East of England Joint Endeavour

Specialised Services Commissioning Strategy 2025-2030

Review, Reimagine, Realise

NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board

NHS Cambridgeshire and Peterborough Integrated Care Board

NHS Hertfordshire and West Essex Integrated Care Board

NHS Mid and South Essex Integrated Care Board

NHS Norfolk and Waveney Integrated Care Board

NHS Suffolk and North East Essex Integrated Care Board (ICB)

NHS England

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Executive Summary

We are pleased to present the East of England Joint Commissioning Consortium's (JCC) Specialised Services Commissioning Strategy 2025 – 2030, which sets out our strategic ambitions and priorities for the commissioning of specialised services and sets the context for ongoing continuous improvement and transformation.

Specialised services are central to the NHS, supporting people with rare and complex conditions, often at times when they are in greatest need. Specialised services are also a catalyst for innovation, supporting pioneering clinical practice and research in the NHS. At the same time, unwarranted variation in patient outcomes and access to services persists. There are continuing financial pressures across the system, combined with changing demographics, workforce pressures, amid significant organisational changes.

To meet these challenges and in line with the ambitions of the **10-year plan**, we need to see a **transformation in the way specialised services are commissioned** and provided in the East of England. High quality specialised care needs to be embedded in the patient pathway, with more personalisation and a stronger emphasis on prevention, whilst ensuring best value for the public.   Delegation has enabled the planning, commissioning and provision of more integrated services for patients, and support key aims of the ten-year plan to bring about a shift from **sickness to prevention** and **from hospital to community**; and strengthen the hand of ICBs to act as strategic commissioners, leading on population health.

In a period of significant financial challenge and a national gap in productivity, reflected in specialised services, an ambitious effort is needed to drive reform in the commissioning and provision of specialised services to the population of the East of England: the fourth largest region, increasingly elderly and predicted to have one of the largest growth rates.

Population health data show variation by existing ICBs in ethnicity, the proportion in CORE20, deprivation, chronic ill health and spend on activity, with over 90% of Norfolk and Waveney spend being in Region compared to just over 40% by Hertfordshire and West Essex. A tailored and prioritised programme of transformation will therefore need to be closely tailored to local population needs and usage patterns. This is reflected in the core principles in the strategy.

The strategy is closely aligned to the JCC's Commissioning Framework where the delivery of ***improved value*** through a systems-based ambition for productivity improvement is defined as improved value for funds invested and not simply activity growth.

After a process of co-production with partners the Strategy adopts four key strategic goals of :

- Delivering value-based care
- Improving quality and outcomes
- Ensuring health equity and access
- Bringing care closer to home

In November 2024 the JCC and the Specialised Services Provider Collaborative (SPC) hosted a Clinical Engagement Workshop at which **Cancer and Cardiac/CVD** were identified as key clinical priority areas.

The remaining clinical priority areas were identified following a review of national, regional and ICB plans and priorities, worked through using the health inequalities population health analysis in 2024 and with stakeholders and partners in a series of Strategic Workshops in April, September and November 2024. These were **Renal, Neonatal and Paediatrics, Neurology/ Neurosciences/Neurosurgery, Trauma and Rehabilitation and Mental Health**

Executive Summary

Each of the seven clinical priority areas has been examined through the lens of the four strategic goals which has resulted in an opportunities matrix, which illustrates the scale of transformation sought (slide 6).

In each clinical area, individually explored in more detail, the scope to achieve the potential of delegation of specialised commissioning is identified and these important improvements make up the main body of this strategy. Progress in establishing programmes of improvement varies between clinical priority areas but they have in common the need to address each of the four strategic goals as a gateway to improved value, outcomes and productivity for local people, with a great deal of work already in hand.

Achievement of the four goals relies on four critical foundations:

1. Good governance, led by the JCC
2. A guiding theory of change including an evidence-based approach to improvement – the '3 Rs '
3. A clear framework and mechanisms to bring about change through commissioning
4. Effective co-ordination and reporting to the JCC

The strategy recognises the importance of involving patients who use specialised services, their carers and the public in planning and improving specialised services and this will be a key component of successful implementation.

The JCC has adopted a Commissioning Framework with which this strategy is closely aligned, so that the levers available to commissioners in achieving these changes are clearly identified. A focus on well integrated, thoughtfully designed care pathways which optimise the potential of innovations such as digital technology and interventions such as secondary prevention is a key theme in each of the seven clinical priority areas.

A high-level roadmap is included, outlining how the cycle of prioritised deep dives, redesign of pathways and services and development of supporting business cases and commissioning and contracting proposals will develop over the five-year strategic period.

The backdrop of organisational change in the commissioning landscape will offer challenges to implementation, however the strong commitment to partnership working with providers will ensure a synergy between stakeholders driving towards improved productivity, outcomes and quality.

An initial detailed 18-month implementation Plan will be developed in Quarters 3 and 4 of 2025/6 with the following key milestones:

- Adoption of a Prioritisation Framework and generation of the first cycle of deep dives in the 3Rs' Review Phase
- Co-design and project planning of the 3 Rs'' Re-imagine Phase for the prioritised reviews
- Translation of agreed re-design proposals into business cases and commissioning and contracting proposals

Given the importance of the drive for improved productivity, Appendix One contains a summary of potential opportunities and levers and focus areas for the East of England suggested by national work

There follows our Strategy on a Page

EoE Specialised Services Commissioning Strategy 2025 - 2030

Strategic Ambition:

Optimising specialised services for everyone who lives in East of England, integrating specialised services within the whole pathway of care, and driving continuous improvement in quality and outcomes that matter most to patients and working together to enable flexibility in how different models can be adapted to local needs

Strategic Goals:

Deliver Value Based Healthcare: Work together to make the most of limited resources and adjust how care is delivered to meet the needs of different communities with a focus on early support and integrating services

Improve Quality and Outcomes: Keep reviewing and improving how care is provided to make sure quality, patient experience and outcomes continue to get better. Supporting across the life course

Ensure Health Equity and Access: Reduce health inequalities – change services to better support those who are more likely to have poor health due to their life situation or personal characteristics.

Bring Care Closer to Home: Plan based on population needs, focusing on full care pathways. Strengthen the connection between services and the people they support and act earlier to prevent problems and provide more care within local communities.

With a Focus on Clinical Priority Areas

1. Cancer
2. Cardiac / CVD
3. Renal
4. Neonatal / Paediatrics
5. Trauma
6. Mental Health
7. Neurology/ Neurosurgery

Delivery Approach:

Review
Analyse, compare, horizon scan and identify which changes, at any part of the pathway including prevention, will bring about the greatest benefit

Reimagine
Multidisciplinary redesign, building the case for change, shared purpose and vision

Realise
Develop the implementation plan, whether iterative or transformational utilising the commissioning process

Our strategy is underpinned by our values and core principles:

- Our Values: Respect, Integrity, Excellence and Courage
- Co-production with Stakeholders
- Bold and Brave Clinical Leadership
- Collaborative and credible system leadership
- Evidence based using population health principles

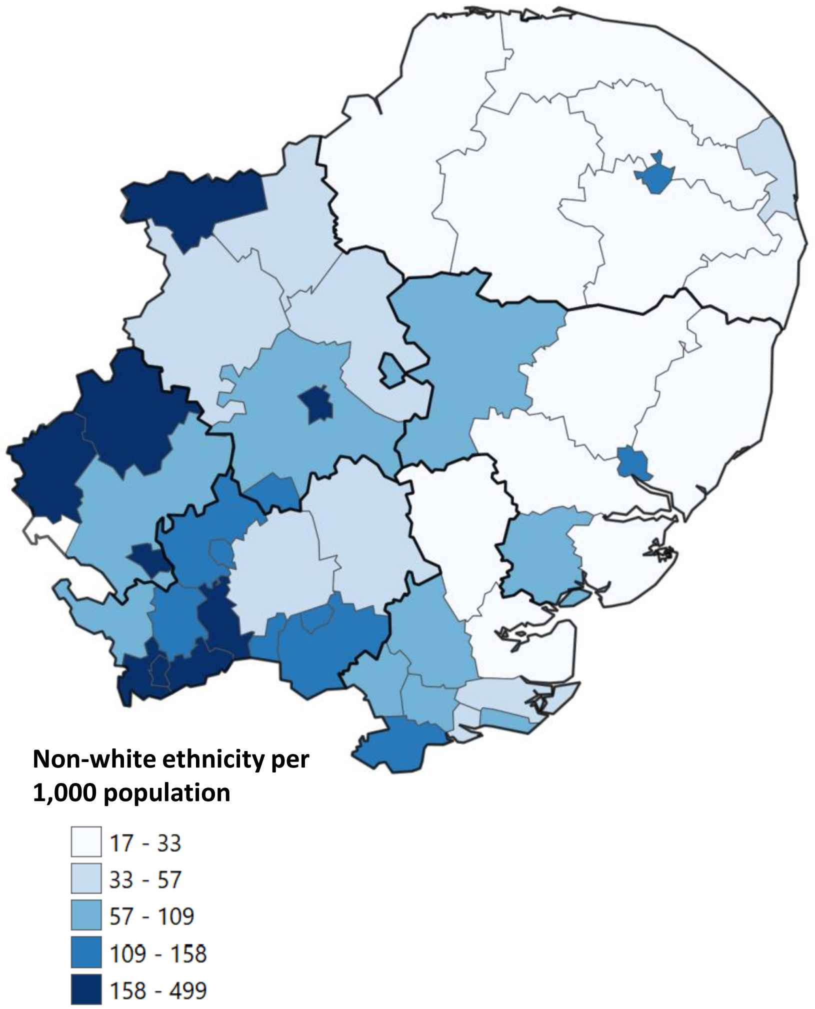
Clinical Priorities Opportunities Matrix

Clinical priority	Deliver value-based care	Improve quality and outcomes	Ensure health equity and access	Bring care closer to home
Cardiac/CVD	• Increase same day interventions • Improve pathway efficiency - reduce LOS • Secondary prevention - identifying and treating at risk patients in primary/secondary care (costs per patient can be 70% lower with early intervention)	• Technology for waiting well • Target early interventions - Outcomes for early vs. late intervention – heart failure: 3.5x survival increase • Support the implementation of video triage for stroke patients and MT 24/7 (early intervention = ↑ morbidity) • Introduce technology to improve outcomes and improve flow e.g. VR goggles for stroke rehab	• Understand variation and blockages across pathway – to inform planning and improve access and efficiency	• Watch pathway evaluation and scale up • Repatriation of after-care to local DGH following surgery at tertiary centre
Cancer	• Significant savings for early v's late intervention, and improvement in outcomes and experience • Significant secondary prevention opportunities – reduced cost over pathway • Opportunities for savings - introduction of AI enabled automation of specialist cancer pathways reduce administrative delays diagnosis/treatment.	• Speed up access to diagnostics and first treatment • Outcomes for early vs. late intervention – lung 6x ↑ survival, colon 9x ↑ survival • Innovative new treatment improved outcomes • Work in partnership to build specialist cancer workforce • Increase use of AI enabled telephone triage and patient reported outcomes to improve virtual supportive care	• Review fragile pathways and redesign to create sustainability across the region not only in hubs • Introduce tele dermatology and AI for skin cancer Increase regional oncology capacity to meet increasing demand, informed by a regional capacity and demand analysis and horizon scanning and modelling for treatment utilisation	• Increase access to home chemotherapy • Explore use of virtual clinics on pathways • Increase use of AI enabled telephone triage to improve virtual supportive care at home
Renal	• Increase earlier transplant numbers (decreases costs across pathway) • Off acute site facilities for routine dialysis model • Increase home dialysis numbers • Early diagnosis and interventions CKD	• Improve transplant readiness pathways and increase transplant numbers • Build in incentives early in pathway for detection and early intervention, improving patient experience and outcomes	• Increase regional capacity to meet demand and enable dialysing at closest unit • Commitment to in-patient provision at strategic sites across the region as part of NHP	• Increase home dialysis availability and support • Potential for virtual e-clinics for kidney disease – supporting GPs to manage patients in community
Neonatal/paediatrics	• Right size and designation of units for regional demand	• Implement OPEL real time data monitoring so ODN can intervene quickly to avoid repatriation out of region • Implement ROP pathway to improve patient outcomes • Resolve capacity issue on Paediatric Orthopaedic Pathway	• D&C review to inform regional strategy • OPEL trends analysis to inform planning • Reduce waiting surgery waiting times to improve access	• Transitional care • Planning across perinatal, to engage community services earlier and avoid need for NIC
Neurology / Neurosurgery	• Opportunity to consider how we commission the whole pathway as a region and explore a collaborative commissioning model.	• Improve oversight of current offer • Reduce waiting times for neurosurgery	• Understand the impact of diagnostic exclusion and reset through influencing specs and system pathways • Strengthen MS pathways across region to improve equitable access	• Reduce out of area placements through provision of facilities within region • Introduce dashboard to profile regional position to support • Repatriate treatment to DGHs
Mental Health	• Eliminating inappropriate outside of natural clinical flow placements	• CYP to Adult Transition • Women's Secure Pathway Transformation • Implement new Developmental CYP Intensive Mental Health Service Specification	• Improving service offer for under 13-year-olds to mental health care and treatment • Understanding the variation across the region	• Eliminating inappropriate outside of natural clinical flow placements through provision of appropriate inpatient and alternatives to admission within region
Trauma and Rehabilitation	• Reduce delays in transition through pathways – stop the blocks • Collaborative commissioning of rehab beds	• Use of NMTR to aid quality and outcome reviews • Undertake peer reviews.	• Pathway decision for the region - – 2nd MTC & Rehabilitation	• Review current use of out of area specialist rehab provision and consider alternative options within region
Cross-cutting opportunities	• Workforce Strategy • Productivity • New ways of working • Acute sites for acute care – consider virtual and alternative options for interventions	• Data – measure the right things – outcomes focussed • Data – coding improvements • Fragile Service – proactive oversight • GIRFT implementation • Proactive use of SDIPs	• Impact of ICB changes – opportunity to reconsider 'normal' flow and pathways • Systematic approach to deep dives and to inform planning • Review pathways meet needs across life course	• Digital – waiting well • Digital – diagnostic and sharing • Digital – home monitoring and management • Review and consider left shift

