

## Financial updates to the PCBC

### Background

NHS England has identified a number of areas where the West North and East (WNE) Cumbria Success Regime is required to develop further the financial analysis underpinning the Pre-Consultation Business Case (PCBC). These areas include:

1. **Financial challenge sensitivity.** Undertaking further sensitivity analysis around the financial challenge.
2. **Efficiencies.** Developing some additional granularity around the organisational plans underpinning the top-down efficiencies identified.
3. **Out of Hospital (OOH) development.** Providing additional detail around the estimated savings delivered through the Integrated Care Communities (ICCs).
4. **Workforce.** Expanding on the workforce implications of the options to provide a more comprehensive picture of the changes implied by the PCBC.
5. **Site-level outputs.** Understanding how the options impact each of the sites in terms of activity, capacity, workforce and cost.
6. **Closing the residual gap.** Further areas to close the residual financial gap in 2020/21 are being explored.
7. **Identifying key risk areas in the plan.** There are number of risk areas in the plan that the system is currently developing further.

Additional work has been conducted in these areas, expanding the evidence base and providing additional context to the top-down targets. The additional work on the efficiencies, OOH and workforce is not intended to replace the top-down estimates, rather provide greater evidence.

This document provides a summary of the work undertaken. There a number of areas that will be subject to further work post consultation.

The overall plans in the PCBC propose significant change and the details of implementation including the risks associated with these are detailed in the PCBC, Section 10.3.

### Summary top-down position

The PCBC estimates that the financial challenge for WNE Cumbria could increase to c. £163m by 2020/21, if the health economy does not respond to current and future pressures.<sup>1</sup> These pressures include demand growth, current deficits and the costs of delivering to clinical standards.

To meet this challenge, a number of mitigations are proposed in the PCBC. Based on top-down analysis, these were estimated to reduce the challenge to £13.4m. Several updates have been made to these estimates:

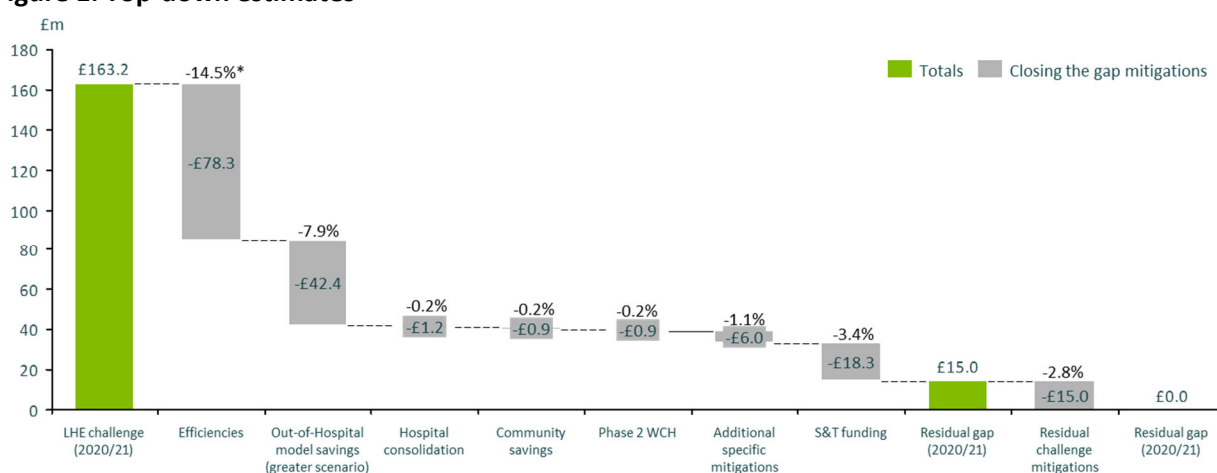
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<sup>1</sup> The financial challenge including its drivers is detailed in Section 2.5 of the PCBC.

- Heli-medicine is not included as part of the preferred option and is now included only in the full consolidation case;<sup>2</sup>
- Mental health impacts in the OOH model have been removed;<sup>3</sup>
- The assumptions around Sustainability and Transformation (S&T) funding have been adjusted to reflect the need to invest c. £1.7m to release the £20m;
- Capital expenditure for Phase 2 WCH has been reduced from £30m to £20m, reducing the revenue costs associated with this by c. £1m<sup>4</sup>, this also avoids c. £10.5m of backlog maintenance, which further reduces the revenue costs by £0.9m in 2020/21; and
- Other minor updates have been made.<sup>5</sup>

Overall these updates would increase the residual challenge to £15m. This remaining residual challenge has been addressed through a range of mitigations outlined in Section 6 of this document, which drives a balanced position by the end of 2020/21 as shown in Figure 1.

**Figure 1: Top-down estimates**



\*%s relate to total 5 year provider expenditure of c. £540m

Source: Success Regime analysis

Further detail on these mitigations is included within the PCBC, these include savings of c. £53m in workforce costs that could equate to a reduction of c. 1,180 whole time equivalents (WTEs) based on a benchmark average cost.<sup>6</sup> The estimated WTE impact is less given the significant opportunity to reduce agency spend, as discussed in Section 4 of this document.

The five year position included in Figure 1 translates to an overall transitional funding requirement of c. £167m - £247m over the period as illustrated in Figure 2.

