at a district level, life expectancy at birth in Peterborough and Fenland being statistically significantly lower (worse) than the England rate. Also we know averages can hide localised inequalities. The gap in life expectancy is driven primarily by early deaths due to cardiovascular disease, cancer, and respiratory conditions.

Through the Health Utilisation Model, and specifically the Managed Care Hub ('nerve centre') functions described later in this Plan, we will further develop our ability to identify those population groups and individuals who are most at risk of healthcare inequalities and provide them with the timely care and support they require. This includes:

- Using our data and wider insights so we are evidence-led in our approaches.
- Promoting healthy behaviours and increase access to early intervention services.
- Improving access to healthcare services for vulnerable and marginalised populations.
- Working with local people and communities to better understand the challenges they experience and coproduce solutions that best meet their needs.
- Embedding a 'Core20PLUS' approach.

Evidence Review

The Health Utilisation New Care Model was based on a review of evidence. We have updated this evidence base to inform this Strategic Commissioning Plan: a summary of the key points is set out below. (The full evidence review including references is available on request).

The ICS faces mounting challenges, including an ageing population, high rates of multi-morbidity, rising demand, workforce burnout, persistent health inequalities, and unsustainable healthcare costs. Studies indicate that the prevalence of multi-morbidity ranges between 14.8% to 42.4% across all age groups. As per the Darzi report, the prevalence of multimorbidity will increase at an annual rate of 6.1 percent; this could mean a dramatic strain on healthcare systems, widening health inequalities. Current approaches, predominantly focused on single-disease prevention, fail to address the complexities of multi-morbidity and integrated care needs. Patients often experience fragmented care, with multiple specialists treating isolated components of their health problems, leading to polypharmacy and complicated interactions with the healthcare system.

Key Findings

- Multi-morbidity is the primary driver of inpatient demand, especially among ageing and socioeconomically disadvantaged groups.
- Integrated care models addressing multi-morbidity demonstrated sustained reductions in hospital utilisation, costs, and disparities.
- Multi-morbidity strategies align with Cambridgeshire & Peterborough ICB's equity and health outcome goals.
- The successful implementation of Integrated care models is a complex task. It is often challenging to disentangle the effects of various components or 'sub-interventions' and understand how the overall initiative impacts healthcare use and costs. These sub-interventions could involve changes in care delivery, new technologies, or modifications to existing processes and change in culture.

Reducing Overall Disease Burden and Resource Use

Multi-morbidity approaches reduced hospital admissions by 17-43%, emergency department visits by 20–41%, hospital readmissions by 17-35%, and length of stay by up to 5.5 days (9,13,15–18). (Refer to table 1 in the appendix of the full evidence review for detailed estimates, available on request).

Place-based Community-Centred Support

- Social Determinants of Health: Address housing, education, and nutrition.
- Culturally Tailored Interventions: sensitive to the specific needs of diverse groups.
- Community Partnerships: Collaborate with partners to create a robust support system.

Recommendations

Based on the evidence reviewed, addressing the growing healthcare challenges in our system requires adopting integrated care models that prioritise a multimorbidity-focused prevention approach, guided by the principle of proportionate universalism to ensure equitable and effective outcomes. This strategy ensures that interventions are universally applied but scaled in intensity according to the level of disadvantage, thereby addressing health inequities.

Activity Model

To inform the Strategic Commissioning Plan 2025-28 we have asked the following questions:

1. What is the forecast demand and capacity for our system for 2030, 2035 and 2040 if we do nothing significantly different?
2. What is driving current use of our services?
3. To what extent are these drivers of ill health amenable to preventative interventions ('reversible risk') and alternative care pathways?
4. What capacity do we need across our system, but particularly in the community, to create a locally sustainable NHS?

Demand will grow for our system, driven by population growth and demographic change with a marked increase in our older age groups as shown in the table below.

Population growth by Lower Tier Local Authority (LTLA) by Age Group for 2041

LTLA	**0-24**	**25-64**	**65+**
Cambridge	-1.7%	5.1%	96%
East Cambridgeshire	1.1%	9.5%	104%
Fenland	5.0%	10.5%	97%
Huntingdonshire	8.0%	11.7%	95%
Peterborough	3.4%	12.6%	98%
South Cambridgeshire	20.3%	27.9%	108%
Total	**6%**	**13%**	**100%**

This will translate into a need for increased beds, A&E attends and community services including primary care. By 2030/31 we would need the equivalent additional bed capacity of a new district general hospital to cope with the demand for beds, under our current care model.

Implementing the new model and realising productivity opportunities to make our system as efficient as possible will have a significant impact on activity across the ICS.

The Activity Model is summarised in the table below, which shows the 2030/31 projected activity, mitigations and residual growth. This model is based on conservative assumptions regarding impact, and we are continuing to work on sensitivity analysis with higher and lower scenarios. Further detail on the forecast modelled impacts is set out Appendix C: Activity Forecasts & Scenario Modelling.

Challenge	Non-Elective bed days (000's)	A&E Contacts (000's)	Primary & Community Care (000's)
2023/24 Current Activity	786	413	7,480
2030/31 Projected Activity (Demographic and Non-Demographic Growth	961	466	8,507
2030/31 Projected growth	175	53	1,027

Mitigation	Non-Elective bed days (000's)	A&E Contacts (000's)	Primary & Community Care (000's)
Managed care approach	-78	-16	1,991
Productivity	-54	TBC	TBC

Outcome	Non-Elective bed days (000's)	A&E Contacts (000's)	Primary & Community Care (000's)
Residual growth	43	37	3,018

Our strategy is to convert a proportion of the demand for acute beds into contacts with people and patients which take place outside a hospital setting, on the basis that such contacts are a more cost-effective way of meeting and reducing demand for services whilst still providing a quality experience for local people and staff. The shift in service provision will create a new demand challenge, away from the acute setting. This challenge will be met by:

- The Managed Care Programme using predictive data modelling to identify reversible risk for cohorts and individuals, overseen by the 'nerve centre' and delivered through local providers including the Integrated Neighbourhood Teams as a key change agent. Health optimisation will reverse risk in the population so that contacts are avoided. This reduces the forecast additional capacity we need by 2030/31 by 78,000 non-elective bed-days.
- Creating more capacity in Sustainable Primary Care and Integrated Neighbourhood Teams which will be funded in line with the Medium Term Financial Strategy.
- Being more efficient and delivering more care through Digital channels.
- Using existing capacity more efficiently by actioning our Elective Care Strategy, which will lower the backlog of people waiting for care and recovering to the 18 week and diagnostic targets. Further work is in progress to refine our modelling forecasts for this.

- Delivering productivity gains (see Appendix C: Productivity Opportunities Summary) based on our analysis of benchmarking and opportunities as set out above, which will reduce the 2030/31 forecast non-elective bed days by 54,000.
- The total forecast benefit is 142,000 non-elective bed days, leaving residual growth of 43,000 non-elective bed days.

Main Workstreams & Programmes

This Strategic Commissioning Plan 2025-28 sets out our aim to deliver three high impact workstreams which build on our JFP foundations to deliver the cross-cutting Health Utilisation Model. These workstreams each contain a number of main programmes and an Enablement Programme, summarised in the table below and set out in more detail in the plan.

<table>
<tr><th>Workstream</th><th>Main Programmes</th><th>Enablement Programme</th></tr>
<tr><td>Managed Care</td><td>Nerve Centre including:
Health optimisation (inc Your Hjealthier Future)
Acute Illness (inc UEC Hub)
Patient Helpdesk & Waiting Well
Referral Management & Booking
Using data, Population Health
Integrated Neighbourhood Teams
End of Life Care
Medicines Optimisation
Community Superhubs (cross-cutting)</td><td rowspan="3">Digital Strategy
Financial Strategy
Workforce Strategy
VCSE
Estates Strategy
Data Strategy
Leading Delivery</td></tr>
<tr><td>Sustainable Primary Care</td><td>Primary Medical Services
Community Pharmacy
Dentistry</td></tr>
<tr><td>Elective Care</td><td>Elective Strategy inc hubs and out-patients reform
Diagnostics</td></tr>
</table>

Managed Care Programme

Cambridgeshire & Peterborough Managed Care Hub ('Nerve Centre')

At present our local health and care system can feel fragmented and difficult to navigate for patients and staff. Although there are huge amounts of data relating to patients and their care, they are often kept in silos which do not connect. This is not only frustrating for patients but also means treatment processes are not always joined up, and staff may have to spend time piecing together information or duplicating tests which is not efficient.

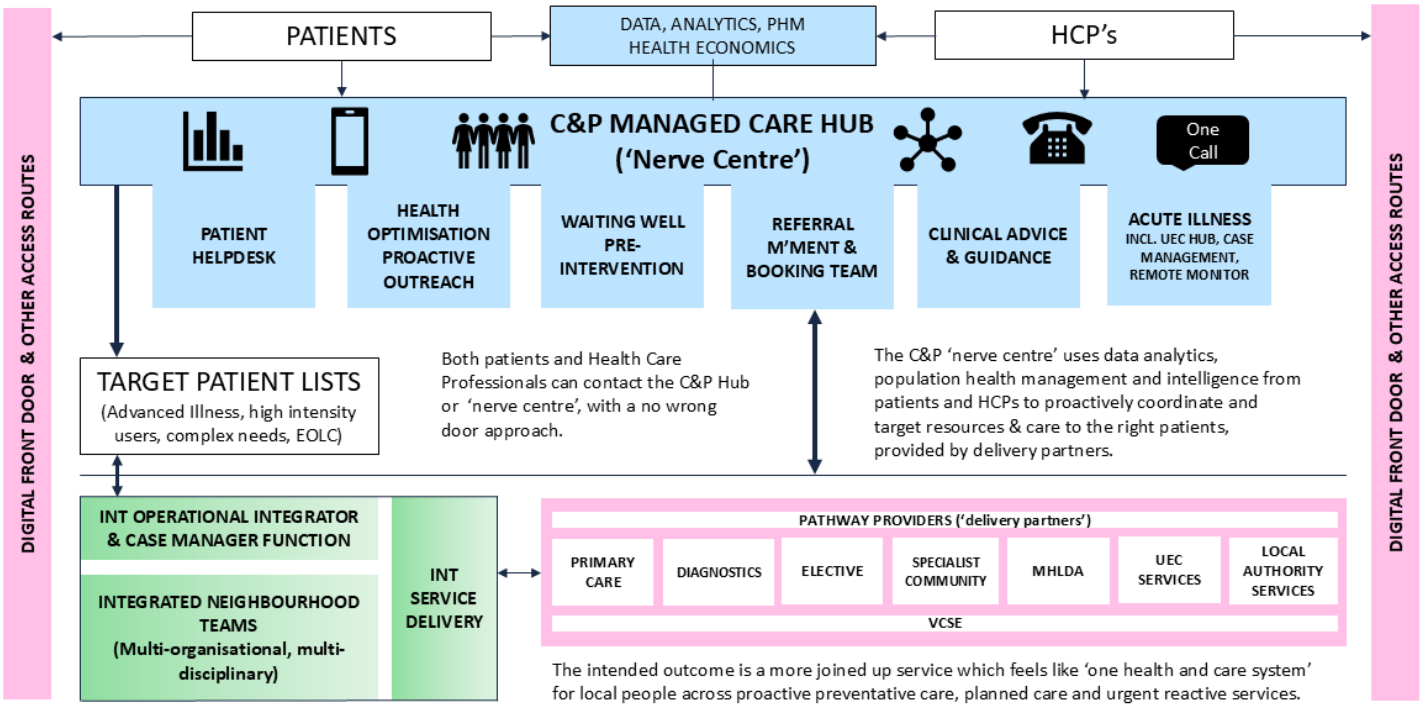
Serving the whole Cambridgeshire & Peterborough population, the Managed Care Hub or 'nerve centre' will bring together a number of managed care functions which support patients and healthcare professionals and drive better use of health and care resources (blue box in the following diagram).