Understanding the Landscape

Population and Ethnicity

Count of Non-white ethnicity per 1,000 population by Local Authority Districts (ONS Census 2021)

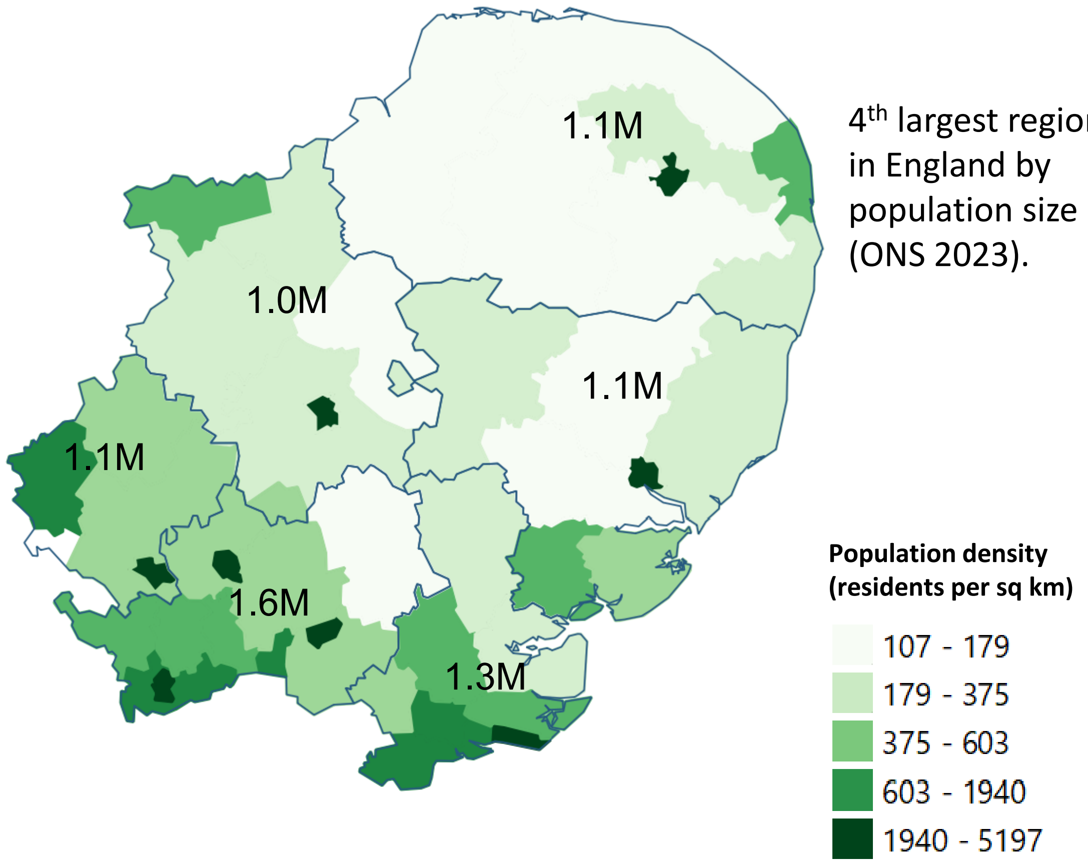


The proportion of ethnic minorities decreases with age.

Asian ethnicity is the second largest proportion after White ethnicity.

The highest proportions of Non-white ethnicity are in Luton, Watford and Welwyn Hatfield.

Registered Population size of each ICB (2022) (East of England NHS England Region= 7.1M) and Population Density by Local Authority Districts (ONS Census 2021).



4th largest region in England by population size (ONS 2023).

Data Source: Analysis of population estimates tool for UK - Office for National Statistics (ons.gov.uk), Registered Population Population and Person Insight (model.nhs.uk), Census - Office for National Statistics (ons.gov.uk)

Population Growth

Growing and Ageing Population

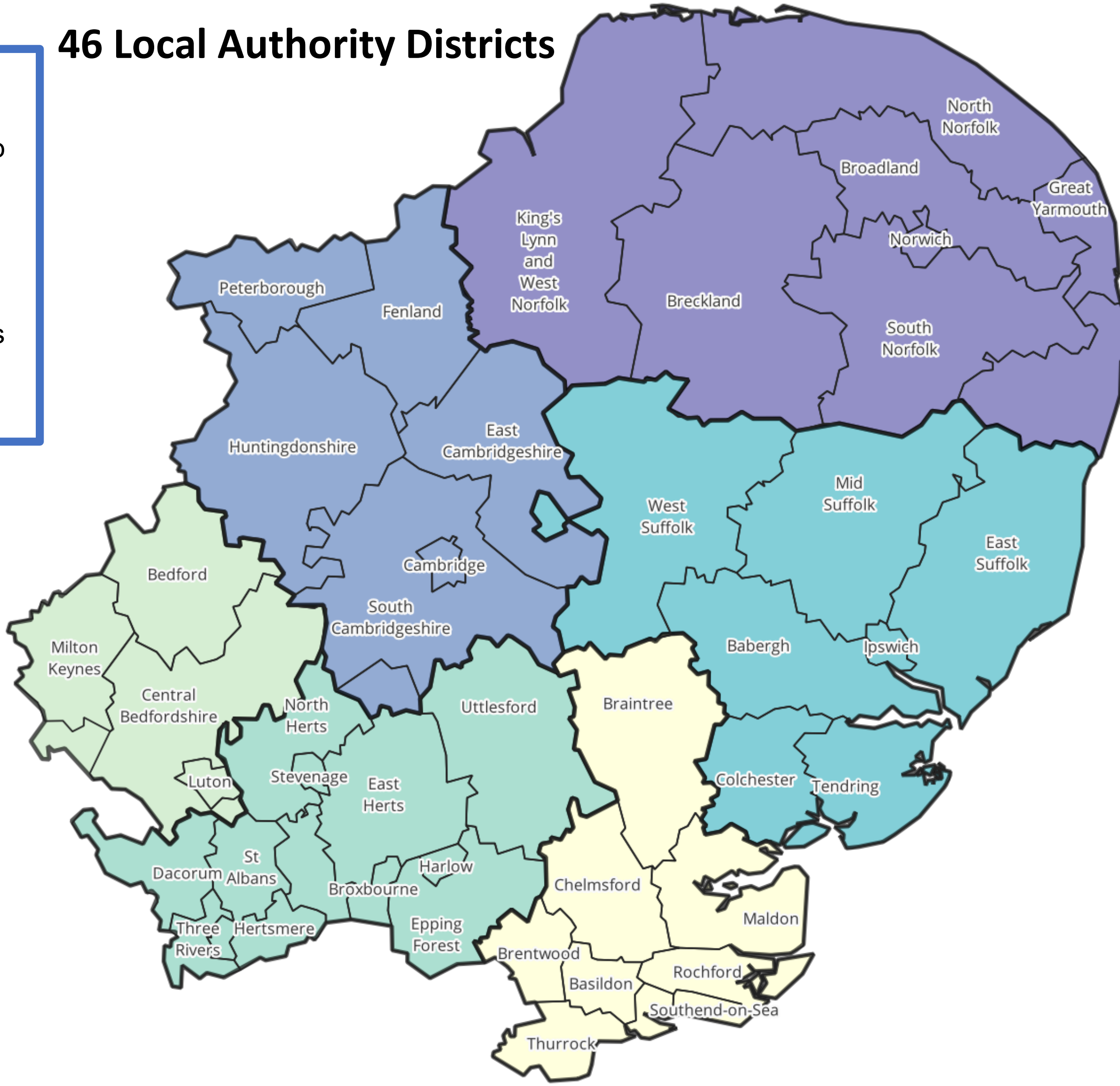
- East of England is one of the regions that will see greatest population growth in the period of the strategy.
- The East of England population increased by 536,000 persons or 9.1% from mid-2011 to 2022 to 6,398,000 persons. (ONS 2023*).
- The Region has seen a 20% increase in persons aged over 75 since the 2011 Census.
- By the 2030s most of rural Britain will have a markedly aged population.
- Locally, nearly one in three people in Norfolk will be over 65 by 2036 with the largest growth forecasts for persons aged 75+ in Milton Keynes, Peterborough, Central Beds and Suffolk. This is before taking account new developments recently announced including the development of Universal Studios in Bedfordshire

10 Year Population projection by Upper Tier Local Authorities (ONS Census 2018) Predicted 10-year change 2021 to 2031

	% change all ages	% change 75+
East (Region)	4.2	26.3
Bedford*	6.3	29.9
Cambridgeshire	3.3	29.4
Central Bedfordshire	6.8	35.2
Essex	5.3	24.7
Hertfordshire	1.8	21.8
Luton*	-3.7	14.1
Milton Keynes	2.0	47.3
Norfolk	5.9	26.9
Peterborough	6.8	31.3
Southend-on-Sea	5.3	22.9
Suffolk	3.6	30.3
Thurrock	8.0	25.6