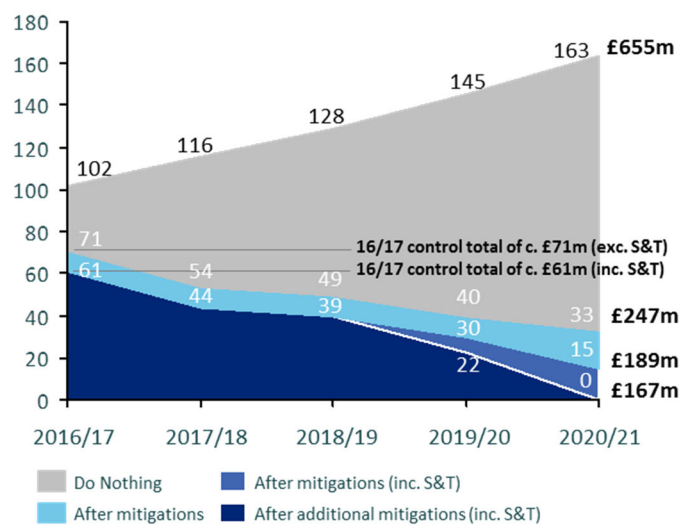
<sup>2</sup> This refers to the full consolidation of acute and emergency medicine, as well as women and children's services at CIC.

<sup>3</sup> There is a separate PCBC for Mental Health and as such it is excluded from this PCBC.

<sup>4</sup> Current estimates suggest that Capital expenditure is required of c. £20m of capital expenditure could be required in order to complete the build of the WCH site and this is the figure included in the PCBC for planning purposes.

<sup>5</sup> Note that currently the additional radiotherapy spend is not included in the PCBC bridge. This spend is not included in the PCBC bridge as the revenue costs are reflected in the plans developed by the NHSE specialised commissioning team as part of the wider SDP process.

<sup>6</sup> Based on £45.2k per WTE.

**Figure 2: Phasing of financial challenge**

Source: Success Regime analysis

Four scenarios for phasing are considered in Figure 2. These are:

1. Do Nothing: the expected financial challenge if current methods of delivering care continue;
2. After mitigations: these are the core mitigations excluding any S&T funding;
3. After mitigations (inc. S&T): as above but including S&T funding<sup>7</sup>;
4. After additional mitigations (inc. S&T): as above but including the c. £15m savings from the additional mitigations discussed in section 6.

As previously noted, the potential areas for further savings to mitigate the residual gap are discussed in Section 6 for further detail.

This is the recurrent position only and non-recurrent funding is not included. It is estimated that transitional funding would be required to support the transformation. These types of costs include double running and implementation support and preliminary estimates from the Finance Directors Group are presented in below.

Table 1: Transition costs

Non-recurrent cost	16/17	17/18	18/19	19/20	20/21	Total
Implementation support	£5.0*	£5.0	£2.5	£1.5	£1.0	£15.0
Double running for OOH	-	£4.1	£4.1	£4.1	-	£12.4
<b>Total</b>	<b>£5.0</b>	<b>£9.1</b>	<b>£6.6</b>	<b>£5.6</b>	<b>£1.0</b>	<b>£27.4</b>

\*This is the Success Regime funding in 2016/17

Source: Success Regime Analysis

<sup>7</sup> This assumes that the S&T published for 2016/17 of c. £10m is received by NCUH and CPFT, increasing to £18.3m in 2020/21. No assumptions around increases in interim years have been made.

The transition costs are not included in the five year financial position, given they are non-recurrent items.

The purpose of the financial analysis included in this document is to develop greater granularity across a number of areas in the PCBC, to help to support confidence in deliverability in the system. In particular, this work seeks to provide a set of evidence to support the plans and the consideration of deliverability, rather than underpinning all of the top-down numbers. As such the analysis does not provide an alternative to the top-down numbers, and further refinement will be required post-consultation to develop the case further.

Further, this analysis has been developed in a short space of time and should be viewed in this context. Finally, the preferred option of partial consolidation for maternity is consistent to the new model for maternity services that is being developed in greater detail as part of a separate addendum to the PCBC.

## **1. Financial challenge sensitivity**

The assumptions which underpin WNE Cumbria's financial challenge have been discussed and signed off by the Finance Directors Group. These assumptions have been developed to reflect the specific circumstances of WNE Cumbria.

NHS England/NHSI have recently released a finance and efficiency template for all STPs footprints.<sup>8</sup> This template includes a set of guideline assumptions for undertaking planning and forecasting analysis. These assumptions are based on national average expectations and as such may not reflect the specific circumstances in WNE Cumbria.