- Health Optimisation – targeted proactive prevention programmes
- Acute Illness – UEC Hub, advice & guidance coordinating urgent care
- Patient Helpdesk & Waiting Well support
- Referral Management & Booking Team
- Integrated Information, Data & Population Health Management Analytics

The nerve centre will offer a 'one call' service for busy clinicians navigating complex care pathways. It will create a 'no wrong door' patient (service user) helpdesk designed to help callers with a range of queries such as where they are in a referral process or waiting list, releasing time for GP practice staff who would otherwise deal with this. The Helpdesk will be complemented by our waiting well pre-intervention information and related support services.

C&P 'NERVE CENTRE' & INTEGRATED NEIGHBOURHOOD TEAMS DELIVERY FUNCTIONS

The diagram below shows proposals for the C&P Managed Care Hub or 'nerve centre' and Integrated Neighbourhood Team functions.



It will use population health management analytics combined with intelligence from patients and healthcare professionals to target health optimisation work, enable effective urgent care coordination and streamline referral management and booking. It will also use and support development of evidence-based interventions using health economics and evaluation.

Managed Care Hub - Health Optimisation

Current Position

Health Optimisation: Focuses on prevention, early detection, and management of chronic conditions. It targets high-risk populations with personalised interventions to improve health outcomes and reduce healthcare utilisation. At present, many local people are at greater risk of ill health because they have either not been identified or treated – for example:

- Preventable under 75 years cardiovascular disease mortality in Peterborough is **significantly worse** than England and regional average, ranked 26th highest district/UA in England with **increasing trend**.
- Coronary Heart Disease Hospital Admissions in Cambridgeshire and Peterborough are **significantly worse** than England average, ranked 40th highest in England.
- Over 50% of local patients with diabetes are not within the nationally recommended target for glycated haemoglobin (HbA1c), which can lead to complications such as eye problems and amputations.

Our Ambition

Identify, Engage, Act – Your Healthier Future

Building on the success of the 'Your Healthier Future' pilot for cardiovascular disease, we will use new sources of powerful analytical data to identify groups of patients with the greatest 'reversible risk' – meaning that we can do something to reduce the likelihood of patients developing acute illness which requires hospital admission. We will engage with these patients to inform, discuss options and provide interventions – this could be prescription of medicines for a particular risk (statins for high cholesterol, for example), or lifestyle support (exercise, sleep or smoking cessation, for example). By preventing ill health, patients enjoy better outcomes, and the NHS alleviates pressure on services, and lowers costs.

Tackling Economic Inactivity

There is a related health optimisation ambition linked to economic inactivity, and development of the Work Well initiative. This also builds on identifying local people with reversible or mitigatable conditions and offering personalised support, in particular associated with major drivers such as mental health, musculoskeletal conditions and Cardio-vascular disease.

Multi-morbidity

During 2025/26 we will extend the 'Your Healthier Future' approach to further patients with reversible risk. This is likely to focus on optimising patients with several long-term conditions (multi-morbidity) because the evidence suggests that this will have the greatest impact on preventing serious illness and helping patients avoid admission to hospital.

Managed Care Hub - Acute Illness, UEC Hub, Advice & Guidance

Current Position

Current urgent and emergency care models are no longer fit for purpose – poor performance, long delays for care (ED 4 hour wait, ambulance response and handover time targets) and poor experience for those with both physical and mental health needs. Entry points are multiple and confusing for patients and professionals alike to navigate with layering of services over time to address identified gaps in provision has created significant service fragmentation.

Managing Risk

Clinical risk management needs a fundamental shift in perspective to enhance patient safety and care quality. Traditionally, it is believed that patients are safer in an Emergency Department (ED) or a hospital than at home. However, this often leads to long waiting times in sub-optimal healthcare settings and deconditioning associated with unnecessary inpatient admissions or extended lengths of stay. Current models prioritise patients based on who has called 999 or self-presented at an Emergency Department and their immediate risk, ignoring those at higher risk who haven't used these access routes.

We must transition from managing visible, immediate risks to overseeing total risk, encompassing both known and unseen patients. This shift requires redefining acute care to extend beyond hospital boundaries, ensuring comprehensive and equitable healthcare delivery.

Our Ambition

Integration

This new clinical model for acute healthcare is designed to streamline patient care, reduce delays, and improve outcomes by integrating multi-disciplinary teams (MDTs), case managers, and a virtual hospital infrastructure to support patients who have physical and mental health urgent and emergency care needs.

Access

There are several elements to the model that are important, starting with the initial access point. Patients will continue to use existing points of contact, such as calling an ambulance for an emergency care need or 111 for an urgent care need, this ensures no disruption or confusion for patients seeking emergency assistance, as these access points are well established, with coordination of care taking place behind the scenes. For healthcare professionals, a single point of access for clinical advice, guidance and onward services will be in place, taking the variation out of potential referral routes and ensuring patients receive the right care, first time.

Multi-Disciplinary Team

The acute illness model will be centred around a core multi-disciplinary team, consisting of healthcare professionals from various disciplines who assess and determine the most appropriate care pathway for each individual patient. The MDT will provide advice and guidance to referrers, receive and clinically triage patient referrals, arranging onward service provision, and case manage patients through their acute illness episode, ensuring they receive the support they need and are safely discharged from all services. The model will operate a 28-day patient initiated follow up approach, through an individual case worker, supporting patients in their recovery and minimising the risk of deterioration.

Service Model

Previously in the NHS, we have separated out different elements of care, i.e. emergency, acute and community, in this model we are clear that a patient can be acutely ill anywhere – a virtual hospital approach which operates 24/7. This means that, through single integrated coordination, patients will have direct access to a range of services to support them during an urgent or acute illness period, including:

- Rapid response services, between 0–2-hour response to support unwell patients in the community who need rapid clinical assessment to identify the most appropriate onward care pathway and treatment plan.
- Urgent community response and wrap around services, supporting 4, 8 hour and 24-hour response model dependant on clinical need, providing a case management approach to people in the community, to manage their period of acute illness.
- Centralised advice and guidance from acute physicians and specialists, rapid access hot clinics for specialist input and direct access to onward acute services as appropriate, including emergency departments and same day emergency care.
- Rapid access social care, reablement and voluntary sector support, ensuring that patients who can be supported to maintain independence do so, with a holistic person-centred assessment on needs that span immediate health concerns.
- Direct access diagnostics and reporting: Patients can quickly access diagnostic tests, with results reported to the MDT or case manager/GP, as appropriate.
- Step-up capacity and remote monitoring: Availability of physical local bed capacity, outside of acute hospitals for acutely ill patients needing closer monitoring and care in a care setting. Routine use of remote monitoring technology to support virtual ward arrangements and case management via the acute illness hub.

When implemented this model will reduce delays for patients and improve access. Continuous support from a designated case manager provides patients with a single point of contact, improving their healthcare experience and coordination of their care supports people receiving the right services, first time. The model promotes a fluid approach where providers work around patient needs, rather than patients adjusting to provider availability.

The model spans all ages, physical and mental health needs, recognising that recovery is most effective when people are treated holistically, with the ability to meet both health and social needs at the same time.

Managed Care Hub - Patient Helpdesk

Current Position

At present there is no centralised Cambridgeshire & Peterborough Patient Helpdesk. Patients are sometimes unsure which part of the NHS to go to for help and will contact various hospital departments or their GP practice which means staff spend time investigating queries which may relate to one or more appointments, procedures or test results in other organisations.

Learning from previous experience

We ran a winter pilot Patient Helpdesk in 2022 which was well received by patients, Healthwatch, the Local Medical Committee, practices and Trusts. Some quotes are shown below:

> Patient: 'I've been passed around and hear nothing about my appointment until the helpdesk called me to tell me when my appointment was. This service is a godsend.'
>
> Patient: 'When the lady on the helpdesk helped me with my hospital appointment, I could see the light at the end of the tunnel, and I started to cry. It's been so distressing not knowing when we were going to be seen.'
>
> GP Practice: 'Just wanted to feedback positively for all your help on the helpdesk today. Both myself and my patient have been very impressed!'

Our Ambition

We will incorporate a patient helpdesk service into the Nerve Centre which support the 'no wrong door' ethos, taking ownership of patient queries or concerns. This will build on positive patient, GP practice and other feedback on a previous Patient Helpdesk pilot, using cloud-based telephony to provide a user friendly but efficient service. For example, where patients are unsure what is happening with their referral for an out-patient appointment or hospital procedure, Helpdesk staff will use access to appropriate levels of primary, community and secondary care information systems to advise, and where appropriate point patients to waiting well information and support services. This will save time for GP practice staff and through centralising a function currently replicated in each individual provider, create productivity and efficiency gains.

Managed Care Hub - Waiting Well

Designed to provide people who are waiting for treatment with relevant information, opportunities, and access to a broad range of services that will optimise the time they are on the waiting list ensuring a holistic approach is taken to maximise their personal objective/health outcome. Waiting Well also includes 'pre-hab' which is about supporting patients to be in the best possible state of health before their hospital procedure, and as a result improve overall outcomes. The Waiting Well function will form part of the Cambridgeshire & Peterborough Nerve Centre.

Our ambition is that Waiting Well will:

- Provide personalised care to individuals supporting their individual needs.
- Provide information to people on a waiting list - about waiting times, and opportunities to optimise health and welfare to patients on waiting lists.
- Identify longer term opportunities to reach out to patients on waiting lists at an earlier stage to provide personalised support or access to other services – through the collaborations made with ARRS roles, digital methods, and partners.
- Continue to utilise the JOY local directory of services and cascade this across the wider system to support people waiting.

This will be the start of individuals elective journey and as the clinical model develops further opportunities to enhance waiting well will be developed.

Managed Care Hub - Referral Management & Booking Service

Current Position

We know we have growing demand now plus ageing population, and as we shift to focus more on prevention, we will see earlier identification of patients who need some form of planned intervention to manage their risk in a proactive way, hopefully supporting reduction in unplanned and urgent interventions.

Referrals

Current referral models are variable, with different documents, thresholds and approaches in place across different providers, driving unwarranted variation. Where advice and guidance is required the approach and timeliness of response from specialist clinicians can be variable, with onward actions often pushed back to the referrer to then complete. This can result in unnecessary referrals for an outpatient appointment or unmanaged risk, as referring professionals do not have the support they need or the capacity to manage the patient in a different way.