***Note:** doesn't account for recent developments, including Luton airport and Universal Studios

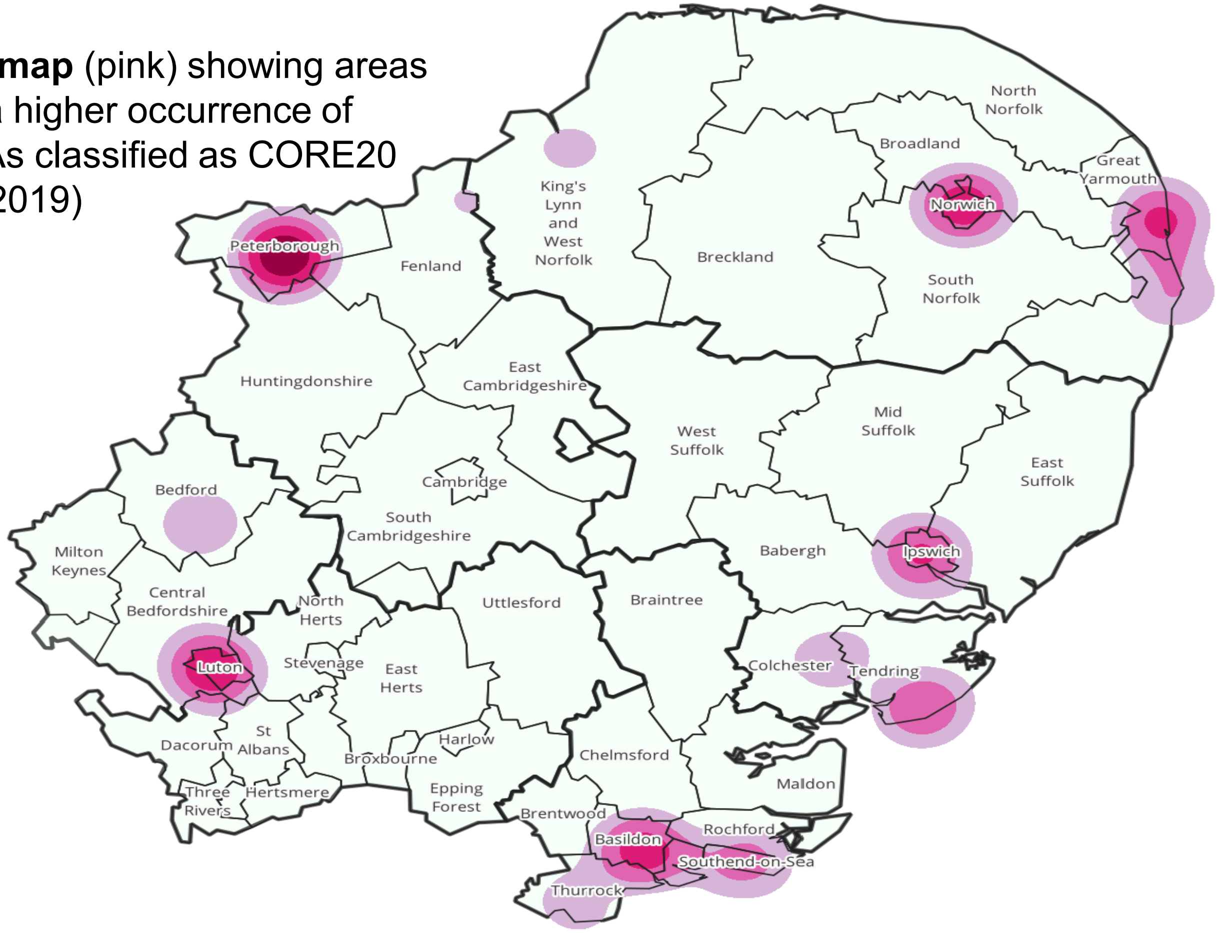
46 Local Authority Districts



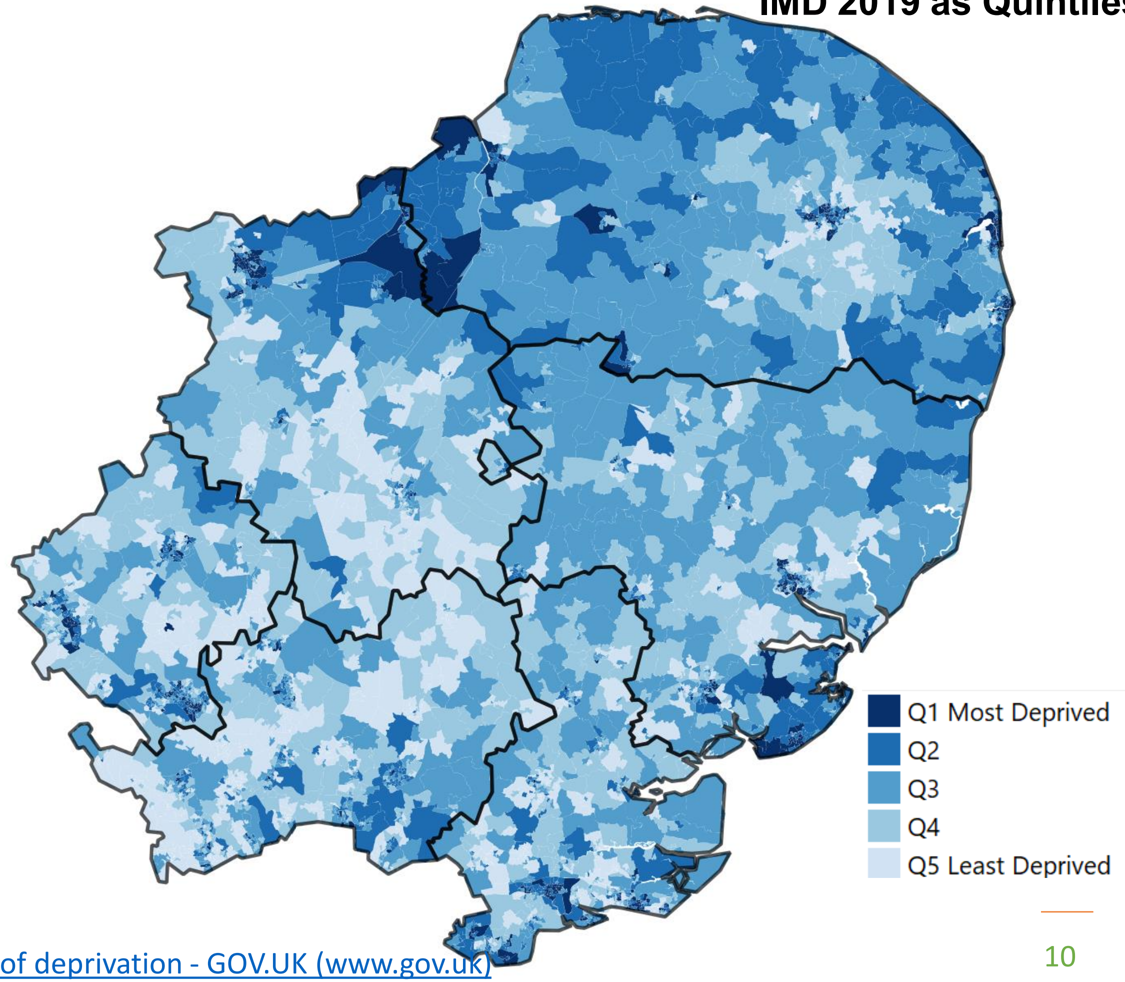
Areas of Deprivation

- **10.8%** of the East of England registered population are residents of the most deprived areas in England (CORE20). The proportion in CORE20 decreases with age.
- Of those who are CORE20, 23.0% are aged under 18 years, 13.1% are aged over 64 years and 15.4% are ethnic minorities.
- The highest concentration of CORE20 populations reside in Peterborough. The highest deprivation score is in Great Yarmouth.

Heat map (pink) showing areas with a higher occurrence of LSOAs classified as CORE20 (IMD2019)



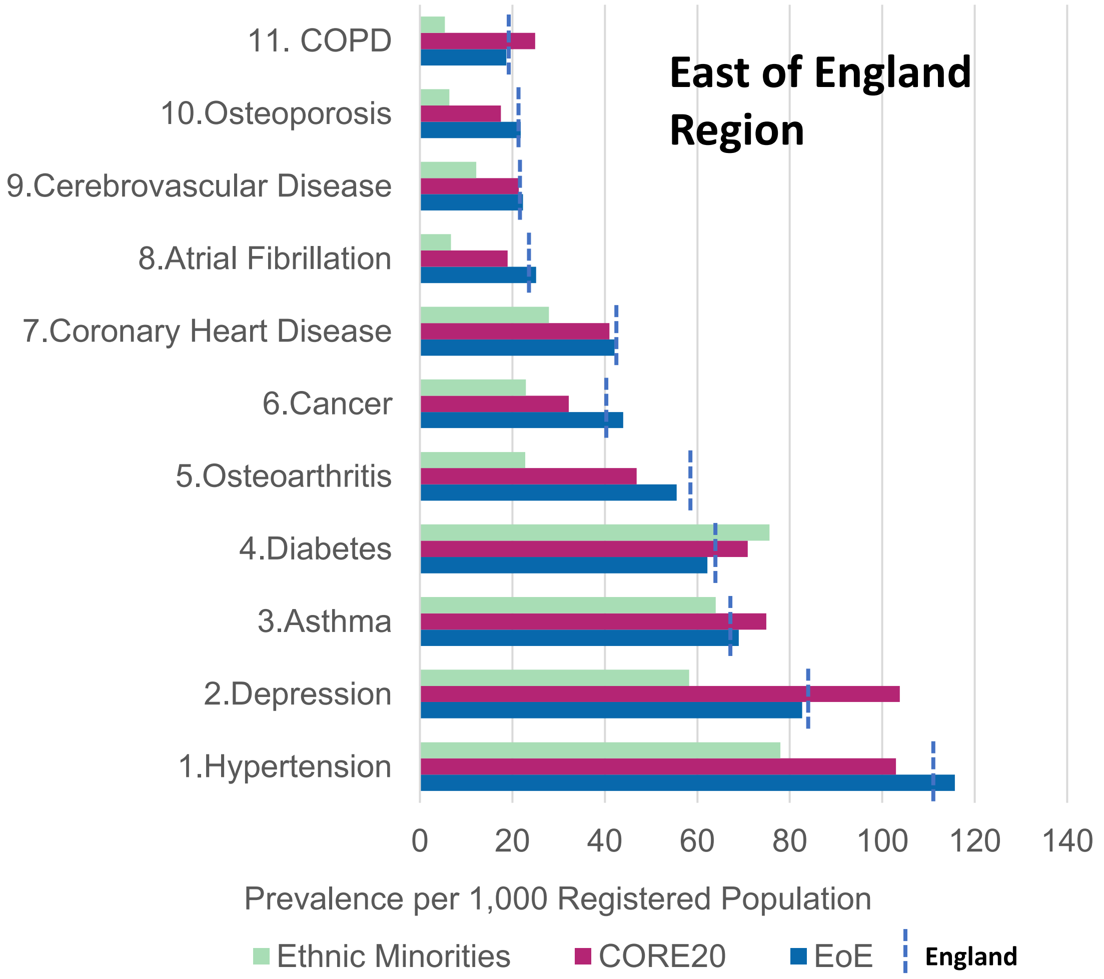
Small Area Deprivation IMD 2019 as Quintiles



Data source: Registered Population Population and Person Insight (model.nhs.uk), English indices of deprivation - GOV.UK (www.gov.uk)

Prevalence of Chronic Conditions*

Highest condition prevalence in East of England registered communities compared to England average (individuals may have multiple conditions) - 2022



- There are estimated to be over five million adults resident within the East of England with at least one chronic condition
- Ethnic minority communities have a higher prevalence of diabetes in the region but lower prevalence of other conditions – possibly due to inequalities in diagnosis or patient registration and notably this is a younger population overall.
- CORE20 communities have a higher prevalence of depression, asthma, diabetes and COPD in the region.
- Overall, East of England has a higher prevalence of hypertension and cancer compared to the England average.
- Asthma is the most prevalent condition for CYP in the region at 32.7 per 1k.
- Older adults have the highest burden of disease and therefore the highest prevalence of chronic conditions is in N&W ICB (35.8% of the population).