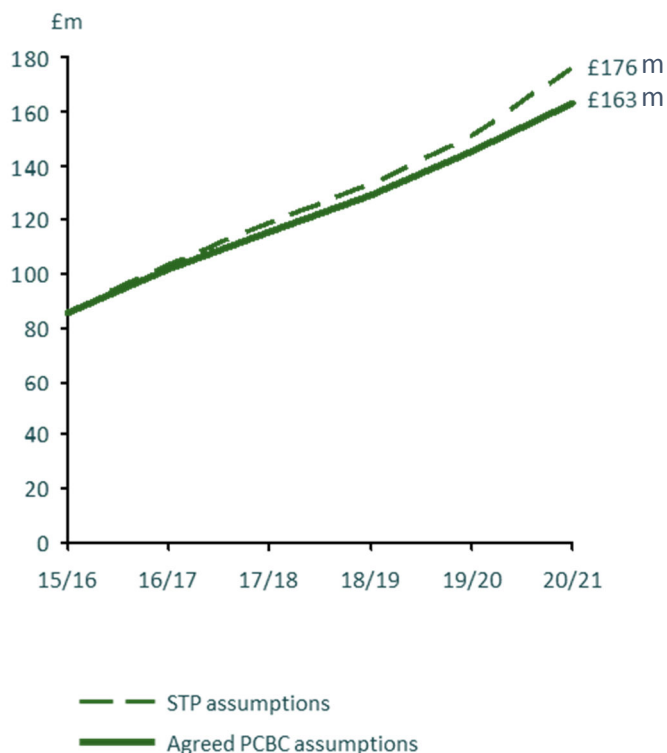
As part of a sensitivity analysis, this section analyses WNE Cumbria's financial challenge under some of the key national STP assumptions.

The locally agreed assumptions and the associated financial challenge of £163m by 2020/21 remain the estimates used in the PCBC. The sensitivity analysis is shown in the figure below.

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<sup>8</sup> <https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/stp/support>

**Figure 3: Sensitivity analysis on the financial challenge**



Source: Success Regime

Under the STP alternative assumptions, initial analysis suggests that WNE Cumbria could face a financial challenge of c. £176m by 2020/21. This is c. £13m more than the challenge estimated based on the assumptions agreed for the purpose of the PCBC. This difference equates to c. 3% of the CCG allocation covered by the PCBC. This should be seen in the context that over the Five Year Forward View period, Cumbria CCG's population is forecast to remain static compared to an average growth of c. 3% for the CCGs included in the NHS England Allocations.

### Assumptions

The greater STP financial challenge is chiefly driven by differences in a number of assumptions:

1. **Continuing Health Care.** The agreed PCBC assumption is an annual growth of 2%, with the STP assumption being 6% growth per annum.
2. **Primary Care Drugs.** The agreed PCBC assumption is an annual growth of 4.2%, with the STP assumption being 7% growth per annum.

## 2. Efficiencies

The top-down analysis identified an efficiency opportunity over the next five years of c. £78m for Cumbria across North Cumbria University Hospitals NHS Trust (NCUH), Cumbria Partnership NHS Foundation Trust (CPFT) and Cumbria CCG.<sup>9</sup> This was based on benchmarking information and the collective view of Finance Directors in the system. This comprises:

- **Provider efficiencies** of c. £56.6m;
- **CCG efficiencies**<sup>10</sup> of c. £17.3m; and
- **Shared organisational arrangements**<sup>11</sup> of c. £4.4m.

A range of schemes have been identified to understand the achievability of the top-down estimates. These underpin the efficiencies related to the individual organisations, less the shared organisations arrangements proportion. On this basis, the top-down efficiency ask has been identified at the organisational level.<sup>12</sup>

Table 2 summarises the efficiency plans. The plans are front-loaded and as such look to identify significant savings in 2016/17 and 2017/18.

**Table 2: Efficiency plans by year**

Organisation	2016/17	2017/18	2018/19	2019/20	2020/21
NCUH (£m)	-£18.2	-£14.8	-£4.2	-£3.2	-£3.1
CPFT (£m)	-£3.9	-£2.5	-£2.5	-£2.5	-£2.4
CCG (£m)	-£6.6	-£2.6	-£2.6	-£2.6	-£3.0
<b>Total (£m)</b>	<b>-£28.7</b>	<b>-£19.8</b>	<b>-£9.2</b>	<b>-£8.2</b>	<b>-£8.5</b>

*Source: Success Regime analysis*

Many of the efficiencies are planned to be delivered in the 2016/17 and 2017/18 and as such the savings are more front-loaded than the assumptions included in the top-down estimates. Revising the phasing of the efficiencies in this way could reduce the total funding requirement by c. £5m – £10m over the five years.

The more detailed plans provided by each organisation are presented in the tables below. These comprise a range of schemes related to cost reduction.

### Cumbria CCG

For Cumbria CCG savings identified in Table 3 relate to non-activity reducing schemes to avoid either any duplication with the out of hospital activity reductions or any shift of financial challenge between commissioner and provider. The savings are focussed on areas such as

<sup>9</sup> The efficiency analysis is detailed in Section 2.5 of the PCBC.

<sup>10</sup> This is made up of both cost efficiencies and out of area QIPP targets.

<sup>11</sup> This includes the streamlining of resources including back office finance, HR and procurement.

<sup>12</sup> This does not currently consider risk of deliverability where this might apply, or the impact of the frontier shift component of efficiencies which is discussed in the PCBC.

mitigating significant growth in prescribing. In addition there are savings related to out of area acute QIPP targets. This is discussed in greater detail in the PCBC Section 2.5.7.