Choice

Choice is only currently available for patients on where they are referred to for their onward care, but this is not consistently offered and where it is, it is often based on limited information at the point of referral. Taking the time to discuss options with patients is not always available in primary care. The usual referral and booking approach is that the patient is contacted by the receiving provider on next steps, this can often be in the form of a letter sent by a hospital booking team with an appointment time, without any discussion with the patient on what would work best for them, when, and their preferences on how to receive their care (where this is possible i.e. virtual or in person).

Variation

We currently have wide variation in specialty waits across Cambridgeshire & Peterborough. Developing shared waiting lists thus far has proved challenging due to different organisational clinical priorities and approaches, thus a single referral management centre should eliminate some of the barriers to this. Moving care closer to home, as described elsewhere in the plan, will provide additional choice to patients and create greater workforce flexibility.

Ambition

We will develop and implement a pan Cambridgeshire & Peterborough referral management centre, which will:

- Reduce variation in referral approaches, through establishing a single and standardised route for all non-urgent planned elective, outpatient and diagnostic referrals, aligned to best practice pathways.
- Improve patient experience by providing individuals with choice as to when their appointments are booked, with the supporting ‘Nerve Centre’ Patient Helpdesk able to provide advice and updates throughout people’s care pathways.
- Provide a single clinical advice and guidance function to referrers, and consistent clinical prioritisation for those who do require further care.
- Centralise booking of all onward care, providing patients with improved access through a single ICS waiting list model.

- Coordinate needs post discharge from an acute elective pathway, ensuring all follow up arrangements are completed, prior to full discharge to primary care.

Managed Care Hub – Using Data & Population Health Management

Current Position

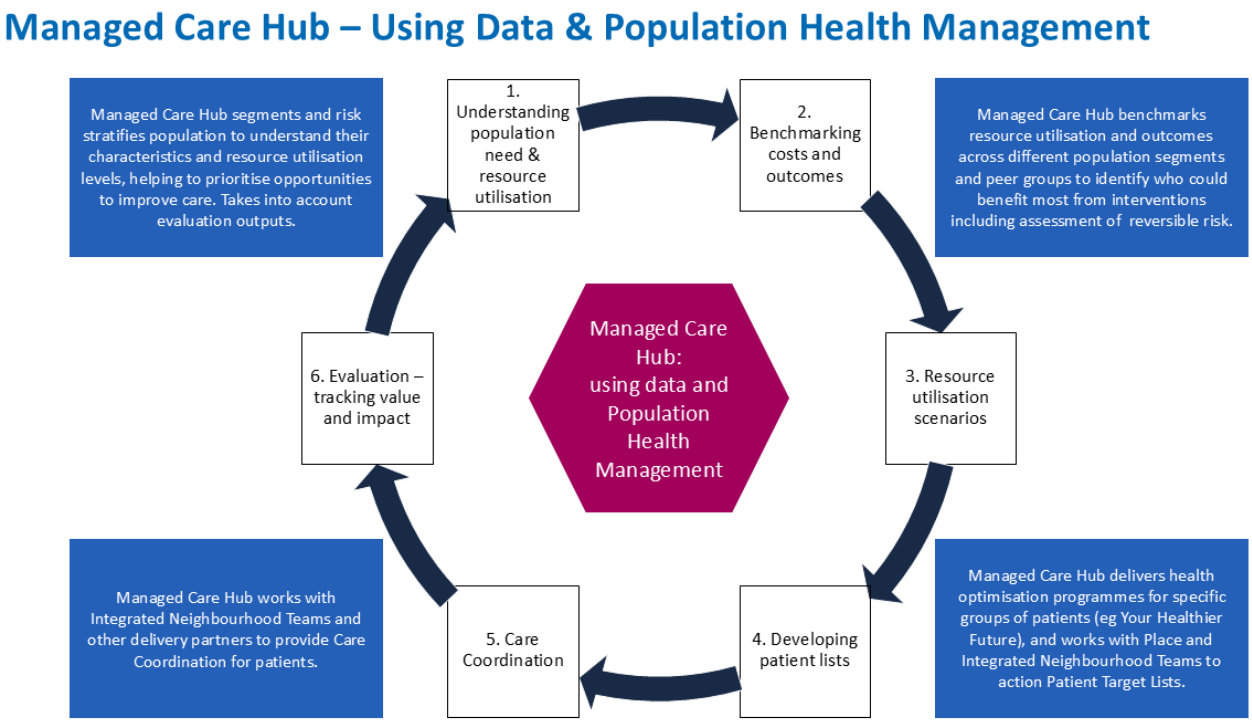
We have access to predictive analytic modelling and sophisticated comparison and benchmarking capabilities, but there is further work required to fully develop our Population Health Management (PHM) dataset and function. During 2023/24 we carried out a comprehensive requirement gathering exercise with ICS stakeholders to understand what PHM meant to each of us and what we needed from a PHM tool in the future. The output of this work was a complete set of requirements that underwent thorough review.

Ambition

We are now working with the Federated Data Platform team to develop PHM infrastructure. This approach will enable us to build on the learning already undertaken by other ICSs in relation to PHM methodologies and tools. It will also allow us to use the latest technologies to carry out PHM Analysis and embed that within the Health Utilisation Model.

We are concurrently working to add Primary Care data to our local data warehouse. This will enable us to link Primary Care, Community, Mental Health, Social Care and Hospital data via a consistent pseudonym. This maintains data security whilst allowing us to re-design services using the PHM methodology.

The Nerve Centre will use this PHM predictive modelling to help NHS staff understand need and generate patient target lists as described above in the section on Health Optimisation. We will work with partners during 2025 to specify and develop further data-driven, actionable insights.



To support this work the ICB will develop an Integrated Care System Data Strategy by the end of 2024/25 which will support a more joined up approach across organisations to sharing and using our data to deliver better care for local people.

Integrated Neighbourhood Teams

Current Position

We have successfully created 22 Integrated Neighbourhoods (INs) across Cambridgeshire, Peterborough and Royston, with intent to focus on the specific local issues that exist in our communities. These locally responsive integrated teams, drawn from partner organisations, are focused on the health, wellbeing and outcomes of the general population as well as people who are under-served or at greater risk of poorer outcomes. There are many local examples of excellent practice and this is spreading across our patch as we recognise that some of integrated neighbourhoods have only recently launched.

INs have identified challenges to equitable care and outcomes which exist in the current service environment:

- Some people (adults, children and families) with complex needs are falling through the gaps of existing services and pathways, meaning that their health and wellbeing needs are not being met. This leads them into a cycle of disadvantage and trauma, usually involving multiple unproductive contacts with different service providers.
- Some people who are at the end of their life are not receiving the support they need to optimise their quality of life and have a comfortable dignified death in a place of their choosing.
- Some staff who work with people with the above characteristics are frustrated that they are not adequately connected into or supported by the wider system, are consequently unable to provide the right level of care.

Ambition

We expect our Integrated Neighbourhood Teams to develop to provide seamless community-based care, holding accountability for their local population and the individual needs within it. Whilst many aspects of how an Integrated Neighbourhood Team functions will be defined in line with local population need, they will share some common qualities:

- Our vision is that Integrated Neighbourhood Teams will all contain the core services of General Practice, VCSE, Public Health intelligence, Adult Social Care, Domiciliary Care, Children's Services (including antenatal and post-natal care), Health Visiting, Social Prescribing, Care Navigation, Community Mental Health, Community Nursing, Community Therapies, Community Pharmacy, Dentistry and Optometry. We will work with partners to determine how best to achieve this vision for local integrated working structurally and culturally.
- There will be transparency of resources within each INT, coordinated through the Place-based Partnerships.
- They will access connecting services for all population groups, which operate at place or wider footprint, in an agile and responsive way.

Priority Population Groups

We will build a proactive community care model which truly delivers neighbourhood health. North and South Care Partnerships are leading development of our INTs, building on learning from the evolving high impact use programme, to deliver enhanced support for the following population groups:

- Adults who are frail or with advanced illness, often with multi-morbidity (+/- social care needs), including people with high impact use of care, and people in the last two years of life
- Adults with complex health and social needs.
- Children and families with complex health and social needs.

The core neighbourhood teams will have clear routes to more specialist services at scale through their acute trusts, local authorities and other specialist service provision.

Patient Target Lists

The INTs will use a combination of population health data (predictive modelling including target patient lists which identify those patients with reversible or mitigable risk) and local professional insight to identify:

- People who would benefit most from assessment and wrap around care, reducing the risk of crisis and use of emergency services.
- People with reversible risk where health optimisation and/or lifestyle support services will help, but who have not responded to other forms of engagement.

End of Life Care

Palliative and End of Life Care is an important component of the Managed Care Programme, reflected in the Health Utilisation Model and in the vision for our Integrated Neighbourhood Teams. Over 27% of hospital bed-days can be attributed to people in the last two years of life, mainly within the last three months of life. There are opportunities to improve communications between professionals, individuals and families/carers, access to up-to-date information, support for the bereaved and for carers. The ICS has a detailed Palliative Care Strategy which sets out the detailed context, and the following aims:

1. Each person is seen as an individual. I, and the people important to me, have opportunities to have honest, informed and timely conversations and to know that I might die soon. I am asked what matters most to me. Those who care for me know that and work with me to do what's possible.
2. Each person gets fair access to care. I live in a society where I get good end of life care regardless of who I am, where I live or the circumstances of my life.
3. Maximising comfort and wellbeing. My care is regularly reviewed, and every effort is made for me to have the support, care and treatment that might be needed to help me to be as comfortable and as free from distress as possible.
4. Care is coordinated. I get the right help at the right time from the right people. I have a team around me who know my needs and my plans and work together to help me achieve them. I can always reach someone who will listen and respond at any time of the day or night.
5. All staff are prepared to care. Wherever I am, health and care staff bring empathy, skills and expertise and give me competent, confident and compassionate care.
6. Each community is prepared to help. I live in a community where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss. People are ready, willing and confident to have conversations about living and dying well and to support each other in emotional and practical ways.

Medicines Optimisation

Current Position

- Prescribing is the biggest expenditure in the NHS, second only to workforce.

- Our system spends over £460m on prescribing of which around £160m sits in primary care.
- Nationally, it is estimated that 10% of all primary care prescriptions are overprescribed. For our system, this would equate to 1.9 million unnecessary prescriptions.
- Over recent years the growth in prescribing expenditure has been driven by drug shortages, price increases, the requirement to implement NICE guidance and our own system strategies to improve population health.
- The above factors have led to significant overspends against prescribing budgets.

Ambition

Moving forwards, our system will ensure that prescribing is considered as a strategic enabler to improve population health and patient outcomes.

- Our strategy will ensure that all system programmes consider the implications of treatment costs when patients are identified and that this investment will transfer to existing prescribing budgets.
- We will ensure that all clinicians are aware of their responsibilities to make best use of NHS resources when prescribing drugs or prescribable devices.
- We will ensure that patient harm resulting from medicines use is minimised and that clinicians are supported to deprescribe medicines when no longer needed.
- Use evidence and data-analytics to determine which drugs will benefit specific patients.
- Use the Managed Care approach and Nerve Centre capabilities to identify patients on multiple medications who would benefit from a review, including compliance, leading to a reduction in unintended side-effects and drug wastage.