*As defined by Papi segmentation Reference Guide - National B2H Segmentation Dataset V3.0_20220930 - Population and Person Insight - FutureNHS Collaboration Platform
Population and Person Insight (model.nhs.uk) Note that Segmentation may underestimate hypertension prevalence compared to QOF

Access and Inequalities: who are the patients that use specialised services in EoE

Overview of NHS East of England Specialised Services Population Health Analysis (2023/24): Access and Inequalities

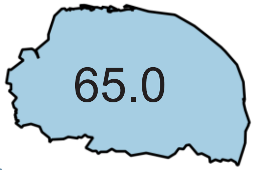
Ref: East of England Specialised Commissioning Inequalities Review 2024

Usage Patterns

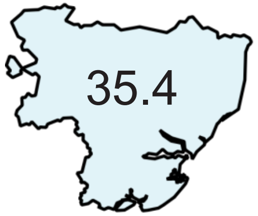
In 2023/24, over 2.8 million EoE NHS patients were treated in hospital. 342,546 (12%) of these EoE patients were treated by Specialised Services

12% Of all NHS patients (342,546)

300K Patients use top 3 service groups:
- 🎗️ Oncology
- 🫀 Cardiovascular [a]
- 🧠 Neurology [b]



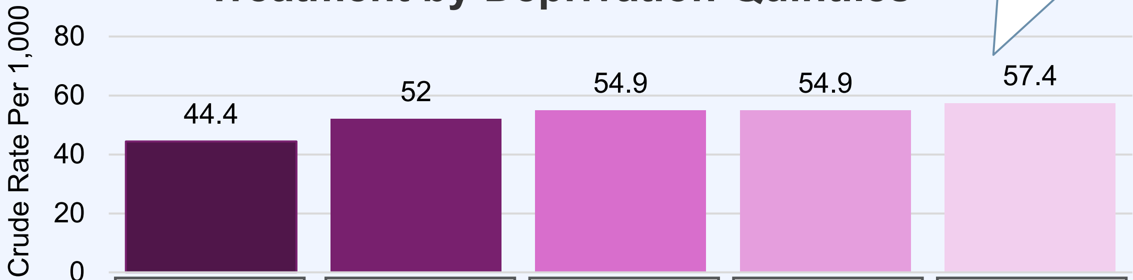
N&W: Highest Use
- Per 1k patients
- 30% of Renal [c]



SNEE: Lowest Use
- Per 1k patients

Treatment by Deprivation Quintiles

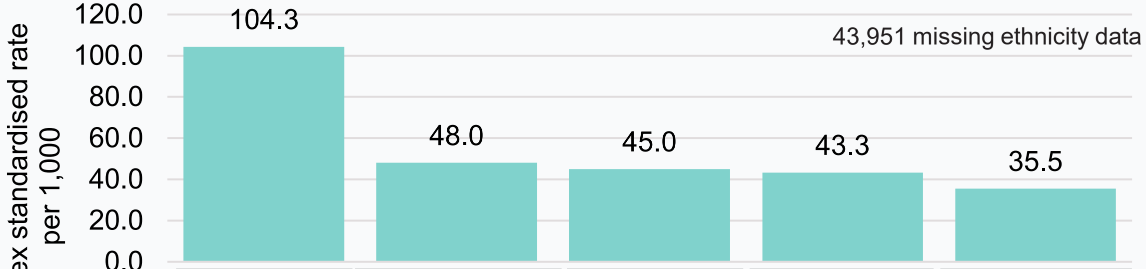
This gradient is seen across service groups except Renal [c]



Patient count	1-Most Deprived	2	3	4	5- Least Deprived
	27,311	55,192	81,543	75,976	15,988

Widest deprivation inequality observed in C&P ICB

Treatment by Ethnicity



Patient count	Other ethnic groups	Black or Black British	White	Mixed	Asian or Asian British
	6,856	7,383	265,888	5,852	12,616

Widest inequality observed in 🎗️ Oncology services

Treatment by Age

👵 75+ years: **131.6 per 1k**

🧑‍💼 25-74 years: **44.5 per 1k**

🧑‍🎓 < 25 years: **58.3 per 1k**

Most likely to use:

25+ years:	< 25 years:
🎗️ Oncology	🧠 Neurology [b]
🫀 Cardiovascular [a]	🩺 Renal [c]

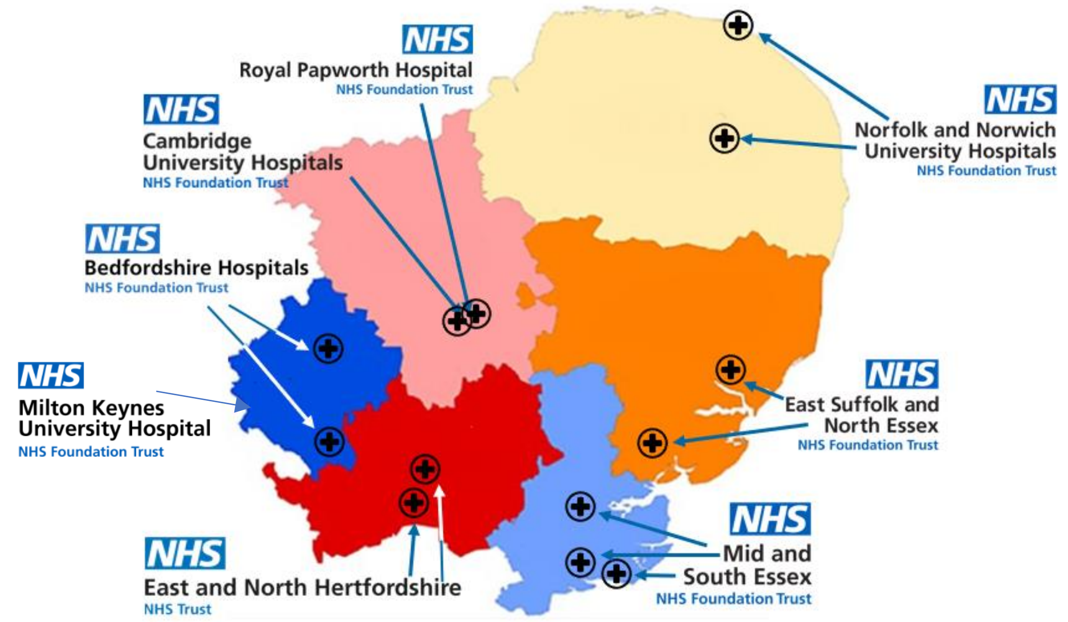
CYP Treatment Rates per 1k:

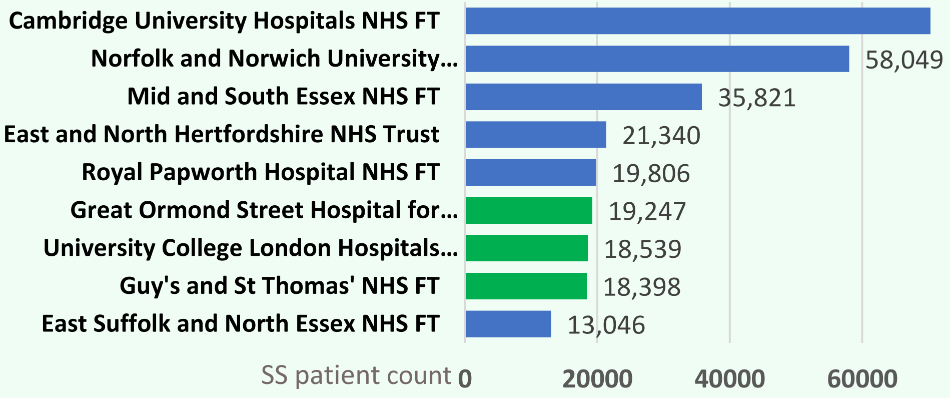
N&W	114.3	C&P	82.1
HWE	53.2	MSE	44.2
BLMK	34.7	SNEE	34.2

[a]Cardiovascular, Cardiothoracics and Respiratory [b]Neurology, Neurosciences, Musculoskeletal, Trauma, Ophthalmology [c]Renal, Gastroenterology, Endocrinology, Metabolic, Hepatology, Maternity

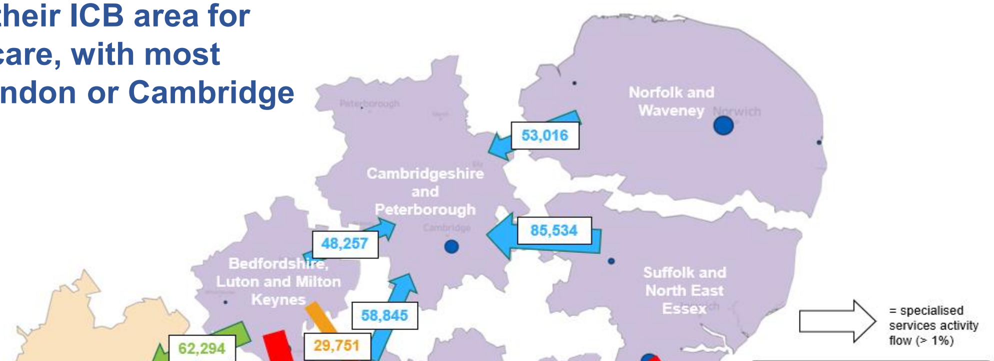
East of England Acute Healthcare Providers

Specialised Services Provider Landscape





In 2022/23, 43% of EoE patients travelled outside their ICB area for their specialised care, with most going to either London or Cambridge



Specialised services patient flows (% of total EoE activity)	
Within ICB	57
London	24
Cambridge and Peterborough	11
Buckinghamshire, Oxfordshire and Berkshire West	3
Other	3
Hertfordshire and West Essex	1

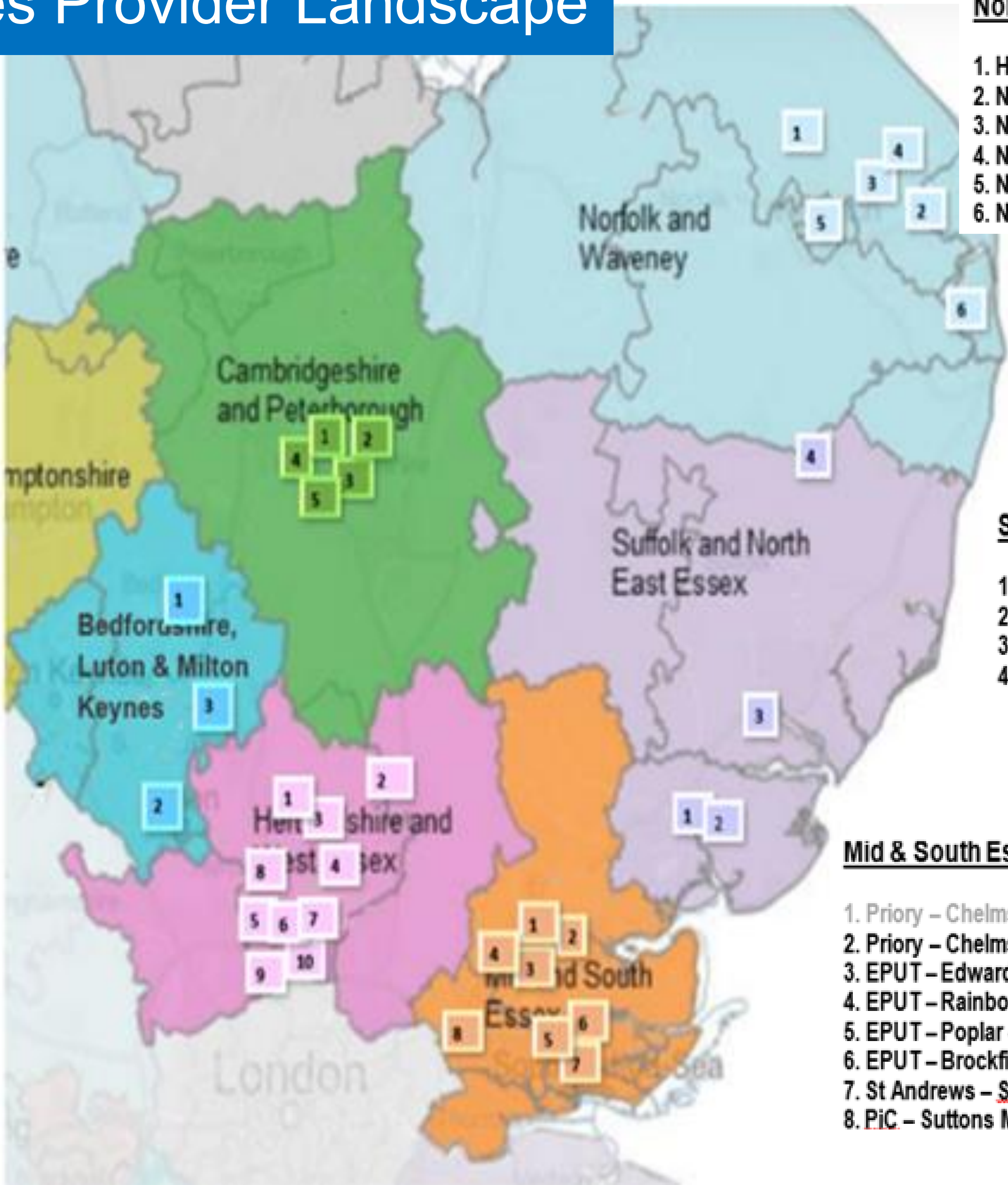
The 2024/25 specialised services split, by ICB, between spend on activity undertaken by providers in EoE region, compared to out of area varies significantly between ICBs :

EoE ICB:	% within EoE Region	% Out of EoE Region
Hertfordshire & West Essex	42.4%	57.6%
Bedfordshire, Luton & Milton Keynes	54.2%	45.8%
Cambridge & Peterborough	89.6%	10.4%
Mid & South Essex	58.3%	41.7%
Suffolk & North East Essex	83.7%	16.3%
Norfolk & Waveney	92.6%	7.7%

Source: SUS data taken from NHS England NCDR ICB Patient Flow Dashboard. Activity comprises inpatient spells and outpatient attendances. Flows less than 1% excluded.