**Table 3: Cumbria CCG (WNE) efficiencies**

Cumbria CCG (WNE) 2020/21 reduction	Savings, £m
Running Cost Reductions	£0.6
Planned Disinvestments & Funding	£2.8
Continuing Health Care Reduced Growth	£1.2
Prescribing	£4.6
High Cost Drugs	£1.2
Pain Management	£0.4
Impact of out of hospital schemes on ambulance activity	£0.8
Reduction in GP Out of hours as a result of 7-day GP working	£0.4
Out of Area Benefit	£5.4
<b>Total</b>	<b>£17.4</b>

Source: Cumbria CCG efficiency plan

#### Provider efficiency

Provider efficiencies are presented in Table 4 and Table 5 for NCUH and CPFT respectively. These relate to the same clinical model but at a lower cost. For NCUH, baseline budget reductions and 2016/17 Business Unit CIPs are being delivered and would be realised in 2018/19 accounting for c. 62% of the overall plan. The remaining benefits are planned to be realised through efficiency programmes around procurement, staffing and site rationalisation.

**Table 4: NCUH efficiencies<sup>13</sup>**

NCUH 2020/21 reduction	Savings, £m
Baseline Budget reductions – delivery in progress	£10.7
2016/17 CIP (Business Units) – delivery in progress	£16.3
Staff Resource Programme	£5.9
Procurement Efficiency	£4.5
Cumberland Infirmary in Carlisle - Rates/Availability Payment/Hard FM/Soft FM	£4.0
West Cumberland Hospital - Site rationalisation	£0.4
Business Unit efficiency programme	£1.6
<b>Total</b>	<b>£43.4</b>

Source: NCUH CIP plan

<sup>13</sup> It is assumed that 99% of NCUH's CIPs relate to WNE Cumbria.

For CPFT, c. 28% of the savings identified are in 2016/17, with the remaining savings then split fairly equally across the remaining 4 years. This represents a greater front loading of savings compared to the PCBC.

**Table 5: CPFT efficiencies<sup>14</sup>**

CPFT 2020/21 reduction	Savings, £m
2016/17 Children's and Families Efficiency Schemes	£0.1
2016/17 Community Efficiency Schemes	£0.6
2016/17 Mental Health Efficiency Schemes	£0.5
2016/17 Specialist Services Efficiency Schemes.	£0.2
2016/17 Operational Management	£0.0
2016/17 Support Services Efficiency Schemes	£0.8
Contingency schemes	£2.7
Care Group Routine Efficiency Programmes	£3.6
Support Services Routine Efficiency Programmes	£1.3
Turnaround/transfer of loss making services	£0.7
Core EPR Efficiency Benefits & Programme Decommissioning	£0.5
Core Agile working Efficiency Benefits	£0.1
Procurement Efficiencies Delivered Via Shared Purchasing	£0.4
Workforce reshaping as ICCs are implemented	£1.0
Reduced overtime and agency usage	£0.3
Targeted estates costs reductions programme (incl. impact of valuation changes)	£0.9
Trust wide waste reduction programme	£0.3
<b>Total</b>	<b>£13.9</b>

Source: CPFT CIP plan

Further work will now be required to develop these plans to the next level of granularity, including refining any areas where there could be overlap with other savings areas in the model.

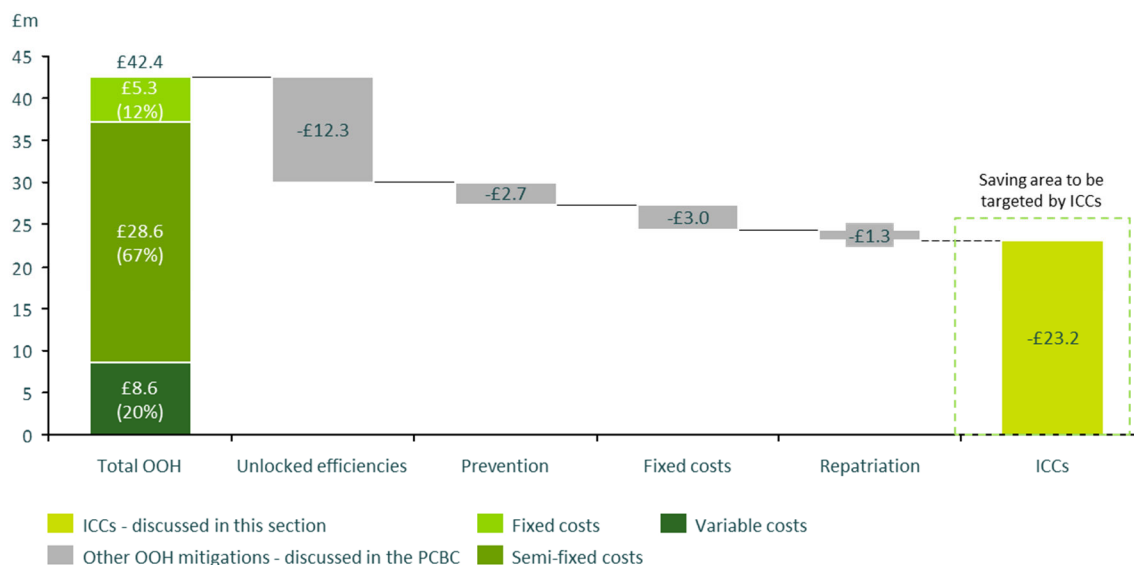
<sup>14</sup> It is assumed that 67% of CPFT's CIPs relate to WNE Cumbria.