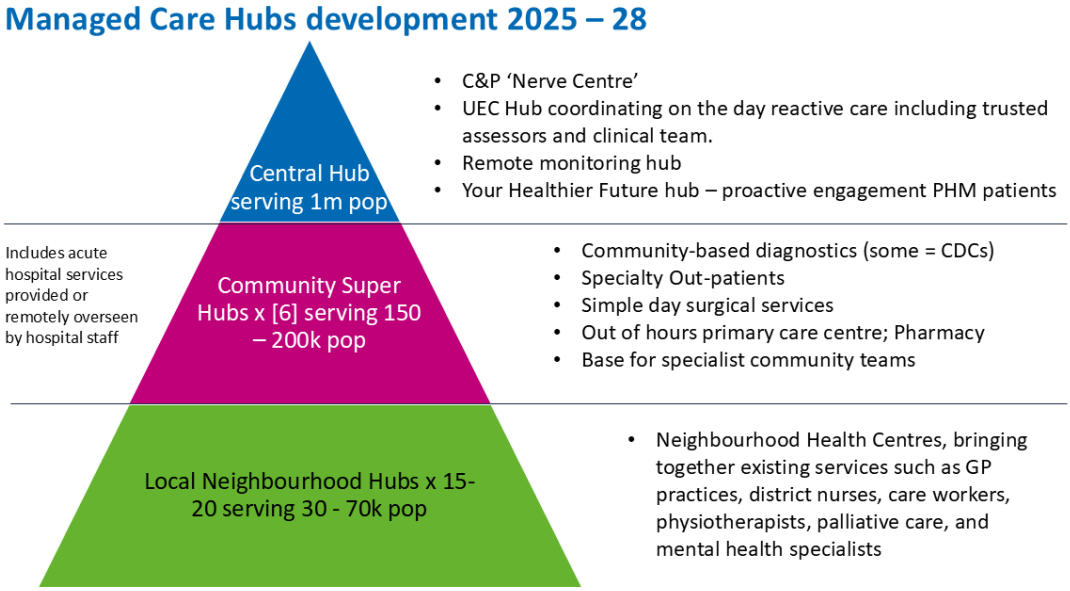
Community Superhubs

Current Position

There is an overall deficit of fit for purpose physical space to provide primary and community care to our current and forecast future population, whilst accommodating and increasing services traditionally delivered in main acute hospital sites.

Ambition

By strategically placing community superhubs in the right locations, the NHS and wider care partners can enhance health and care accessibility, address health inequalities, and provide comprehensive services tailored to the needs of the local communities.



The functional content for community superhubs is shown in the diagram above, typically serving populations of 150,000 – 200,000, they would offer a means to deliver services more locally for people, which could not be efficiently or cost effectively provided for each Integrated Care Neighbourhood. The community superhubs would also enable digital / remote and face to face outreach from acute hospital staff / services, in line with the principle of acute delivery beyond the walls of the traditional District General Hospital.

Draft Criteria for Selecting Locations

- Population Density and Growth:
- Areas with high population density and significant growth projections.
- Healthcare Demand:
- Regions with high demand for healthcare services, including underserved and rural areas.
- Accessibility:
- Locations with good public transport links and accessibility for all community members.
- Existing Infrastructure:
- Utilisation of existing healthcare facilities and integration with local services.
- Health Inequalities:
- Targeting areas with significant health disparities to improve overall health outcomes.

Sustainable Primary Care Programme

Sustainable Primary Care - GP practices

Current Position

General practice has a vital role to play in our health system overall, and specifically in delivering the ambitions set out in this Plan, including population health improvement, care of people with complex needs and of those individuals who have advanced illness. It is important that they have the capacity and infrastructure to focus on these patient needs.

As the Darzi report has highlighted, nationally, there are significant patient concerns about access to GPs. GPs are seeing more patients than ever before, but with the number of fully qualified GPs relative

to the population falling, waiting times are rising and patient satisfaction is at its lowest ever level. There are variations in the number of patients per GP, and shortages are particularly acute in deprived communities.

We recognise that the Carhill formula is not providing an equal playing field for our practices, and that practices in some of the most deprived areas receive lower funding on average per patient than practices in less deprived areas. Locally, we have increasingly seen general practice raising concerns about workload pressures and financial stability associated with workforce and estate costs and non-recurrent funding streams. Population growth is presenting additional challenges for capacity and investment in primary care, with a number of major new settlements in development across the ICS footprint.

Ambition

Our people and communities need to have sustainable, thriving general practice in Cambridgeshire, Peterborough and Royston that responds to the specific needs of the communities it serves, has a happy workforce and patients who feel they receive a good service.

Proposed key ambitions underpinning sustainable general practice:

- Equity in access and patient experience.
- A core set of standards that people and communities can expect and are met by general practice.
- A sustainable workforce model aligned to the needs of our communities.
- A financial and business model aligned to need of the local population and incentivising the right care.
- Preventative activity supported at scale is the norm for the main areas of disease experienced by our population.
- Digital innovation helps empower patients to manage their health.

Sustainable Primary Care - Community Pharmacy

Current Position

In May 2023, NHS England and the Department of Health and Social Care launched the Primary Care Access Recovery Plan (PCARP) to address growing demand for primary care services.

Key components of the PCARP include:

- Expanding community pharmacy services by commissioning a Pharmacy First service which enables supply of NHS medicines for seven common health conditions
- Increasing provision of the community pharmacy NHS Pharmacy Contraception Service and the Blood Pressure Checks Service.
- Investing to significantly improve the digital infrastructure between general practice and community pharmacy.

In our system, over an eight-month period, almost 62,000 PCARP consultations took place in our community pharmacies. This greater access for our population to healthcare has resulted in our system having the second highest usage of Pharmacy First services in the East of England.

Ambition

The NHS England Priorities state that a key action for ICBs is to:

➢ Align community pharmacy services with wider health system priorities, focusing on improved access to primary care, management of long-term conditions, and reduction of health inequalities.

- Integrate community pharmacy services with other primary care providers for seamless patient care.

From September 2026, all newly qualified pharmacists will be independent prescribers on the day of their registration. Our system will maximise the use of this newly trained (and upskilled existing) workforce to rapidly expand the range of clinical services provided by community pharmacy, thereby allowing patients improved access and be treated in community pharmacy rather than having to make an appointment with a GP.

Sustainable Primary Care - Dental Practices

Current Position

In April 2023 the NHS Dentistry contract was devolved to Integrated Care Boards. The contract came with a plethora of historical issues. Nationally it is well documented that the NHS contracted activity is not stable and practices are handing back contracts and unable to offer appointments to meet demand.

Ambition

Cambridgeshire and Peterborough ICB have an ambition to understand the drivers behind the local decline in NHS dental activity. To address the problem an evidence base is needed that explores the impact of the lack of access, the impact on inequality and fundamentally why NHS dentists are handing back their contracts. A route map was designed that contains three key milestones:

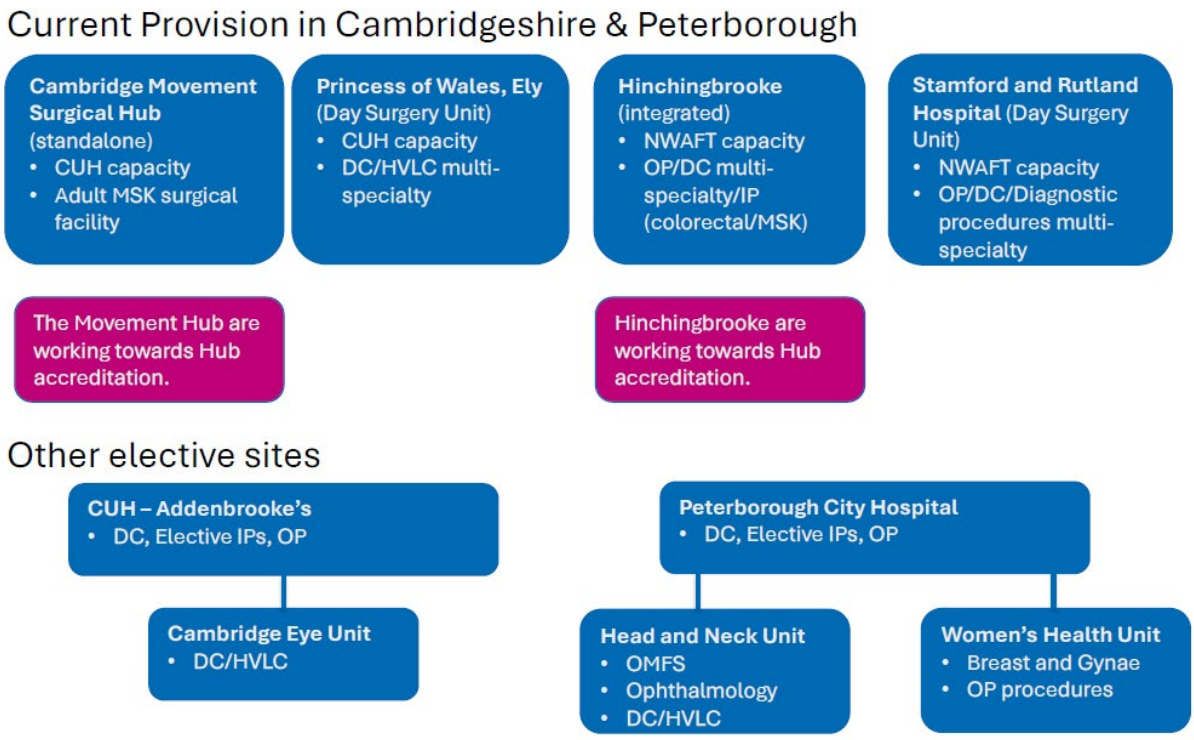
1. Discover: recruit proactive practices for the pilot, start data interrogation.
2. Model: data modelling, create benchmark for change, co-design success criteria.
3. Test: test design, installation, exploration & evaluation process.

This approach has already enabled the delivery of Discovery and Model to be undertaken and completed. The Discovery and Model phase has formed the evidence base for testing change.

Elective Care Programme

Current Position

Cambridgeshire & Peterborough Integrated Care System (CPICS) has seen an increase in the elective waiting list for routine procedures following the COVID 19 pandemic. Work has been taken across the system to reduce the waiting list and wait times for patients within our three acute providers. Whilst good progress has been made in reducing wait times opportunities to improve these further through having protected elective space and activity have been identified. A change in delivery of elective care will also support Cambridgeshire & Peterborough ICS to manage the expected increases in demand over coming years and support clinical improvements to ensure that the system delivers improved patient outcomes, patient experience whilst maximising resources across all providers.



Ambition

Our planned care strategy encompasses elective care, diagnostics, out-patients, waiting well and cancer. The key features of the strategy are set out below.

1. End to end pathway redesign (which spans elective, outpatients and diagnostics) recognising that demand for some specialties, particularly in the context of moving to greater prevention does not meet population needs. We need to redesign specialty pathways to ensure they are technology and digitally enabled, diagnostic led, flexible to meet patient needs i.e. through more localised models where possible and maximising efficiency and productivity through standardisation and adoption of best practice. Initial focus pathway re-design priorities based on need, performance, waiting lists include: dermatology, ophthalmology, ENT, Urology, Gynaecology. (Dermatology end to end pathway redesign has already been agreed and is being started this year).
2. To support service redesign, we will also look at how and where we deliver treatment, adopting a closer to home model where this works best but scaling up to hubs or elective centres where this generates the best outcomes. Moving to an elective hub model is one part of this. This is about productivity , efficiency, maximising our current resources.
3. An underpinning feature to the success of the referral management approach and our elective strategy is that there are shared waiting lists across Cambridgeshire & Peterborough, enabling timely treatment and choice to patients.