Mental Health and Learning Disability and Autism

Specialised Services Provider Landscape



Norfolk & Waveney

1. HPFT – Broadland Clinic – Adult MSU
2. NSFT – Northside – Adult MSU
3. NSFT – Hellesdon – Adult LSU
4. NSFT – Kingfisher – MBU
5. NHC – Adult ED
6. NSFT – Dragonfly – T4 CYPMH GAU

Cambridgeshire & Peterborough

1. CPFT – GMH – Adult LSU
2. CPFT – Darwin – T4 CYPMH GAU
3. CPFT – Phoenix – T4 CYPMH ED (temp closure)
4. CPFT – Ward S3 – Adult ED
5. CPFT – The Croft – T4 Children & Family Service (NHSE Retained Service)

Bedfordshire, Luton & Milton Keynes

1. EPUT – Woodlea – Adult LSU
2. EPUT – Robin Pinto – Adult LSU
3. ELFT – Evergreen – T4 CYPMH GAU

Hertfordshire & West Essex

1. Cygnet – Stevenage – Adult LSU/MSU
2. PiC – Kneesworth – Adult LSU/MSU
3. HPFT – Beech – Adult LSU
4. HPFT – Eric Shepherd – Adult MSU
5. HPFT – Bowlers Green – Adult LSU
6. HPFT – Thumbswood – MBU
7. HPFT – Forest House – T4 CYPMH GAU
8. HPFT – Rosanne House – OCD/BDD Adult Service (NHSE Retained Service)
9. Elysium – Potters Bar Clinic – T4 CYPMH LSU
10. Elysium – Rhodes Wood – T4 CYPMH ED

Suffolk & North East Essex

1. EPUT – St Aubyn – T4 CYPMH GAU
2. EPUT – St Aubyn – T4 CYPMH PICU
3. NSFT – Foxhall House – Adult LSU
4. PIC – Burston House – Adult LSU

Mid & South Essex

1. Priory – Chelmsford – T4 CYPMH GAU (temp closure)
2. Priory – Chelmsford – Adult ED
3. EPUT – Edward House – Adult LSU
4. EPUT – Rainbow – MBU
5. EPUT – Poplar – T4 CYPMH GAU
6. EPUT – Brockfield – Adult LSU/MSU
7. St Andrews – StA Essex – Adult LSU
8. PiC – Suttons Manor – Adult LSU

Provider Collaborative Lead Provider	Service Line Responsibility
Hertfordshire Partnership NHS FT	Children and Young People's MH (CAMHS T4)
	Perinatal Mother and Baby Units
Cambridgeshire and Peterborough NHS FT	Adult Eating Disorder
Essex Partnership NHS FT	Adult Secure

Landscape on Finance and Productivity

Financial Backdrop

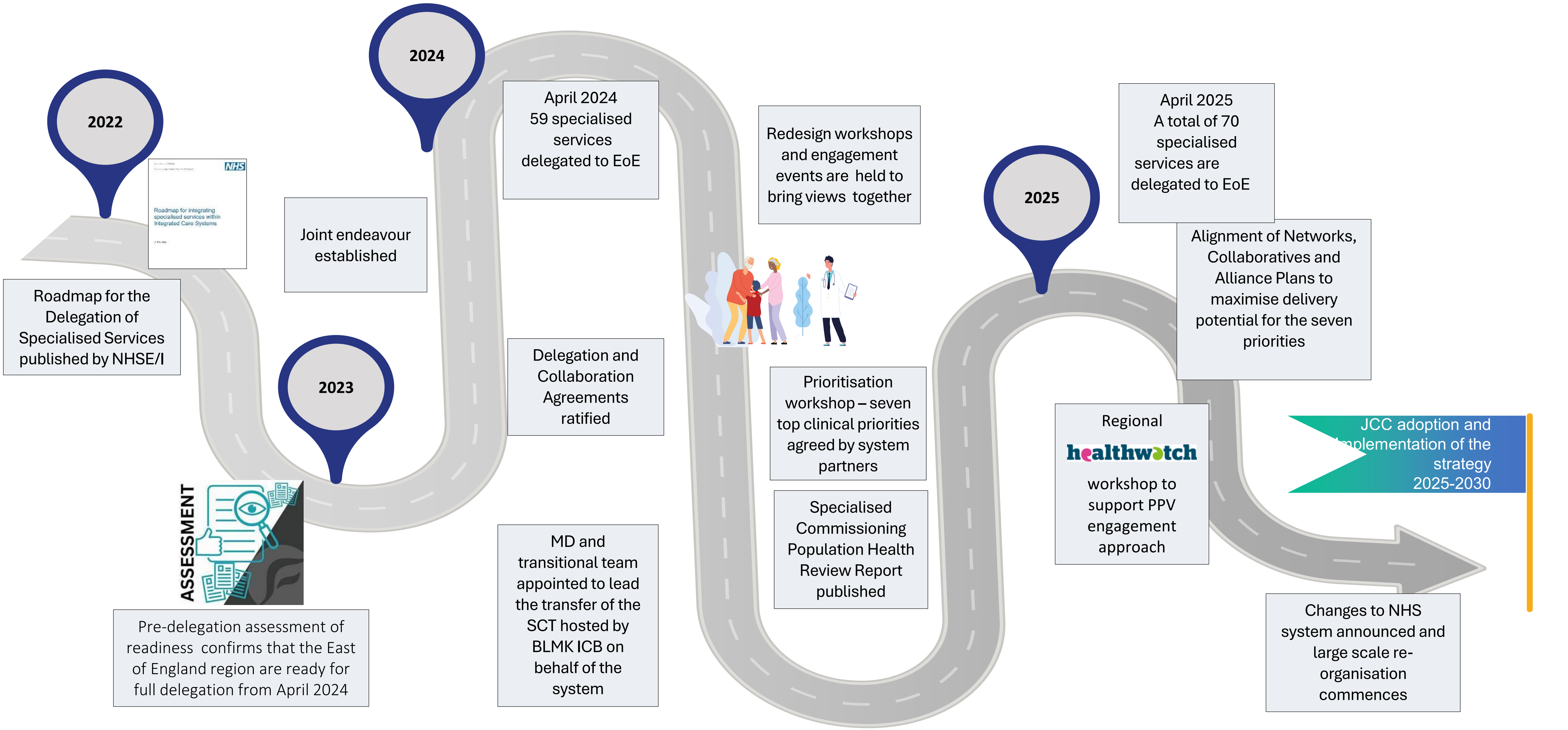
- The current East of England ICBs are experiencing significant financial challenges as are East of England providers.
- The JCC's Commissioning Framework identifies the following approaches to financial management:
  - Risk sharing agreements, with pooled and delegated budgets to smooth system pressures;
  - Baselines mapping of activity and costs;
  - Continuous improvement of financial data; and contracting processes which enable the exchange of financial and activity data to improve insight into overall flow of funds and alignment with commissioner priorities
- The creation of three new ICBs in the East of England will necessitate significant financial planning work including re assignment of contracts within and outside the East of England, subject to any reorganisation of commissioning infrastructure.
- This will add impetus to the requirement to seek a productivity premium for the system as a whole by implementing more efficient ways of working and transformation of pathways through the creation of a shared programme between commissioners and providers, extending over the period of the strategy.

Productivity Backdrop

- The focus on improving productivity and efficiency is around how we create headroom to reinvest in front line care, innovation and deliver the commitments in the 10-year plan.
- The NHS is facing an unprecedented requirement to improve productivity, with the 2025/26 National Planning Guidance setting out an expectation that acute providers will double their second half of 2024 productivity achievements of 2%, to 4%
- A key part of the JCC's Commissioning Framework is the delivery of *improved value* through a systems-based ambition for productivity improvement defined as improved value for funds invested and not simply activity growth and achieved by testing existing contracts and applying new commissioning approaches
- There are challenges in applying an end-to-end pathway approach to productivity improvement given the disparity in data flows and availability of detailed activity and costing information in different provider sectors and the problematic identification of specialised activity – a principal focus for the Review Phase of the 3Rs – Review, Reimagine, Realise
- This does not negate the need to apply *existing productivity measures* within activity charged as specialised and this will need to be a prominent component of the Strategy's Review Phase. This is explored further in Appendix One.

Our Strategy

Development of the Strategy for the Delegated Specialised Services



Achieving Our Strategic Ambition

Our strategic ambition is - **Optimising specialised services for everyone who lives in East of England, integrating specialised services within the whole pathway of care; driving continuous improvement in quality and outcomes that matter most to patients; and working together to enable flexibility in how different models can be adapted to local needs**

- We aim fully to integrate the delegated specialised services across the East of England. By this we mean joining up pathways, reducing fragmentation and variation and delivering improvement in patient outcomes and experiences. We will do this by earlier identification of need, faster delivery of care and provision of more care close to home.
- Our approach to change and transformation is to review and re-imagine specialised services pathways, considering health inequalities and barriers to access and applying the Commissioning Framework across pathways, realising the delegation opportunity.
- Through collaboration with our partners in ICSs, Networks, Alliances, Collaboratives and patients we will use evidence to identify priority pathways for review and we will systematically undertake deep dives to identify opportunities to improve productivity, performance, equity, outcomes and experience.
- We recognise the importance of collaborating to achieve change, both across the East of England and with commissioners and providers in other Regions.
- Understanding what is important to our users, carers and providers is a priority for us and we will achieve this by listening, sharing our analysis transparently and assessing the implications, risks and benefits of re-imagined pathways.