### 3. Out of hospital

A significant part of the PCBC relates to a step change in OOH service provision through the Integrated Care Communities (ICCs)<sup>15</sup>. Based on the work conducted by the system's Finance Directors, the top-down analysis in the PCBC estimated that c. £42.4m<sup>16</sup> of savings could be realised through OOH, of which c. £23.3m could be targeted through the ICCs, as illustrated in Figure 4 below.

**Figure 4: Top-down out of hospital savings**



Source: Success Regime analysis

Further work has been undertaken to provide greater detail on:

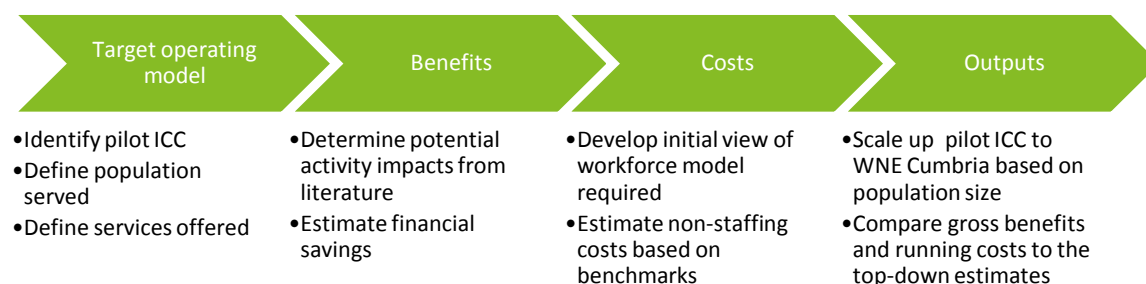
- **The benefits identified in the top-down modelling**, by identifying the specific services the ICCs could provide, the population subgroups that these services could impact and where the activity reductions could be expected; and
- **The reinvestment rate assumed in the top-down modelling**, by developing an initial view of the workforce model required to deliver the ICCs as well as potential non-staffing costs.

Further detail has also been developed around governance and implementation, which is provided as a separate addendum to the PCBC.

The ICCs analysis has been developed based on the approach set out in Figure 5 below.

<sup>15</sup> Please refer to Appendix C of the PCBC for further information.

<sup>16</sup> Please note that these figures exclude c. £3.5m of OOH savings related to Mental Health outpatient activity given this will be considered as part of a separate PCBC.

**Figure 5: Approach for ICC analysis**

The Workington ICC was identified as the pilot ICC for the analysis, and is being developed around a group of GP practices with a registered list size of c. 33,500. This therefore represents c. 10% of the West, North and East Cumbria population. The Workington ICC is also one of the early adopters and as such represents the current thinking on what the ICCs could look like.

#### Defining the target operating model

An initial view of the target operating model (TOM) has been developed through engagement at a WNE Cumbria and Workington specific level; with input from across the health economy including Commissioners, Primary Care, Social Care and Secondary Care. Based on this, an initial view of the services that could be offered by the ICCs has been developed and is presented in Table 6.

**Table 6: Services to be offered by the ICCs**

Service	Population subgroup impacted
Early diagnosis	Cancer, Long Term Conditions
Self-management	Long Term Conditions
Use of assistive technology	Frail Elderly, Long Term Conditions, Good Health Adults
Remote access to a healthcare professional	All (excluding maternity)
Single point of contact	All (excluding maternity)
Rapid response team	Frail Elderly, Long Term Conditions, Dementia, Mental Health
Early supported discharge	Frail Elderly, Long Term Conditions, Mental Health, Dementia, Cancer, Good Health Adults
Case Management	Frail Elderly, Long Term Conditions, Dementia
Step-change in dementia provision	Dementia
End of life care	End of Life
Frailty Unit*	Frail Elderly
Paediatric short stay assessment unit*	Children and Young People

\*Note that these services would be co-located at the acute site rather than provided by the local ICC.

Source: Success Regime

Although these services are separated out in Table 6, operationally these would represent the core functions of the ICC provided by a single workforce model. The services to be provided range from pro-active prevention through to end of life care, and would be targeted at specific subgroups of the population.

### Estimating the benefits

The impact that these services could have on the total 2020/21 activity by point of delivery (POD) is presented acute activity in Table 7 and for community and mental health in Table 8. These are the activity reductions before the impact of activity growth. The estimates are based on relevant literature evidence as well as clinical and operational input, and have been adjusted to reflect where these services are already up and running in the Workington area<sup>17</sup>. The total benefit is compared to the top-down estimates to understand the share of the total benefit that is currently underpinned by the plans.

This is the opportunity identified to date and further work is ongoing to underpin the remainder of the opportunity.

**Table 7: Acute Activity reductions by 2020/21**

POD	A&E	EL-IP	EL-IP	EL-DC	NEL-IP	NEL-IP	NEL-DC	OP
Unit	Att.	Adm.	LoS	Adm.	Adm.	LoS	Adm.	Att.
<b>Top-down</b>	-6.4%	-14.8%	-	-14.8%	-25.0%	-	-	-16.2%
<b>ICCs</b>	-12.9%	-12.5%	-11.7%	-10.1%	-17.7%	-9.8%	-8.6%	-16.8%
<b>Identified</b>	✓	-	✓	-	-	✓	✓	✓

Source: Success Regime analysis

Table 7 illustrates that the activity reductions in the acute setting identified to date could underpin a significant amount of the activity shift estimated in the top-down analysis for each of the PODs. Although the reduction in non-elective inpatient admissions is less than in the top-down analysis, the ICCs work has identified opportunity to reduce the length of stay and as such the reduction in the bed base is similar.