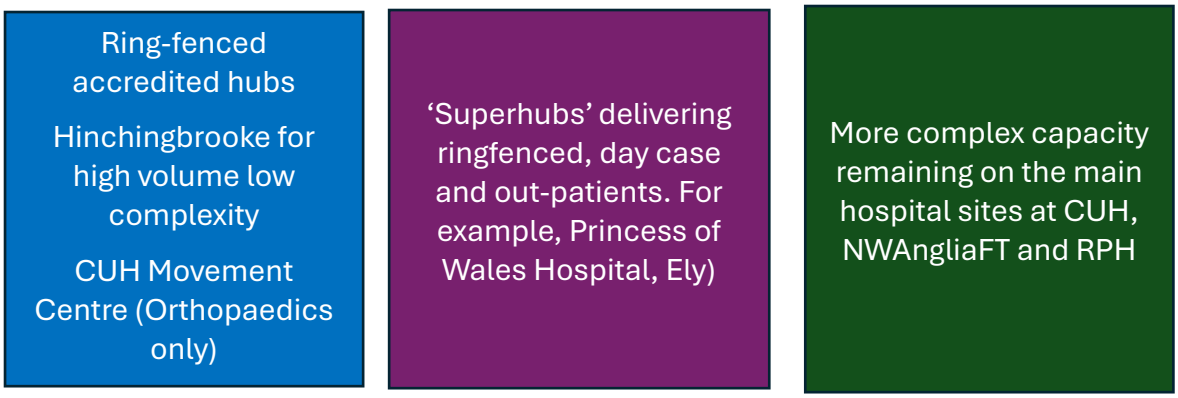
Also see referral management centre and diagnostics given interdependencies.

Elective Hubs Strategy

Our Elective Hubs Strategy is set over the next 10 years but broken down into short, medium-and long-term ambitions to support the current provision whilst allowing the system to develop more protected surgical hub capacity ahead of the redevelopment of the Hinchingbrooke Hospital site. The strategy has been developed involving system partners across clinical and operational teams, incorporating patient feedback, drawing on national guidance, best practice and learning from other systems. It

aims to maximise our elective capabilities and deliver sustainable elective care initially through current estate and in a collaborative and cohesive approach.

Elective Hubs Delivery Model for Cambridgeshire & Peterborough



Over the period 2025-28 we will implement the strategy with key developments being:

- Increase use of Hinchingbrooke Hospital Elective Hub for Cambridgeshire & Peterborough high volume low complexity procedures.
- Maximise use of Orthopaedics Movement Centre at CUH.
- CUH and PCH carry out the most complex elective in-patient and complex day case work.
- Begin development of a network of community superhubs provide simple day case procedures, out-patients and diagnostics (one stop where feasible).
- Hospital staff working beyond walls to provide services in community superhubs F2F and through remote support.
- Initial focus pathway re-design priorities based on need, performance, waiting lists etc: dermatology, ophthalmology, ENT, Urology, Gynaecology.
- Consider hub and spoke models to leverage specialist expertise across Cambridgeshire & Peterborough.

Diagnostics

Current Position

Performance

Diagnostics: the national planning expectation is for 95% of patients to wait no more than six-weeks for their procedure or test by the end of March 2025. Currently the system is achieving 63.8%. Specific challenges exist at present for Sleep Studies, Echocardiography, Audiology Assessments, Urodynamics, Audiology Assessments and Non-obstetric Ultrasound.

Attain Report

The ICB commissioned a detailed analytical report into diagnostic services, produced by Attain in late 2023 which reviewed the current position, best practice, service demand; productivity and efficiency improvement opportunities. The process included clinical and operational engagement with over 50 stakeholders. There was also a deep dive into specific diagnostic tests.

Community Diagnostic Centres

The current position for Community Diagnostic Centres (CDC), commissioned in line with the NHSE CDC specification is

➢ Ely CDC fully live and operational as Hub model.

- Peterborough (interim location) and Wisbech CDCs live but as Spoke models. Work has commenced on Peterborough permanent CDC building.
- Both NWAngliaFT and CUH flowing current waiting list demand to respective sites, but there is scope for more efficient utilisation of available capacity.

Ambition

The Attain report concluded that 'A significant improvement to the current state can be achieved through targeted productivity improvements; increasing capacity from existing assets. The proposed initiatives will first and foremost address backlogs but also include transformational objectives to place services on a sustainable footing. The combination of system and Trust-based opportunities will drive improvement at every level, move providers towards greater collaboration and strengthen programme management through a structured approach.' The report identified specific improvements covering cardiac imaging, non-obstetric ultrasound, endoscopy and echocardiography.

Community Diagnostic Centres Ambition

The ambition is to develop out of hospital infrastructure and capacity including diagnostics across Cambridgeshire & Peterborough through 'superhubs' – see Community Superhubs. The ambitions specifically for CDCs are to:

- Make CDCs directly accessible to GP bookings.
- Develop digital solutions to allow cross provider working and maximise patient choice - current interoperability issues prevent this.
- Reduce reliance on hospital site diagnostic presence to maximise CDC utilisation, and free up hospital diagnostic capacity to accommodate growth in in-house demand/reduce waiting times.
- Provide community outreach diagnostic provision for geographies where patients can't access CDCs.

Out-Patient Services

Current Position

The current position is that there are very high volumes of out-patient appointments, but a large proportion are not effective, with limited risk prioritisation, and limited choice for patients on how these are delivered, or when. Patients are often not engaged in decision making, which would be addressed through introduction of the Managed Care Hub - Referral Management & Booking Service.

We need to be more sophisticated in terms of clinical risk management and prioritisation. Current models are limited based on varied quality of initial referral and then patient initiated concern on deterioration, but this does not guarantee any change in approach. A lot of models are not diagnostic led but could and should be, ensuring that on 1st appointment, work up is robust and there is flexibility to initiate treatment.

Follow-Up Appointments

Follow up value is often limited. Acknowledging all the work to date, we see a significant opportunity to further reduce out-patient follow ups including through Patient Initiated Follow Up approaches. Delivery from elsewhere shows that this is possible and high DNAs from patients for follow up demonstrates that patients do not always value follow up appointments either, representing significant waste. By fundamentally shifting to a patient-initiated model for follow ups, it would release significant clinical capacity to focus on 1sts and other clinical activity i.e. ward rounds / elective care. Introduction of remote monitoring, proactive monitoring of vitals in higher risk categories should give us better assurance on clinical risk and response.

Ambition

Our ambition is to transform delivery of outpatients through:

- Enhanced direct access provision in community or local settings for diagnostics.
- The introduction of an enhanced single referral management centre approach across Cambridgeshire & Peterborough – providing consistent and enhanced clinical assessment and referral of patients where onward outpatient or elective care is required.
- Consistent and effective clinical risk prioritisation of patients requiring specialist input, with a single shared PTL across Cambridgeshire & Peterborough to support timely access and patient choice.
- Focused prehabilitation while patients are waiting for onward care, through expanded and proactive reach of waiting well services.
- Treating patients as quickly as possible with standardised commissioning of best practice diagnostic led pathways, resulting in more patients being seen, treated and discharged on first outpatient contact and reducing unwarranted variation in clinical practice.
- Utilising artificial intelligence and clear risk parameters to remotely and actively monitor patients on waiting lists for outpatient and elective services, supporting more real time clinical risk stratification.
- Eradicating periodic outpatient follow ups through a risk-based approach to surveillance waiting lists and introducing patient initiated follow ups as the primary route of access for patients who have had a previous appointment in the last 12 months (subject to further work with partners and recognising that this will vary depending on specialty).
- Offering a broader range of services to ensure patients can access specialist care at times and locations (physical or virtual) which suit them, reducing waste and increasing productivity.

- Reducing unnecessary out-patient follow up appointments.

These ambitions cover all specialties, and will complement specific existing strategies for areas such as cancer (Cambridgeshire & Peterborough is part of the East of England Cancer Alliances, which has a strategy called Improving Cancer Services Together).

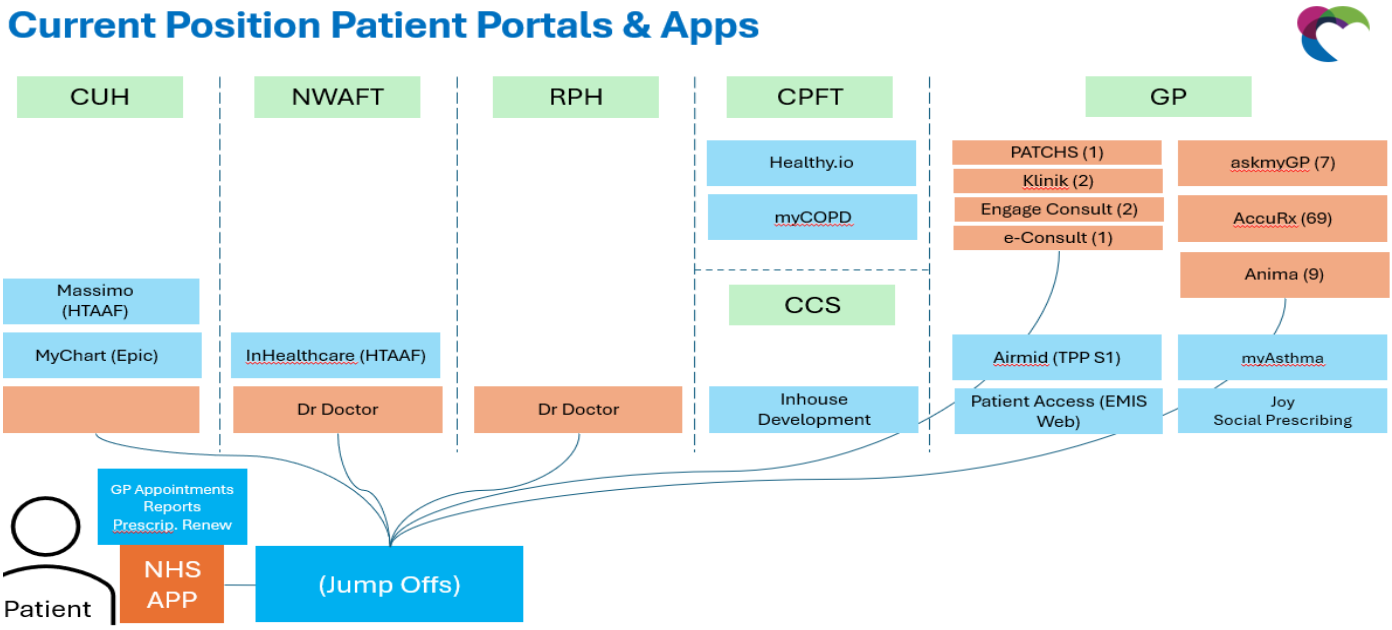
Enablers

The next section of the Strategic Commissioning Plan sets out work on key enablers: Digital, Finance, Delivery, Workforce, VCSE, Estates and Data.