Our Values – to ensure we create a system culture and the conditions required for success

- **Respect** – we will foster trust, build understanding and provide solid foundations for developing robust relationships
- **Integrity** – we will act ethically, be honest and adhere consistently to professional principles
- **Excellence** – we will consistently strive to meet the highest standards
- **Courage** - we will do the right thing for local people, addressing difficult issues and risks and have the strength and vision to take difficult decisions, innovate and embrace new ways of working

Core Principles - we have agreed four core principles that provide a framework to keep us focussed :

- To co-produce with our stakeholder partners
- To support bold and brave clinical leadership
- To collaborate to solve the system's most difficult problems led by credible and effective system leadership
- To utilise evidence-based healthcare including population health intelligence

Our Strategic Goals

The EoE Specialised Services Commissioning Strategy has put four highly complementary and mutually reinforcing strategic goals at the heart of transformation to deliver a shared ambition:

1. Deliver Value Based Healthcare

	Focus on the Whole Pathway	Identify and Tackle Clinically Unwarranted Variation	Compare Models of Delivery to Obtain Better Value
What we want to achieve	Maximise the outcomes from our finite resources by considering investment *in all parts of the pathway*	Reduce *clinically unwarranted variation* and redesign to produce better outcomes for the same investment	Achieve the *optimal scale and configuration* in specialised services to improve productivity and value
Actions we will take	As part of the Review Phase, we will use intelligence on the relative costs and productivity of different pathways and models of delivery As part of the Re-design Phase, we will identify the scope to move care activities from specialised care to lower complexity settings and to shift resources to secondary prevention As part of applying the Commissioning Framework we will explore contracting models such as Year of Care, Lead Provider or Gain Share which will enable reduced waste, improved incentivisation or streamlining of care	As part of the Review Phase, we will access resources such as Model Health System, GIRFT and data on comparative prescribing levels of drugs and devices and assess the financial implications of variation and the potential to improve outcomes As part of the Re-design Phase, we will work with clinical leaders to build improved pathways where variation is clinically based or reflects appropriateness to the needs of different communities, for example to tackle inequalities	In the Review and Redesign Phases we will work with providers and Collaboratives (including out of area stakeholders) to identify scope for integrating and consolidating sites, teams, or patient lists As part of effective contracting, we will maintain a flow of information to assess relative operational productivity such as throughput in beds and theatres
Enablers for success	**Business Intelligence** – connected data used for informing system efficiencies, service innovations, and enabling adaption of services	**Workforce** – investing in clinical leaders; building the right teams to deliver new ways of working – e.g. one team across multiple sites, multi-disciplinary team working	**Partnerships** – creating effective partnerships across providers that support efficiencies and improve the patient pathway; building alliances with out of area commissioners and providers to facilitate change

Our Strategic Goals

The EoE Specialised Services Commissioning Strategy has put four highly complementary and mutually reinforcing strategic goals at the heart of transformation to deliver a shared ambition:

2. Improve Quality and Outcomes

	Test and Measure Quality of Care	Test and Measure Patient Outcomes	Test and Measure Patient Experience
What we want to achieve	Deliver measurable improvements in quality of care with a focus on clinical safety and effectiveness and those aspects of quality that patients and their carers have told us mean most to them	Deliver measurable improvements in patient outcomes with a focus on equity	Eliminate unacceptable waits and achieve improvements in those aspects of experience that patients and their carers have told us they value most
Actions we will take	As part of the Re-design and Realise phases, work with clinicians and patient groups to identify, test and agree quality measures to be included in our pathways We will integrate quality measures into our contracting models in accordance with the Commissioning Framework and systematically measure, monitor and evaluate the quality of care being delivered to our patients, collaborating with out of area commissioners to ensure we have a satisfactory flow of information about all services our patients use, regardless of location	We will analyse intelligence on patient outcomes in the services we commission, reporting and sharing them widely in pursuit of improvement initiatives, particularly in the Re-design phase of our approach We will seek out evidence of variation in outcomes based on patient characteristics such as ethnicity or location and test that evidence with clinical leaders, providers, patients and carers to eliminate unwarranted variation	We will reduce waiting times and improve pathways by : • the application of intelligence from sources such as GIRFT • optimising delivery models such as Advice and Guidance which achieve prompter patient treatment and better value, understanding variation in their take up and the reasons for this • collaboration with providers to support innovation in operational delivery including digital delivery and patient led models of care
Enablers for success	**Clinical Leadership –** to adopt meaningful measures of quality of care **Rigorous contracting** – with quality monitoring fully integrated into the contracting cycle	**Public health and Business Intelligence** – informing dialogue about variation in outcomes and how that can be tackled and applying a population health management approach **Contracting Focussed on Outcomes**	**Digital and Data** – adopting new models of care that enable clinicians and patients to experience improvements **Collaboration with Patients and Carers –** using their expertise to shorten and eliminate pathway components

Our Strategic Goals

The EoE Specialised Services Commissioning Strategy has put four highly complementary and mutually reinforcing strategic goals at the heart of transformation to deliver a shared ambition:

3. Ensure Health Equity and Access

	Achieve Equitable Improvement in Outcomes	Eliminate Unwarranted Variation in Access to Services
What we want to achieve	Elimination of unfair and avoidable differences in patient outcomes, ensuring services are responsive to different population needs	Service design and delivery that is sensitive to and appropriate for the different people accessing our services
Actions we will take	We will use our data and intelligence to focus on people at risk of poorer health outcomes because of their circumstances or characteristics We will work with stakeholders to understand the drivers of this variation and integrate this into our revision of pathways, incorporating user experience, addressing the cultural competence of care delivery and barriers to access such as digital inequalities and monitor and measure the results	We will use models of patient engagement that have been co-produced with the community concerned, to identify aspects of planning, communication and operational delivery that create barriers and difficulties for patients We will identify improvements and build these into the Redesign and Realise phases so that they are implemented, measured, monitored and reported
Enablers for success	**Bold and Brave Clinical Leadership** to lead the difficult dialogue about the causes of inequity **Public Health Intelligence**	**Co production and Collaboration** with our different communities **Transparency and Humility** as part of the culture for building equity

Our Strategic Goals

The EoE Specialised Services Commissioning Strategy has put four highly complementary and mutually reinforcing strategic goals at the heart of transformation to deliver a shared ambition:

4. Bring Care Closer to Home

	Optimise Repatriation to Shift Care Locally	Reduce the Travel Burden on Patients and Families
What we want to achieve	A configuration of services such that they are delivered at distance only where there are current compelling reasons to do so and not because of historical precedent	Reduce this burden through a combination of repatriation and innovation in service delivery where the potential for technological advance is realised
Actions we will take	In the Review Phase we will test the rationale for service location and as part of Reimagine and Realise phases we will work with partners to assess the estate, workforce, equity, training and research implications of more care being delivered locally and of repatriation subsequent to tertiary treatment, with productivity benefits through reduced length of stay As part of the Realise Phase and in accordance with the Commissioning Framework we will monitor and evaluate the outcomes of such shifts	In the Review and Reimagine Phases we will identify the travel burden on patients and families, including the unintended consequences for access to and outcomes from, treatment, for example through incomplete treatment plans We will horizon scan and work with Collaboratives and providers to explore local models of alternative virtual delivery that will reduce the travel burden and improve patient access. As part of this we will carefully monitor for unintended impact on our goal of improved equity
Enablers for success	**Partnerships :** to gain a comprehensive view of costs, risk and benefits and plan the workforce **Bold and Brave Clinical Leadership**: to drive change and overcome inertia	**Investment in Digital Solutions –** with proven financial and patient benefits **Workforce Re-engineering** - to staff innovative digital solutions safely and productively

Our Clinical Priorities

Identification of Strategic Clinical Priorities

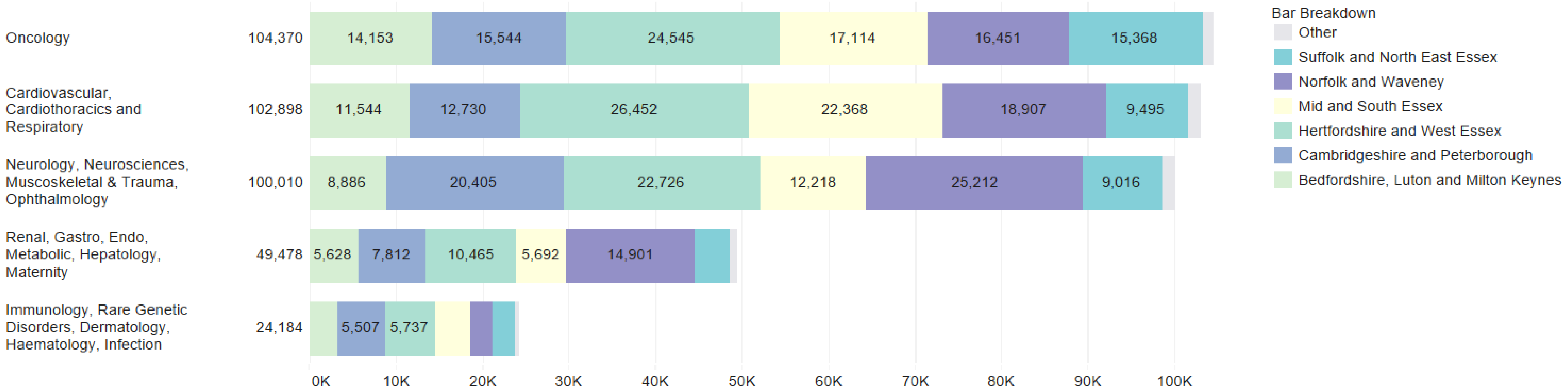
The strategy is based on achieving key goals in **seven clinical priority areas.** This does not discount the **important existing programmes** and Networks delivering on current national and regional programme goals, which is seen as continuous improvement of current business as usual.

Activity by Service Line Groups broken down by ICB are described below. In November 2024 the JCC and the Specialised Services Provider Collaborative (SPC) hosted a Clinical Engagement Workshop to review priorities, at which **Cancer and Cardiac/CVD** were identified as key immediate clinical priority areas.

The remaining clinical priority areas were identified following a review of national, regional and ICB plans and priorities, worked through using the health inequalities population health analysis in 2024 and with stakeholders and partners in a series of Strategic Workshops in April, September and November 2024. These were **Renal, Neonatal and Paediatrics, Neurology/ Neurosciences/Neurosurgery, Trauma and Rehabilitation and Mental Health**

For each of the four strategic goals, opportunities are identified in each clinical priority area in the next slide, followed by a detailed assessment of each clinical priority area.

Number of SS Patients by Service Line Group, all EoE



Cancer : Context

East of England Cancer Alliance

Cancer makes up a large component of **Specialised Commissioning** activity. **Specialised Commissioning** is a key commissioner for **cancer** services.

There are great opportunities to work together between Specialised Commissioning and the Cancer Alliance, which brings together key partners working in cancer services across the East of England to improve cancer pathways and outcomes for patients.

- We have seen a large rise in **cancer referrals** in recent years, from 22,000 patients pre-pandemic to more than 30,000 patients now referred for urgent cancer checks every month in the East of England. Around 94% of patients referred for urgent cancer checks have cancer ruled out.
- 90% of 31-day first **cancer treatments** for patients living in the East of England are delivered in EoE NHS trusts. Around 20% of first treatments are undertaken in a different ICB to the residence of the patient.
  - Tertiary referral and inter-provider transfer management are fundamental in providing patients with consistent cancer care.
  - Oncology services have been challenged, with East of England radiotherapy median waiting times the highest in the country.
- **Early stage:** In recent years, we have seen the highest ever numbers of early stage cancers diagnosed in the East of England.
- **Survival outcomes:** More people are surviving their cancer than ever before – the East of England one-, five- and 10-year survival rates are similar to the national average. Cancer survival is lowest in pancreatic, liver and brain cancers.

Opportunities with Delegation:

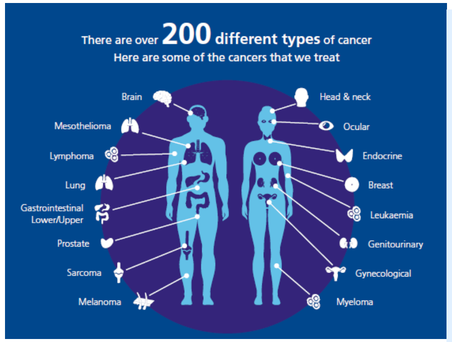
- **Proactively collaborative and aligned approaches across the East of England** in PHM, pathway transformation, and reducing unwarranted variation.
- **Partnership working** with ICBs and cancer clinical networks to support the development of new models of care in alignment with the 10-year plan, National Cancer Plan and acute collaboratives, group models and neighbourhoods.
- **Faster Diagnosis:** Improvement in cancer waiting times across the three standards: Faster Diagnosis Standard, 31-day decision to treat to treatment and 62-day urgent referral to first treatment, including urology, gynae, breast and skin.
- **Local Early Diagnosis:** Increased support for the early detection of cancer in primary care via the introduction of more diagnostic pathways in CDCs/Neighbourhood Centres. Increased support for PHM approaches to maximise access to cancer screening programmes. Awareness raising with GPs and the public about signs and symptoms.
- **Treatment and Care:**
  - **Reduce unwarranted variation** in diagnostics and treatments, including for CTYA.
  - **Explore virtual/AI enabled community models** to improve access to supportive care in rural areas.
  - **Living with and beyond cancer**, PSFU, PIFU and remote monitoring.
  - Horizon scanning for new/**innovative diagnostic testing and treatments** to support improved outcomes and supportive care for patients.
- **Cross-cutting:**
  - Workforce enabling programme – ACCEND and OPTICS. Work in partnership with providers, regional clinical networks, WT&E and deaneries to implement a strategy for a more sustainable specialist cancer workforce. Review medical staffing for oncology across the region.
  - Experience of care and engagement. Tangible support and leadership of co-production of cancer transformation with people with a lived experience of cancer.
  - Data-driven demand, capacity and productivity initiatives to support rising demand.