**Table 8: Community and Mental Health activity reductions by 2020/21**

POD	Com-IP	Com-IP	Com-OP	MH-IP	MH-IP	MH-OP
Unit	Adm.	LoS	Cont.	Adm.	LoS	Att.
<b>Top-down</b>	-19.6%	-	-1.4%	-	-	-
<b>ICCs</b>	-0.3%	-12.7%	-3.6%	-	-	-
<b>Identified</b>	-	✓	✓	-	-	-

Source: Success Regime analysis

No activity impact from the ICCs has been considered against the mental health setting as this will be considered in a separate PCBC. For the community setting, the ICCs analysis has identified more opportunity than the top-down on length of stay, however further analysis is required to estimate the potential impact the ICCs could have on community inpatient admissions, which as shown in the top-down analysis is expected to be significant.

<sup>17</sup> This is defined as up and running in 2014/15; the year of the baseline data.

### Estimating the costs

An initial view of the workforce model that could be required to deliver the ICC demand has been developed by the Workforce Repository and Planning Tool (WRaPT) Team in conjunction with local support. This is presented in Table 9 below and represents both the additional local workforce which could be required as well as clinical oversight (for example as part of a network) to manage these patients in a community setting. Evidence has been used to develop these estimates where possible, although the literature around what a fully scaled up care model in this context would look like is limited.

**Table 9: Workforce model (2020/21)**

Staff Role	Junior / Senior <sup>18</sup>	WTEs
Admin and Clerical	Junior	5.00
HCA	Junior	4.00
HAWC	Junior	1.60
Rehab Therapies	Junior	4.00
Reablement worker	Junior	4.00
Care co-ordinator / navigator	Junior	2.00
Assistant Practitioner	Junior	3.00
Social worker	Senior	2.00
District/community nurse	Senior	8.00
Occupational Therapist	Senior	2.00
Physio	Senior	2.00
Community matron	Senior	2.00
Specialist Nurse	Senior	1.00
Consultant input	Consultant	1.30
<b>Total</b>	<b>All</b>	<b>41.9</b>

*Source: WRaPT and Success Regime analysis*

Non-staffing costs have been estimated based on benchmarks from other community based services for equipment, supplies, Information Management and Technology (IM&T), transport, estates<sup>19</sup> and overheads.<sup>20</sup>

### Outputs

<sup>18</sup> Junior staff relate to Band 4 and Below, Senior staff relate to Band 5 and above.

<sup>19</sup> Where staff or services are to be co-located, it is anticipated that existing estate would be used for this.

<sup>20</sup> Based on Monitor (2015), 'Moving Healthcare closer to home'.

Based on the services and activity impacts identified to date, the gross benefits for the Workington ICC are estimated to be c. £3.3m in 2020/21, and the running costs of £2.0m.<sup>21</sup> This implies a reinvestment rate of c. 60%.

The next step is to develop a similar target operating model for each of the remaining seven ICCs. In order to estimate the benefits at a WNE Cumbria level at this stage, the Workington estimates are scaled-up to a high-level, in line with population size, in order to support comparison with the top-down numbers. It is recognised that there are likely to be specific circumstances in Workington which may not generalise to the other ICCs. As such, it will be important to revise the model to account for these differences as the other ICCs are developed.

Table 10 summarises the scaled-up ICC outputs for WNE Cumbria and compares them against the top-down numbers included in the PCBC. In each case, a comparison is made of the (1) total benefits (gross savings) and (2) the total costs (running costs) and therefore the implied reinvestment rate overall.

**Table 10: Comparison of OOH costs and benefits**

	ICCs work	Stretch OOH	Greater OOH
<b>Gross savings (£m)</b>	£31.5	£34.9	£38.6
<b>Running costs (£m)</b>	£19.0	£17.4	£15.4
<b>Net benefits (£m)</b>	£12.5	£17.4	£23.2
<b>Reinvestment Rate (%)</b>	60%	50%	40%

Source: Success Regime analysis

- **Stretch OOH** – the net benefit of this scenario in the top-down model is c. £17.4m. The ICCs work identifies c. 90% of the gross benefits included in the stretch OOH top-down modelling. A greater reinvestment rate of 60% compared to the benchmark 50% included in the top-down modelling means that c. 72% of the net benefit has currently been identified through the ICCs work.
- **Greater OOH** – the net benefit of this scenario in the top-down model is c. £23.2m. The ICCs work identifies c. 82% of the gross benefits included in the greater OOH scenario (where the activity impacts are greater across non-elective activity). The 60% reinvestment rate is also higher than the 40% used in the greater OOH scenario in the top-down modelling, as such c. 54% of net benefits have currently been identified as part of the ICCs work.

Work is ongoing to underpin the remainder of the net benefit included in the greater OOH scenario, through a number of areas.

- 1. Developing the benefits side further.** The ICCs could provide more services than those identified in Table 6 potentially within the current workforce model, and in addition the services already identified could impact further population subgroups and PODs.