Digital

Current Position

The current digital landscape is complicated, with multiple different digital systems operating across the ICS and even within individual providers. There are pockets of excellent innovation, but overall interoperability is lacking which results in poor information flows between services and ultimately experience for the patients and staff who use digital services is not as good as it could be.



There is also significant variation across Cambridgeshire & Peterborough in terms of patient experience. Our Let's Talk engagement campaign in 2022 found that 69% patients had struggled to get a GP appointment, and 69% would like to be able to book online – **but experience for patients varies across our area.**

The 2024 GP Patient satisfaction survey, analysed by PCN shows:

- Patients reporting it's easy to get through to their practice by phone ranges from 19% to 66%.
- Patients reporting it's easy to get through to their practice via the website ranges from 28% to 69%.
- 63% of patients in Cambridgeshire & Peterborough contacted their practice by phone, 23% by an online method – but in some localities / practices online access is >60%.

Ambition

Our ambition is to offer consistently excellent online services where local people can easily find reliable health-related information, select service options, manage their health care appointments, and self-refer where the option exists. We have heard how frustrating our current fragmented online

tools and apps can be for local people and healthcare professionals – we want to improve interoperability across providers so everyone can more easily navigate their way through their health care journey – with better information about their progress, and less need to ring practices because they are unsure what is happening with their care. We also want to use online apps to drive health optimisation programmes which will help us achieve a move from treatment to prevention, supporting the long-term sustainability of NHS services.

Digital technology can significantly enhance patient care, increase efficiency, and reduce costs, helping to address the growing demand for healthcare services. The case for improving digital enablers and our use of them is summarised below:

- **Improved Patient Outcomes:** Digital technology facilitates better monitoring and management of chronic conditions through apps and devices.
- **Better access**: Digital platforms can provide people with easier access to healthcare services. Online portals help people to manage appointments, access medical records, and communicate with healthcare providers.
- **Better Information**: Digital technology enables informed decision-making across settings and promotes self-care practices among patients using information about treatments, preventative measures, and general health management.
- **Personalised Care Options:** Digital tools allow for the customisation of healthcare plans to suit individual needs. For example, electronic health records (EHRs) help in tracking patient history and conditions, which can guide doctors in tailoring treatments and follow-up care.
- **Sustainability:** Better digital services can reduce the NHS carbon footprint by reducing the need for people to travel for healthcare, transferring information digitally and enabling staff to work remotely (less travel).
- **Cost-Effectiveness:** By reducing the need for physical infrastructure and automating routine tasks, digital solutions can help cut costs. This is vital for the NHS, which operates under tight budget constraints, as it can allocate resources more efficiently to areas of greater need.
- **Enhanced Efficiency**: Digital tools can streamline administrative processes, allowing healthcare professionals to focus more on patient care.
- **Data Analytics and Insights:** Digital systems enable the collection and analysis of vast amounts of healthcare data, which can be analysed to gain insights into health trends, effectiveness of treatments, and operational efficiencies.
- **But - digital options cannot be the only option:** it is important that local people have alternative means of getting information, options and access. We believe that better digital options will in fact 'take volume and weight' out of other systems (telephone, for example).

Requirements

In summary our requirements are to:

- Provide a more consistently high-quality online experience for local people and healthcare professionals wherever they live in Cambridgeshire, Peterborough & Royston, in particular via primary care which handles >90% of patient contacts – our 'digital front door'; this includes funding for GP online tools.
- Support health services and local people to use digital tools effectively – we need suppliers to work with us as partners to enable the business change, service transformation and behavioural shifts needed to deliver the full benefits of digital services.
- Enable local people to self-manage their health and well-being with access to tailored, reliable information, connection with services and health optimisation programmes.

- Simplify the journey for local people through our health and care system when they need help, tackling the current fragmentation and disconnects and enabling inter-operability across systems / sectors.
- Digitally enable delivery of the wider Health Utilisation Model.

Digital Exclusion

We have heard concerns regarding access for people who are not confident with online services and the risk of exacerbating health inequalities. We need to ensure our digital offer is as easy to use as possible, but it will be a choice complementing traditional means of access (telephone etc.) for those who prefer it.

Medium Term Financial Strategy

Financial Context

In the East of England, we are having unprecedented investment in the new hospital programme, but we recognise that revenue funding for the NHS cannot continue to grow to a level that is unaffordable by any government. In Cambridgeshire, Peterborough & Royston, to achieve our financial sustainability over the last four years our strategy has been to hold all cost flat plus inflation, but this has not created funds for investment and innovation. We therefore need to go further in order to fund the Health Utilisation Model.

In 2024/25 the financial allocation for Cambridgeshire, Peterborough & Royston is over £1.95 bn; by 2028/29 this grows to over £2.17bn; this growth occurs through the baseline adjustment, inflation, capacity and discharge funds, System Development Funds (SDF) and growth less convergence.

Creating Investment Fund

The first proposal for funding the change would be an extension of the current model deployed in our ICS area. We would utilise growth less convergence after funding pressures such as prescribing, which would leave £10m-£15m.

A medium risk option would be if we added in the re-purposing of additional funding streams. If we re-purpose 10% of the better care fund, 30% of the capacity in demand fund and 25% of the SDF's excluding cancer and CDC's, we would annually have a further £28m, and over five years this is the equivalent of around £130m. This would not be a further £28m, but £28m to repurpose and use differently. We would need to stop something to do this.

In summary, assuming a five-year funding settlement based on flat cash plus inflation, we would be able to create an investment pot of between £180m rising to a maximum of £205m over the period. There is a further opportunity around the tech fund announced nationally, although this is yet to be quantified, as well as use of capital funds.

In our assumption of flat cash plus inflation for providers we would be clear that their obligations would be on productivity, through the achievement of national benchmarks and following best practise guidelines. Any innovation that we would ask them to do would be funded out of the innovation pot that we are creating through this mechanism, and they would not be expected to fund it through their core contract. This approach needs a level of reasonableness from commissioners on the real cost of running a trust, therefore the baseline needs to be fair.

Commercial Opportunities

The second option we think is viable for funding this Health Utilisation Model is through commercial opportunities. ICBs are in a unique position, with the balance of health and community, research and

total population data, that we can open commercial avenues to support new models and, more importantly, create the continued improvement and learning environment.

With the right setup and a strong commercial arm, we believe we could access between £20m and £200m over five years.

It is important to recognise that we have to approach this commercial funding with ethics and mindfulness around the purpose and the motivations for engagement. If partnerships are assessed on social value, research value and data management security we believe the NHS could greatly value from entering into more strategic partnerships. The strategic opportunities are not always only with commercial bodies they are also available by dealing with other government departments, for example, the Department of International Trade has money available to support pump priming for digital social impact funds.

Working Assumptions

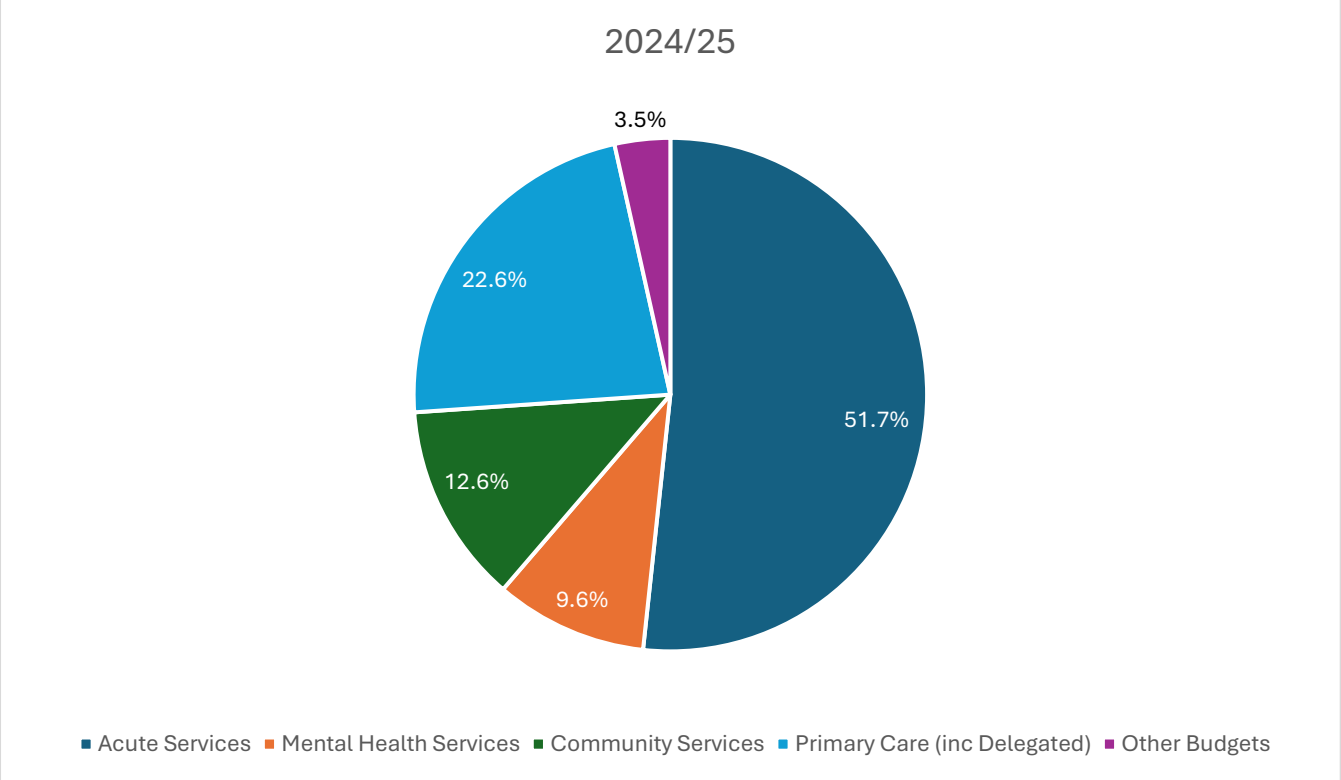
Below are the assumptions we will be using for the five-year financial plan:

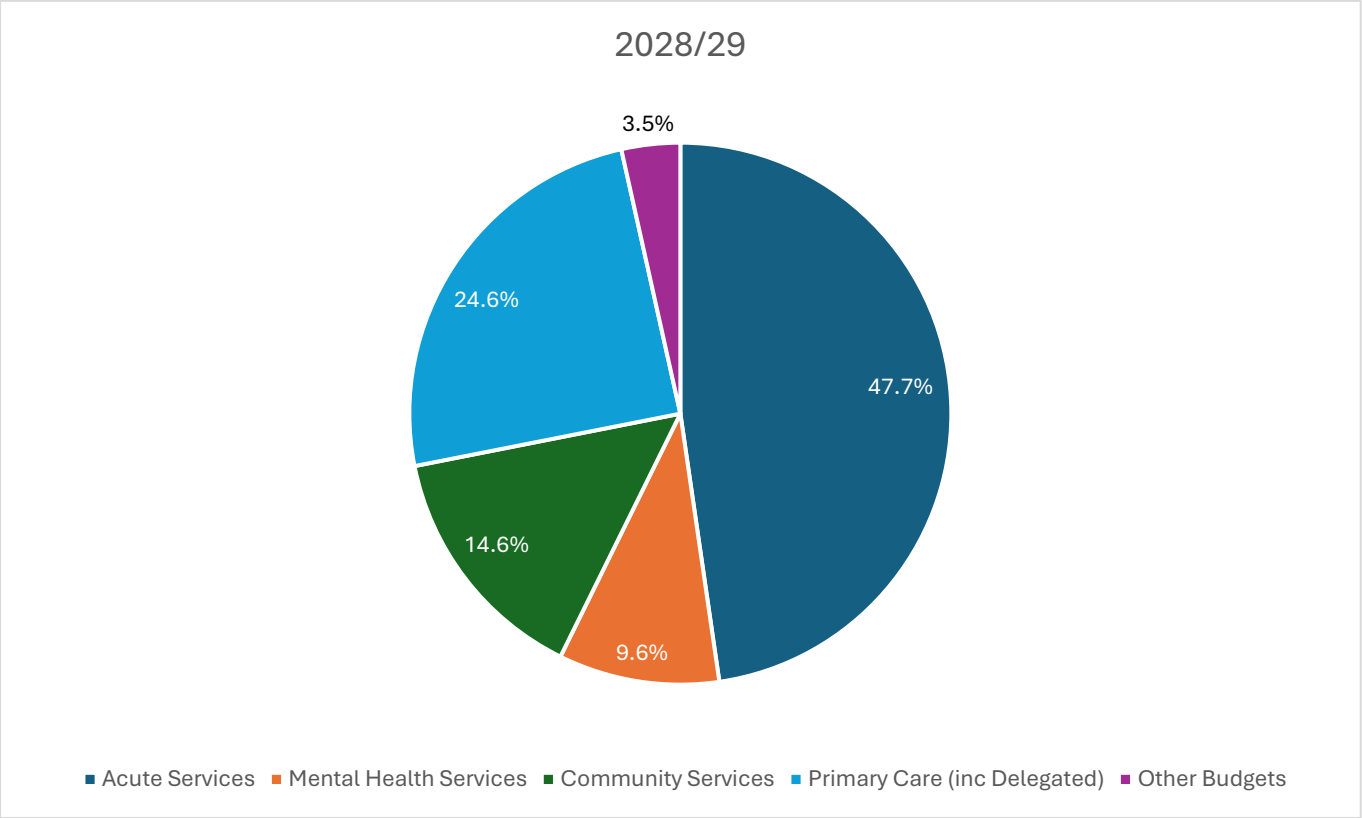
- Inflation at 1.5% from 2025/26 onwards.
- Efficiency at 1.1% from 2025/26 onwards.
- Growth at 2024/25 (2.3%) levels from 2025/26 onwards.
- Convergence at 1% removed from 2026/27.

To create an investment pot to allow 'left shift' we will assume the following:

- Repurpose 10% BCF.
- Repurpose 30% Capacity and Demand.
- Repurpose 35% of SDF's (excluding cancer and CDCs).

The pie charts below illustrate a gradual shift the share of investment funding towards Primary and Community Care over the next five years.





Workforce

Workforce is a key enabler for delivering the Strategic Commissioning Plan. We face a range of challenges such as poor availability of affordable accommodation for staff, turnover, recruitment, retention and financial constraints. It is also important to recognise the cultural shift associated with the transformation described in this plan, which will require new workforce models, digital upskilling and increased system collaboration. We see opportunities to increase flexibility for people to work across the system where needed, collaborate on recruitment, training and workforce planning.

Our ambition is for a more integrated and flexible workforce, an attractive system-wide career offer, equipping staff with skills for the future, an equal, diverse and inclusive workforce. Some of the associated actions to deliver these ambitions include sharing workforce data to build system plans, multi-sector apprenticeships, enabling easier staff movement across organisations in response to need, fostering diversity.

We are developing a Cambridgeshire & Peterborough People Strategy and workforce plan, which will set these themes out in more detail in Spring 2025.

Voluntary, Community & Social Enterprise Sector

There are 3,500 registered charities across our area, with 5,300 employees, 30,000 volunteers and 11,000 Trustees, which underlines the important role the sector will play in delivering the Strategic Commissioning Plan. The sector faces a number of challenges including funding (NI contributions, for example), difficulty recruiting staff and volunteers, increases in demand, and lack of digital systems in the sector.

In 2022, the ICS VCSE Strategy was approved, leading to creation of the 'Voluntary Sector Network' (VSN) with 110+ members, established VSN Strategic Steering Board, strengthened VCSE representation across ICB governance. We have also embedded VCSE voice further across strategic

programmes to shape policies and strategies (digital enablers, health inequalities, People Strategy, Work Well etc).

We have developed a VCSE action plan which focuses on collaboration to identify need and align VCSE support, funding and processes across partners, targeted approaches to prevention, further embedding the VCSE voice in decision-making, and improving information and use of data.

Estates

The Strategic Commissioning Plan provides a vision and framework which will help determine the range and location of services. This will complement the ICS Estates Strategy which sets out the current position and development approach. We have inadequate primary care capacity in some areas, and a lack of diagnostic facilities in the community, and one of our main hospital sites is impacted by RAAC planks. Post pandemic hybrid working has led to under-utilisation of some back-office estate that we would seek to address.

Our ambition is to develop integrated locality hubs at Integrated Neighbourhood level and community superhubs as described previously, taking specific account of areas of highest population growth, and increasing access to community diagnostics. We will move to a smarter and greener NHS, improving estate flexibility and utilisation, rationalise back-office estate. We also want to support our Net Zero Carbon reduction targets by 2032 and 2040 as set out in our ICS Green Plan.

We will continue to work with partners to progress major capital projects including the Hinchingbrooke Hospital Re-development Programme, Cambridge Children's Hospital and Cambridge Cancer Research Hospital. We will also continue to work with CUH colleagues and other stakeholders on the early stages of planning for the future demand and capacity at CUH. This work is taking into account various population growth scenarios associated with potential significant housing growth in the 'Cambridge Quarter' over coming decades.

As set out earlier in this Plan, our ambition is to develop proposals for Community Superhubs bringing together a range of out-patient, diagnostic and other community services. We are also working with partners on service and estate plans for new communities (Northstowe, for example) and areas of significant housing growth.

Data Strategy

This programme has a reliance on the effective management of data to support the design, planning and delivery of care as well as to support people in managing their own care. The Health Utilisation Model is underpinned by an actuarial approach to population health which relies on segmenting, stratifying and proactively streaming people to the most appropriate source of support. To this end the programme will deliver a new data strategy, route map and a prioritised workplan which maximises our local investments, for example by leveraging the Federated Data Platform.

Leading Delivery

Governance

Delivering the Strategic Commissioning Plan will need robust governance. Further discussions are needed within the ICB and with wider ICS partners to determine what the most effective arrangements will be.

Leading and Enabling Change Management

The Strategic Commissioning Plan 2025-28 will require effective, clear leadership. It is important not to under-estimate the investment of time and skills development needed. Subject to agreement of the

Strategic Commissioning Plan further work will be needed to review and re-deploy resources accordingly.

Our approach will be defined by the Ethos set out earlier in this Strategy.

The strategy includes stakeholder engagement beginning in 2024, pilot testing, and full-scale implementation by 2026. It involves integrating digital technologies, optimising health management, and reconfiguring acute and advanced illness care. The approach will be incremental, leveraging existing opportunities for gradual transformation while maintaining operational stability.

Continuous Quality Improvement

We will use Continuous Quality Improvement (CQI) methodology, making our CQI approach accessible to all staff and volunteers across the system. There will be clear communications about our improvement programmes and how they work together. There will be an inclusive approach to our engagement across the system. We will also use tried and tested improvement methodologies such as PDSA cycles (Plan, Do, Study, Act)

Commissioning & Contracting

The ICB will improve its commissioning and contracting approach using the System Assurance Framework with consistent application of thresholds and actions to assure delivery of contract requirements including finance, operational standards, delivering safe and effective care to our population, workforce/leadership and our populations experience of our Providers.

Summary & Conclusion

This Strategic Commissioning Plan sets out our high-level intentions for 2025-28, focusing on how we translate the Health Utilisation Model into action. We will continue our engagement with partners and wider stakeholders to develop the detail on how we work together to deliver this ambitious set of transformation and enabling programmes.

Appendices

A. Outcomes Framework & 'I' Statements.
B. Evidence Review recommendations, utilisation metrics and references.
C. Productivity Opportunities Summary.
D. Activity Forecasts & Scenario Modelling.
E. 3 Year Delivery Route map.

Appendix A: Outcomes 'I' Statements

"I have options and choices in my healthcare, ensuring that my preferences and needs are respected."

"My care is seamless, and I don't have to repeat my story over and over again."

"The NHS communicates with me proactively, allowing me to carry on with my life without unnecessary interruptions."

"I am supported in maintaining my health through proactive management and preventive care initiatives."

"I have access to my genetic information, and I can choose to allow Healthcare Providers access to ensure I stay healthy and avoid prescribing medications that won't be effective for me."

"I can access healthcare services and information about my health digitally, making it convenient to manage my health."

"I can easily book appointments with my GP and receive timely care when I need it."

"I have convenient access to dental care to maintain my oral health."

"I can easily access optometry services to ensure my vision is regularly checked and well-maintained."

"I can quickly and conveniently obtain my prescriptions, ensuring I have the medications I need."

"I receive high-quality care in my community, reducing the need to travel to the hospital."

"I benefit from coordinated care through integrated neighbourhood teams that understand my health needs."

"I can receive emergency care on the same day, avoiding the need to travel to the hospital and wait for hours in A&E."

"I have access to comprehensive mental health support and services that are responsive to my needs."

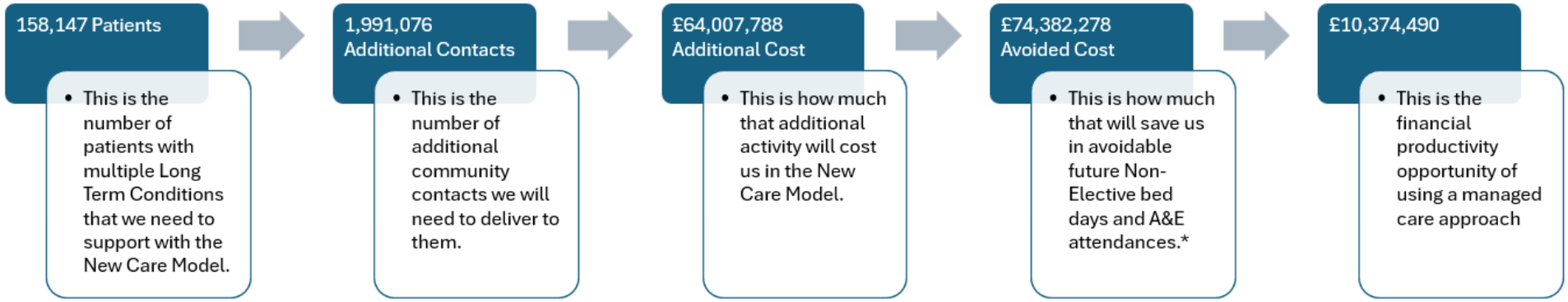
"I can access quick turnaround diagnostics that avoid delays and ensure seamless onward referral."

"I will receive my elective care in a timely manner, ensuring that my treatment is not delayed.