The cancer pathway

Prevention	Access Route	First Triage	Diagnostics	Diagnosis/ Exclusion	Treatments	Follow Up/ End of Life	Survivorship	Outcomes

Cancer: Priority One Children,Teenagers and Young P

East of England Cancer Alliance



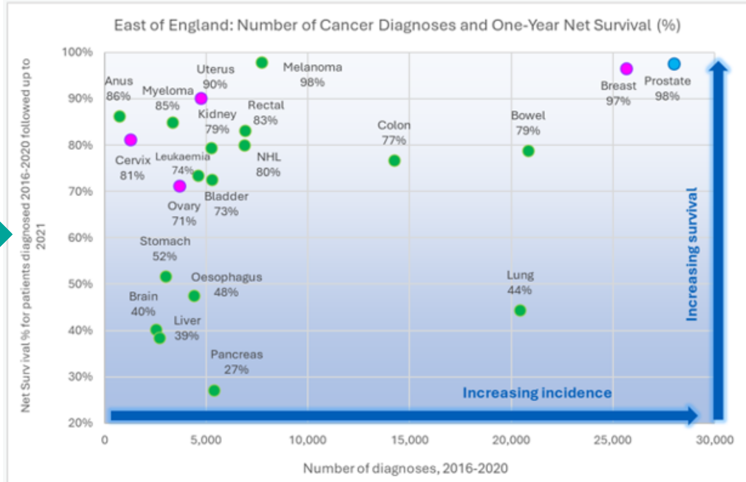
There are 3 current priorities:

Cancer

1. Children, teenagers and young people (CTYA)
2. The lung cancer pathway
3. Radiotherapy treatment

Around 60% of people survive their cancer diagnosis for one year or more

Diagnostics and treatments depend on the tumour site, stage diagnosed and the patient



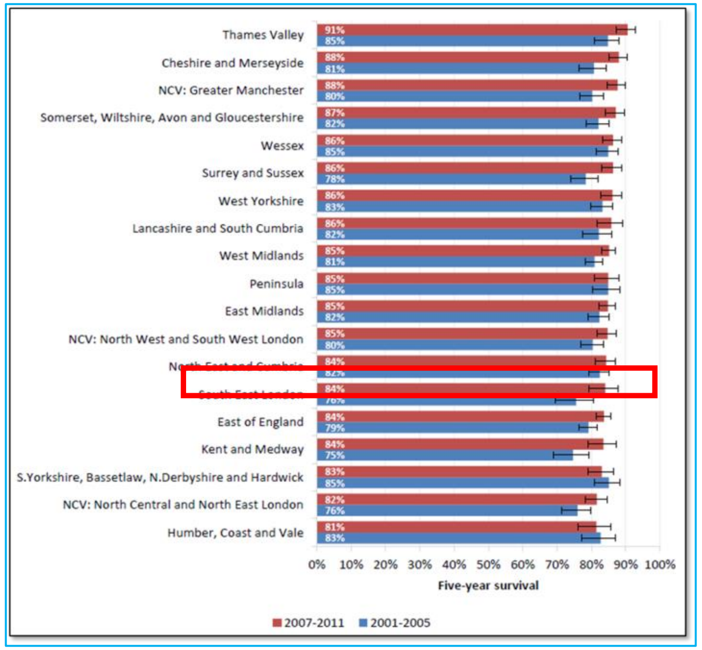
Priority 1: CTYA

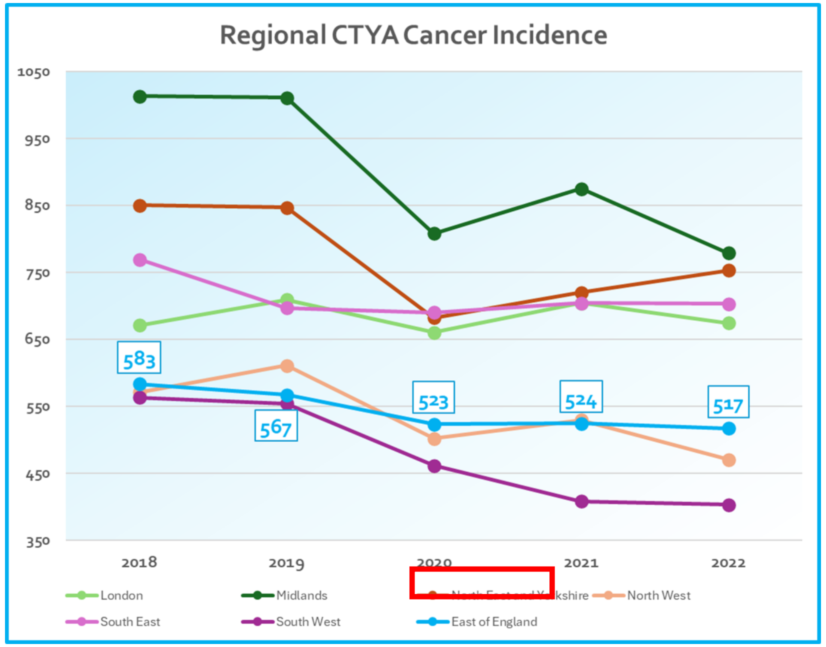
We have some of the lowest survival rates; working together we can identify variation and support cancer care for young people. Children, teenagers and young adults require a focus to ensure they are receiving optimal care to improve their outcomes and experience.

12% of all cancer diagnoses in children, teenagers and young adults in England in 2022 were in the **East of England**, with the EoE population making up around 11% of the population in England.

28% of CTYA cancers diagnosed were **haematological** cancers and **19% brain cancers** in the East of England in 2022 (similar to the proportion seen nationally, 32% haematological and 17% brain cancers).

In the **East of England five-year survival** improved **by 5 % points to 84%** in 2007-2011 compared to 2001-2005. However, at a Cancer Alliance level **survival in the East of England is the 5th lowest nationally**.





Cancer: Priority Two Lung Cancer

Priority 2: Lung cancer

Lung cancer is the fourth most commonly diagnosed cancer and the leading cause of cancer mortality; often diagnosed in emergency settings and at a late stage. By understanding variation in access, treatment modalities and patient flows, we can help to improve earlier detection and survival outcomes for patients in the East of England.

Emergency diagnoses are high for lung cancer

- 30% of patients with a lung cancer were diagnosed on an Emergency Presentation (EP) pathway in 2024.
- At trust level, between 20% to 42% of patients are diagnosed through an EP with the highest rates seen in Milton Keynes (42%), Bedfordshire (40%), West Suffolk (39%) and North West Anglia (37%). *For all tumour sites combined, 17% of patients are diagnosed through the EP route in the EoE.*

Lung cancer screening is leading to more early stage diagnoses

- 3% of patients with a lung cancer were diagnosed through the Screening route in 2024, an increase from previous years (1% since 2021).
- 39% of lung cancers in the East of England in 2024 were diagnosed at an early stage 40% in England.
- Early stage diagnosis is greatest in lung cancers diagnosed through screening (circa 63% are early stage) and lowest in diagnoses through an EP (22% diagnosed at an early stage).
- **A knock-on effect is that more patients may be eligible for curative surgery, which impacts on local treatment capacity.**

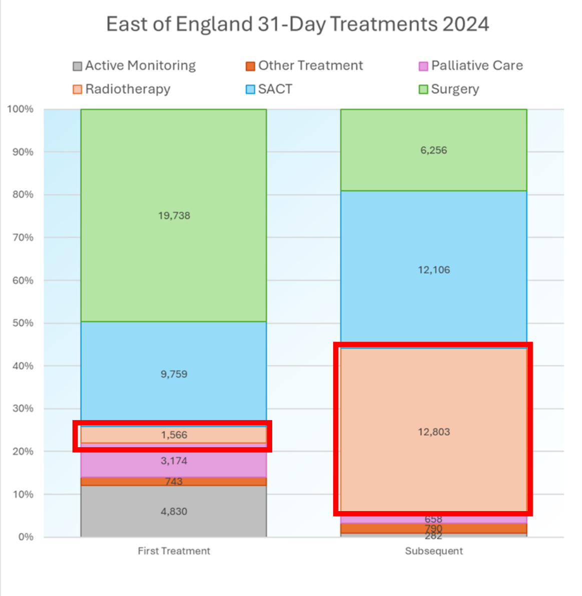
Priority 3: Radiotherapy treatment

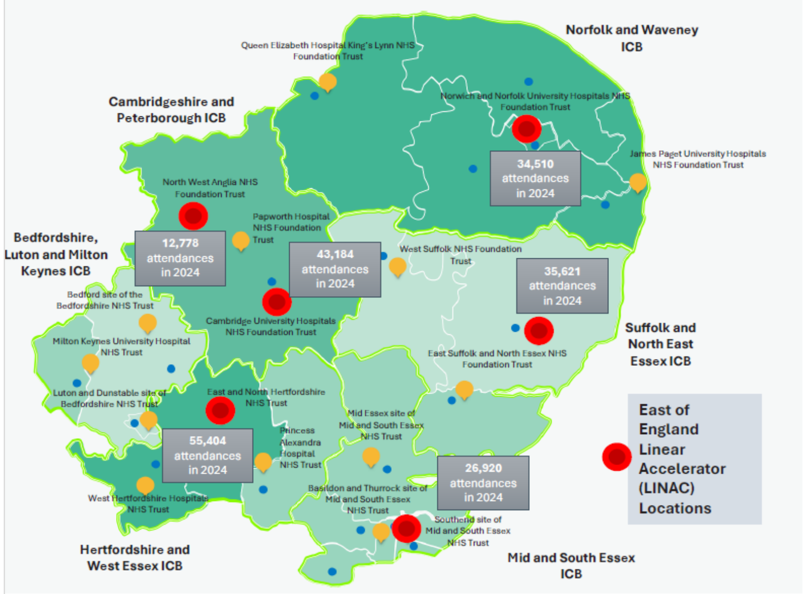
We have great potential to work collaboratively with the RT ODN, Cancer Alliance, NHSE Region, GIRFT and oncology staff to improve radiotherapy services within the East of England.

Waiting times for radiotherapy treatment in the East of England have been the longest in the country

We have six main locations delivering radiotherapy in the East of England. Radiotherapy episodes appear fairly stable with some increases over time since 2018.

- Around 5% of first treatments recorded in CWT are radiotherapy and 40% of subsequent treatments are for radiotherapy.
- Around 79% of patients receive radiotherapy treatment within 31 days in East of England trusts, in Oct-Dec 2024.
- The East of England Cancer Alliance had the longest median waiting time for radiotherapy in the country – 26 days from decision to treat to treatment in Oct-Dec 2024.





Cardiac and Cardio-Vascular Disease: Context

Cardio-vascular disease is among the leading causes of disability and mortality – more than 7.6 million people in the UK live with CVD, which **causes around a quarter of all premature deaths** (under 75 years) each year.

Access to timely diagnostics is a priority for the East of England – the region currently have **the longest waiting times for echo across the country** with 18,172 (Dec 2024) echos outstanding.

The East of England has areas of high elderly population and there is an estimated Heart Failure **detection gap of 21,363** (Dec 2024), with most people being diagnosed in acute admission.