<sup>21</sup> With workforce accounting for c. £1.7m and non-staffing costs c. £0.3m.

- 2. Refinement of the running costs.** The workforce model will need to be refined, particularly in the context of understanding how the aggregate workforce model could look across all ICCs. This is likely to include significant sharing of resources through the network component of the model as well as further synergies through the integration of the existing out of hospital workforce. For example, if there were workforce scale efficiencies of 20%, the implied reinvestment rate could fall from c. 60% to c. 50%.

The assumptions in this scenario across both the increased demand shift to ICCs and the lower reinvestment rate are ambitious assumptions and will be challenging to achieve. While bottom up work is ongoing to develop models to target the demand shifts and lower reinvestment rate, the pilot ICC analysis does not yet underpin these assumptions fully.

In addition, for the ICCs model:

- There will need to be a unified and strong governance structure in place for the ICCs in order to deliver the OOH benefits;
- There is likely to be some lead time required for the ICCs to acquire and train/retrain staff; and
- There may need to be some up-front investment to ensure that the ICCs have the capacity to accept the initial activity going out of hospital.

#### 4. Workforce

Initial workforce analysis has been undertaken to understand the levels of staffing required in the system if the plans in the PCBC were put into place. In addition, bottom up modelling of individual services has been carried out to triangulate the savings identified in the top-down financial model.

The analysis should be viewed in the context of further work being required post consultation with regards to the workforce implications of the new service models. Table 11 summarises the workforce estimates.

**Table 11: Workforce impacts**

	2020/21 Do Nothing	2020/21 Post mitigations	2020/21 Post ICC reinvestment
WTE	6,573	5,751	6,036
Total Pay (£m)	£326	£261	£273
Unit Cost /WTE (000's)	£49.6	£45.4	£45.2

*Source: Success Regime analysis*

By 2020/21 there is estimated to be 6,573 WTE if no action is taken, based on activity growth and delivering to clinical standards. If the PCBC plans are put in place, the WTEs required to deliver services could be reduced to 5,751. However, re-investment in the OOH model, particularly in the ICCs, is expected to result in the recruitment of 285 WTE. This analysis therefore suggests that staffing levels will not change significantly compared to the current state, but will be 8.3% lower compared to a scenario whereby the system takes no action.

Despite aggregate numbers potentially remaining unchanged there are a number of significant changes the WTE numbers do not highlight:

1. The plan aims to **reduce premium pay**; and
2. There will be **significant skill mix changes**.

The total pay cost is estimated to reduce by c. £53m as a result of the mitigations included within the PCBC. The current average unit cost per WTE is £44.7k in WNE Cumbria, as shown in Table 11. This high average unit cost is driven predominantly by a high use of agency staff. In particular, currently 2% of WTE account for 8.3% (£28.1 million) of total pay. The unit cost per WTE could increase to £49.6k in the 2020/21 Do Nothing scenario, based on assumptions around pay inflation.

After efficiencies, out of hospital and other mitigations, this could reduce to £45.4k. The lower unit cost is driven by workforce efficiencies and a significant reduction in agency spend by c. £20m.

Finally, the average unit cost per WTE could further reduce to £45.2k through the re-shaping of workforce to account for the changes in skill mix from delivering greater care in out of hospital settings through the ICCs. In particular, 58% of the initial ICC staffing model comprises of junior roles compared to 40% of staff currently working in CPFT and NCUHT overall.

These changes drive a total pay cost saving of c. £53m in 2020/21 compared to the Do Nothing scenario; with c. 50% of this reduction due to agency spend. The remainder focuses on mitigating the c. 10% growth in substantive workforce between 2015/16 and 2020/21 and optimising the skill mix delivering care in the ICCs.

The c. £53m saving in staff pay would be equivalent to c. 1,180 WTEs at a benchmark unit cost of £45.2k per WTE. The reduction of c. 536 therefore reflects the significant opportunity to reduce agency spend within the system.

It is important to note that there will be other changes in the skill mix that will provide opportunities for staff to enhance their skills and develop their careers. An example of this is with acute medicine in West Cumberland. The proposals at Whitehaven outline a vision where middle grade physicians are replaced with enhanced professionals from other clinical backgrounds. This example is in line with other transformational proposals in the trust that aim to reduce agency spend and improve the efficiency of the delivery of care resulting at a lower unit cost per WTE. It is recognised that the transition to a new workforce model will take time and investment. However, detailed plans have been constructed within the clinical work streams to train staff to enable the new ways of working outlined in the PCBC.

This, combined with the wider workforce strategy, has the potential to improve staff recruitment and retention across the system. The evidence in reducing the reliance on agency staff has additional benefits, namely less fragility of clinical services and an increase in the quality of the patient care.

Despite the estimates of the workforce remaining flat over the period, it should be noted that:

1. Further work is required to identify at a service level the specific workforce changes and the outcome of this work may change the workforce profile envisaged as part of this work; and
2. The current workforce story doesn't include a number of mitigations (e.g. those to close the residual challenge of c. £15m in 2020/21). Some of these areas could have workforce implications and were these to be considered this could impact upon the workforce story.



## 5. Site level breakdown

The PCBC develops a set of mitigations at an LHE level and does not develop mitigations by organisation or by site.