Appendix B: Productivity Opportunities Summary

Opportunity		Daycase Rates	Daycase Rates (Adjusted to include all 0 LOS BADS Procedures)	Emergency Length of Stay - Excludes 0 LOS	Readmissions	Theatre Utilisation	Theatre Utilisation - Avg Cases per Theatre per week	Patient Initiated Follow Ups	Diagnostics (Cardiac MRI & CT, Endoscopy and NOUS)	Medicines Optimisation	Use of Resources
Operational/JFP Plan Standard		85%	85%	N/A	N/A	85%	N/A	6.8%			
Current Performance/Activity	CUHFT	75.8%	77.4%	9.2 Nov 22 to Oct 23	6.09% (Q1+Q2 2023/24)	78.2% (03/12/23)	17.5	3.4%	44,046 tests per annum		
	NWAFT	79.2%	79.9%	8.3 Nov 22 to Oct 23	10.63% (Q1+Q2 2023/24)	75.3% (22/10/23)	16.4	4.2%	46,562 tests per annum		
	RPHFT	N/A Small Numbers	N/A Small Numbers	7.8 Nov 22 to Oct 23	5.26% (Q1+Q2 2023/24)	80.9% (30/07/23)	9.8	4.4%	7,530 tests per annum		
	England				8.2% (Q1+Q2 2023/24)	77.4% (03/12/23)	17.8	3.0%			
Opportunity against 2024/25 Target	CUHFT	2616 bed days per annum	1,382 bed days per annum	18743 bed days per annum*	0	3750 cases per annum	510.0	6,400 appointments per annum	21874 tests per annum		
	NWAFT	1700 bed days per annum	1,027 bed days per annum	17102 bed days per annum	2300 admissions per annum	4750 cases per annum	2100.0	13,000 appointments per annum	18303 tests per annum		
	RPHFT	N/A Small Numbers	N/A Small Numbers	TBC	0	50 cases per annum	N/A	1,765 appointments per annum **	4131 tests per annum		
Estimated Potential Financial Productivity Opportunity		£3,828,292	£2,136,783	£12,545,750	£5,635,000	£7,583,850	£2,315,070	£4,042,515		£19.2m	£10m - £20m
Methodology		Assumes bed days used for DC activity at average tariff of £887.	Assumes bed days used for DC activity at average tariff of £887.	CUH code 0 LOS patients differently to the rest of the ICS and their peers. Therefore we have excluded 0 LOS patients. £350 bed day cost applied.	Assumes readmission rates reduced to national average. £350 bed day cost applied. Average LOS of re-admisson at NWAFT is 7 days.	Identifies how many cases could be done in current sessions by reducing unused time. Assumes cases are used for DC activity at average tariff of £887.	Looks at average cases per theatre per week and calculates an opportunity based on reaching national average. Assumes cases are used for DC activity at average tariff of £887.	Identifies how many appointmens could be freed up if we achieve national 85th percentile. Assumes appointments are re-used for first outpatient attendances at tariff of £191.	Opportunity is based on various actions e.g. reducing slot times and DNAs. Financial opportunities to be calculated as programme develops.		
2024/25 Target	CUHFT	85%	85%	8.6 (Peer average - Excludes 0 LOS)	6.10%	85%	17.8	6.80%			
	NWAFT	85%	85%	7.8 (Peer average)	8.20%	85%	17.8	6.80%			
	RPHFT	85%	85%	TBC	5.26%	85%	N/A	6.80%			
Source		Model Health System	Hospital Episode Statistics via HED Tool	Secondary Uses Service (C&P Only)	Hospital Episode Statistics via HED Tool	Model Health System	Model Health System	Model Health System	Attain Analysis		Model Health System
Savings Type		Non cash releasing	Non cash releasing	Non cash releasing	Non cash releasing	Non cash releasing	Non cash releasing	Non cash releasing	Non cash releasing		

Appendix C: Activity Forecasts & Scenario Modelling



- This is based on the multi-morbidity approach assumptions.
- We have used national Reference Cost information to apply a value to this activity.
- *This assumes a 25% reduction in ED attendances and that we mitigate the reversible risk in our Medium - Very High risk cohorts. This does not include the low risk cohort.
- Growth is based on Cambridgeshire County Council Research Group projections applied at age-band level. We have included a 0.7% non-demographic growth factor which is in-line with the New Hospital Programme.
- Baseline year is 2023/24, the model runs to 2030/31

Appendix D: 3 Year Delivery Plan (Draft)

Strategic Plan Delivery Gantt 2025 – 28 – Indicative Deliverables

Portfolio: Managed Care

Programme: Nerve Centre (incl Acute illness / UEC hub / optimisation / YHF, helpdesk / waiting well, appts. Bookings).

Programme	2025/26	2026/27	2027/28
Acute Illness, UEC Hub & Advice and Guidance	Further development of the 'UEC hub' single point of access. Integration of 999 ambulance provision into the UEC hub. Expanding the scope of the hub through the year to bring on additional onward care pathways. Full external review of community services. Full mental health crisis pathways review.	Continuous improvement and redesign of existing services. Strategic redesign of rapid and urgent services to meet 24/7 demand profiles. Introduction of referral / appointment only Emergency department access. Develop model for single integrated clinical assessment. Development & testing of model for full case management approach. Develop approach for direct access diagnostics and centralisation of remote monitoring services. Introduction of direct referral into the hub from the Cambridgeshire & Peterborough nerve centre. Implementation of new mental health crisis mode.	Expanded acute illness. Implementation of case management model. Develop specs for fully integrated suite of coordinating hub and virtual hospital services.

Programme	2025/26	2026/27	2027/28
Patient Helpdesk and Waiting Well	Develop referral management centre operating model and supporting workforce model. Development of standardised clinical protocols and processes for advice and guidance, clinical prioritisation and onward care booking. Recruitment to referral management centre model. Agree approach to identification of priority pathways for phased implementation. Implement a single shared waiting list.	Development of referral management model. Identify additional specialties for further rollout for referral, advice and guidance and clinical prioritisation approach.	Develop and implement post-acute care discharge model and follow up approach. Continuous development and improvement of the full model. Shared elective waiting lists in place across Cambridgeshire & Peterborough. Specialty expansion of post discharge coordination.
Health Optimisation - Your Healthier Future	Launch 'Your Healthier Future'.	Include Diabetes, Respiratory and multi-morbidity.	
Population Health management - Using the data	Phase 1 – Work with Primary Care to incorporate their data into our current infrastructure. Phase 2 - Develop ICS Data Strategy aligning data and digital to the New Care Model.	Phase 3 – Review processes and ensure they are optimised by data and are digitally enabled. Phase 4 – Review PHM reporting.	

Programme	2025/26	2026/27	2027/28
Integrated neighbourhood teams	Deliver more complex care. Establish locality hubs.	Full implementation of MDTs and cross-organisational approach.	
End of life care	Demand and capacity planning.	Palliative care hubs and phone 'Gold Line'. New urgent care pathways.	Integrated Technology & AI tools. Monitor performance and outcomes.
Medicines Optimisation	Develop robust methods of horizon scanning and budget setting. Develop and launch the 5-year general practice for the delivery of prescribing efficiencies. Develop communications for all clinicians to support effective use of NHS resources. Ensure that delivery plans form part of provider contracts.	Consider new models of delivery capitalising on increased digital connectivity. Develop locally commissioned services to allow delivery of medicines efficiency programmes.	Scope new models where standardisation of prescribing choices where only most cost-effective options are used in the majority of cases.

Portfolio: Sustainable Primary Care

Programme	2025/26	2026/27	2027/28
Primary Medical Services	Financial levelling up process for GPs.	Engagement including through LMC Business cases for prioritised primary care estates developments. Roll out New Care Model across all departments and secure additional funding.	
Community Pharmacy	Increase use of pharmacies as Healthy Living Centres providing self-care advice and treatment.	Early hypertension evaluate pilot and reset contracts	Expand clinical services to support overprescribing and deprescribing in the community Review and expansion of long-term condition management in community pharmacy
Community Superhubs including Diagnostics	Complete analytical work on need and critical mass plus outline functional content. Development of options. Stakeholder engagement. Development of Strategic Outline Case / Outline Business Case for Community Superhubs.	Development of Outline Business Case(s) / Full Business Case for community superhubs.	Completion of Full Business Case, final design work and refurb or construction work commences.

Programme	2025/26	2026/27	2027/28
Dentistry & Optometry	Run test Phase with cohort of practices to boost NHS Dental appointments and create additional capacity.	Run test Phase with cohort of practices to boost NHS Dental appointments and create additional capacity.	Evaluate the Test phase and consider roll out to all NHS dental providers.

Portfolio: Elective Care

Programme	2025/26	2026/27	2027/28
Elective Care strategy	Focus on maximising current estates and hubs across the system to ensure ringfenced capacity and best use of resources. Deliver Getting it Right First Time (GIRFT) principles across theatres, day cases and High Volume Low Complexity procedures; Achieve national accreditation for main hubs. Assess future requirements for interoperability across sites.	Focusing on embedding change and developing joint pathways ahead of redevelopment at Hinchingbrooke Hospital. Continuous improvement of pathways across the system.	Long term delivery of strategy maximising Hinchingbrooke Hospital re-development.

Programme	2025/26	2026/27	2027/28
Outpatient Services	See Referral management centre, elective and diagnostics also as significant interdependencies. Implement best practice diagnostic led pathways. Develop risk-based approach to surveillance waiting lists. Agree services excluded from zero follow up approach. Adopt national best practice pathways for patient initiative follow up. Development of super hub and localised delivery models.	Implement further best practice diagnostic led pathways. Implement risk-based approach to surveillance waiting list and PIFU as primary model of access. Additional sites / models of provision available for patients to be able to access services in different ways.	Implement further best practice diagnostic led pathways. Patient initiated follow up model embedded across all specialties.
Diagnostics	Develop digital solutions to provider interoperability challenges – Sept 25. Open up direct GP access to all available modalities – Dec 25.	Develop system waiting list approach – March 26.	

Portfolio: Enablement

Programme	2025/26	2026/27	2027/28
Digital	Digital Roadmap. Award Digital Enablers Contract.	Digital Enablers implementation.	Digital Enablers phase 2 implementation.
Data	Data Strategy.	Federated Data Platform early adoption Implementing use cases.	
Workforce	Quantify staffing requirements, develop training routes aligned with NMC. Establish and Further Develop Multi-organisation and Multi Sector Apprenticeships and trainee routes. Strengthen skills in leading across systems. Enable easier staff movement across organisations. Engage with students from underrepresented groups in schools. Support colleagues from Global majority and disadvantaged groups into leadership roles. Improve our support for unpaid carers.	Ensure equitable access to health and wellbeing support for staff across the system. Open access to staff banks for all system partners.	
Estates	In development (see also Community Superhubs development).	In development (see also Community Superhubs development).	In development (see also Community Superhubs development).
Change Management	Change Management - Programme & Project Management, Stakeholder engagement & communications, Training, Quality Improvement, Plan Do Study Act cycles.		

Contact us


cpics.org.uk


03300 571030


Gemini House, Bartholomew's Walk, Cambridgeshire Business Park Angel Drove, Ely, Cambridgeshire, CB7 4EA

Version 1 February 2025