An initial site level breakdown of the impacts of the new care models by acute site, Cumberland Infirmary Carlisle (CIC) and West Cumberland Hospital (WCH), and CPFT has also been undertaken based on NHS England requirements. This analysis involves estimating the capacity (beds) and cost at each of the acute sites in the future 2020/21 Do Nothing state and post the mitigations identified through efficiencies, ICCs and the preferred clinical option. This analysis is summarised in

Table 12 and Table 13 below.

The purpose of the analysis is to develop a picture of the cost in each site. The analysis in the PCBC remains at an LHE level, and the LHE level picture is the most important. This section is not intended to apportion the cost savings to individual organisations.

**Table 12: Current and end state - CIC**

	2020/21 Do Nothing	2020/21 Post mitigations
<b>Total cost</b>	£292m	£233m
<b>Beds</b>	452	359
<b>Cost per bed</b>	£0.65m	£0.65m

*Source: Success Regime analysis*

In the Do Nothing scenario, based on the cost, demand pressures and clinical standards included in the financial challenge, the cost base could increase to c. £292m and the bed base to 452, leading to a cost per bed of c. £0.65m. Post efficiencies, out of hospital strategy and the preferred clinical option, the cost base in CIC could decrease by c. 20% to c. £233m and the bed base also by c. 20% to c. 359, reflecting greater care being delivered in the ICCs. The cost per bed remains unchanged as the economies of scale from consolidating some activity at CIC is traded off with a decrease in scale from significant activity shifting to the ICCs.

**Table 13: Current and end state - WCH**

	2020/21 Do Nothing	2020/21 Post mitigations
<b>Total cost</b>	£99m	£77m
<b>Beds</b>	192	129
<b>Cost per bed</b>	£0.52m	£0.60m

*Source: Success Regime analysis*

In the Do Nothing scenario, based on the cost, demand pressures and clinical standards included in the financial challenge, the cost base could increase to c. £99m and the bed base to 192. Post efficiencies, out of hospital strategy and the preferred clinical option, the cost base in WCH could decrease by c. 22% to c. £77m and the bed base by c. 33% to c. 129, reflecting

greater care being delivered in the ICCs and some activity consolidation at CIC. The cost per bed could increase to £0.6m, which could reflect fewer economies of scale available across some services from a decrease in capacity required from both the out of hospital strategy and the preferred clinical option.

For CPFT, in the Do Nothing scenario, based on the cost, demand pressures and clinical standards included in the financial challenge, the cost base could increase to c. £148m. Post efficiencies, out of hospital strategy and the preferred clinical option, the cost base for CPFT could decrease by c. 15% to c. £126m, reflecting greater care being delivered in the ICCs.

## 6. Closing the residual gap in 2020/21

The residual gap in 2020/21 could be reduced through a number of potential measures currently being developed. This considers:

- Greater clinical efficiencies including increased bed utilisation and delivering care closer to home;
- Beginning to realise the benefits from IM&T investment;
- Improved population health, including decommissioning procedures of limited value; and
- Additional decommissioning of loss making services locally.

The system is committed to reaching financial balance. It is expected that the areas listed above would contribute to closing some of the residual challenge in 2020/21, however there are still further areas to be considered.

**These mitigations have not been worked up in the same level of detail as some of the other areas and as such will need to be refined on this basis post consultation. These additional savings are likely to be more back loaded and, if the c. £15m could be identified, could decrease the overall funding requirement over the five years by c. £22m over the period, from c. £189m to c. £167m, as shown in Figure 2.**

## 7. Key risk areas in the plan

There are a number of key risk areas in the plan that the system is currently developing further. The most significant of these are on the greater OOH savings and the mitigations to close the residual challenge and could reflect c. £20.7m of uncertainty in the plan. These can be seen in Table 14 below.

**Table 14: Risk areas in the plan**

Area	Value of risk (£m)	Description	Plan
<b>Greater OOH</b>	c. £6m	Greater out of hospital stretch assumptions of an additional c. £6m	Develop the ICC model for a further locality, focussing on understanding potential greater efficiencies from a network of ICCs
<b>Residual challenge</b>	c. £14.7m	Residual challenge mitigations across 4 areas including greater clinical efficiencies; IM&T; improved population health; and decommissioning of loss making services.	Investigate areas in greater detail, including working up estimates for each mitigation, and identifying potential risks of double count
<b>Total</b>	<b>£20.7m</b>		

*Source: Success Regime*

The table above summarises only the key areas of risk and it is acknowledged that there could be sensitivity around the other estimates.

## Considerations and challenges

### For ICCs

- There will need to be a unified and strong governance structure in place for the ICCs in order to deliver the OOH benefits
- There is likely to be some lead time required for the ICCs to acquire and train/retrain staff
- There may need to be some up-front investment to ensure that the ICCs have the capacity to accept the initial activity going out of hospital
- To implement this practically, it will be important to bring social care leads to the table

### Generally

- There needs to be internal capacity to run and implement these programmes
- There will need to be strong local health economy leadership and commitment to navigate through potential opposition to these plans, and to keep the within the five-year timeframe
- There will need to be local buy in to a decrease in capacity
- There may need to be further analysis in the full business case to ensure that the benefits identified do not overlap