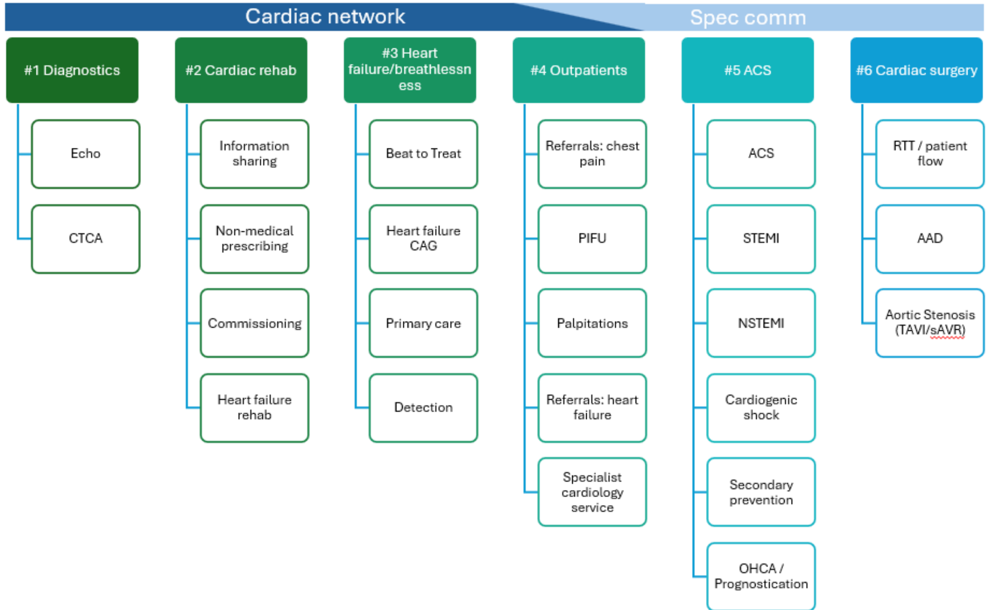
The region also have an average **readmission rate of 24%** (Dec 2024) which if not addressed along with length of stay in heart failure there will be a total cost increase of 8.3% with an increase in bed days of 38.5% and a rise in admissions by 16.7% by 2029.

Challenges and System Considerations:

- Changes to NHSE, DHSC and ICBs
- Workforce and resource concerns (vacancy freezes, pilots not securing sustainable funding).
- Need for collaboration with systems to deliver action plan
- Desire to innovate, however pump prime funding not sustainable
- Lack of access to diagnostics – echo and CTCA
- Plenty of surgeons but not enough staff or resource to man theatres and ICU to match
- Complex geographical footprint to ensure access to spec comm services are equitable for all
- Desire to have more same day admissions to improve patient flow and reduce bed days, however infrastructure prevents this
- Spec comm services meeting minimum requirements, compliance numbers and processes

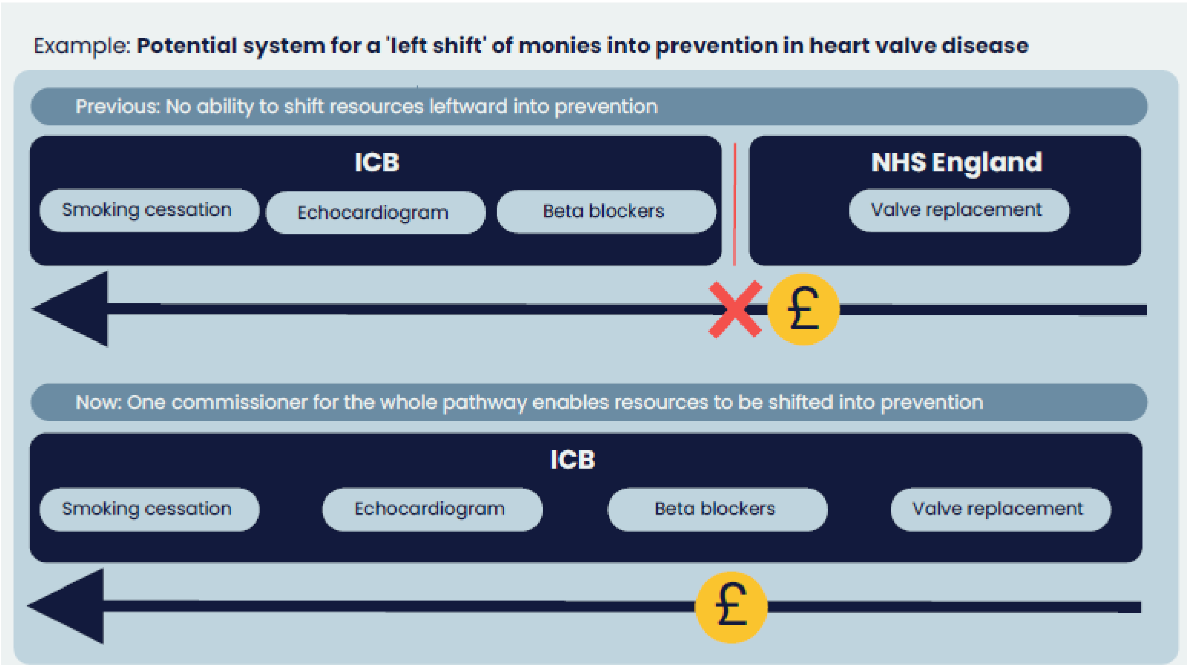
The Delivery Network collaborates across the regional geography and across all elements of the pathway

Cardiac Network programmes



Cardiac and Cardio-Vascular Disease: Key Themes

- GIRFT recommendations for all ICBs in region cite the need for increased access to echo and a move from invasive angiography to Computerised Tomography Coronary Angiography (CTCA), and a call for more Transcatheter Aortic Valve Implantation (TAVI) interventions will require increased capacity.
- Key themes across all 6 systems were:
    1. Cath Lab activity efficiencies
    2. Diagnostic access
    3. Workforce utilisation
    4. Outpatients and waiting lists
- Currently Acute Coronary Syndrome emergency treatment is increasing - for a variety of reasons spanning an ageing population and longer elective waiting times.
- Call/door to balloon times are challenging to maintain at a high standard.
- NSTEMI treatment within 3 days is a challenge often due to patient pathway blocks including difficult geography across the region, coordination across EEAST and Primary Percutaneous Coronary Intervention provision.
- Currently diagnostics, interventional and specialist cardiac surgery demand is increasing (particularly urgent).
- Longer Referral to Diagnosis times via echo and CTCA and longer Referral to Treatment times for elective & urgent referrals.
- There is variation across the region for patient pathways, extended Length of stay impacting patient outcomes and bed availability and there are workforce capacity strains.



NHS Confederation; 2025; A vision for specialised commissioning: lessons for future delegation

Opportunities/priorities with Delegation:

- Support **expansion of Mechanical Thrombectomy services** to increase the number of patients being treated with thrombectomy to the national target of 8% by March 2026
- Improve prevention activity and early detection and interventions
- Improve access to remote monitoring and waiting well initiatives
- **Pathway work** - move from invasive angiography to Computerised Tomography Coronary Angiography (CTCA),
- Reduce diagnostic waits
- Right size Cath Lab capacity and improve productivity
- Improve access and consistency of prehab and rehab services

Cardiac and Cardio-Vascular Disease: Actions

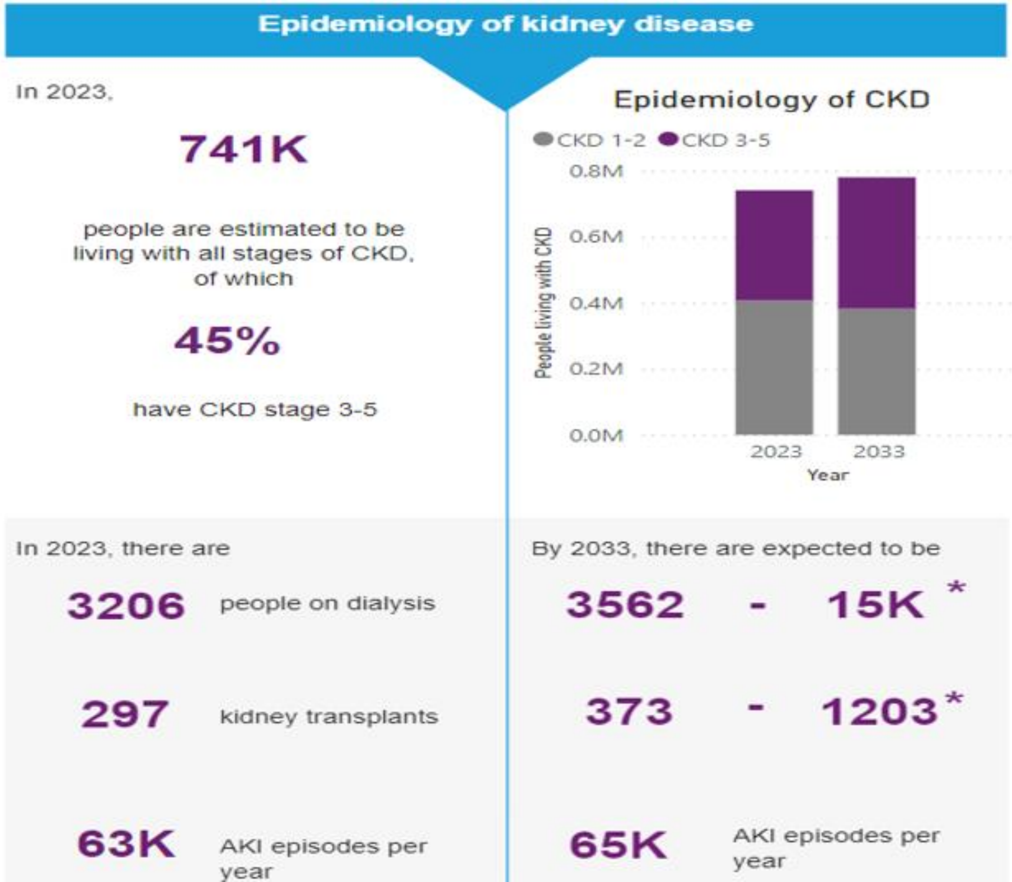
Acute Coronary Syndrome Plan			
Rationale/ challenge	**Aims/Metrics**	**Outcomes**	**Activity/milestone**
Currently ACS emergency treatment is increasing for a variety of reasons spanning an ageing population and longer elective waiting times. Currently call and door to balloon times are challenging to maintain a high standard, and NSTEMI treatment within 3 days is a challenge – often due to patient pathway blockers; difficult geography across the region; coordination across EEAST and PPCI provision.	Improve STEMI call to balloon <120 mins from 30% to 35% Improve STEMI door to balloon <60 mins from 77% to 87% NSTEMI treated in 72 hours from 50% to 55%	Reduced call to balloon times Standardised workup criteria and Streamline patient flows Improved communications across EEAST Patients discharged faster reducing LOS with effective follow up procedures	ACS – standardised workup criteria NSTEMI – ATLAS pathway NSTEMI - PPCI protocol socialised with PCI matrons and EEAST Cath lab mapping Cardiogenic Shock– implement better cardiogenic shock standardised treatment algorithms Prognostication – Map access of prognostication tools across region

Cardiac Surgery Plan			
Rationale/ challenge	**Aims/Metrics**	**Outcomes**	**Activity/milestone**
Currently diagnostics, interventional and specialist cardiac surgery demand is increasing (particularly urgent); longer RTD times via echo and CTCA; longer RTT times for elective & urgent referrals; varied regional patient pathways; extended LOS affecting bed availability and workforce capacity strains.	Increase RTT in <18 weeks from 66% to 72% and ensure it does not fall below 66%	Reduced elective and urgent waiting times Standardised workup criteria Increased surgical activity Reduced RTD time Increased access to diagnostics e.g. TAVI CT Prioritisation of patients SDA increased Reduced LOS and patients discharged faster	Implement the surgery think tank recommendations P2/P3 workup criteria Patient flow - MSE Watch pathway pilot Patient flow – Same Day Admission clinic pilot at RPH TAVI data dashboard Aortic stenosis protocol MSE aortic stenosis pilot TAVI CTCA pilots – DGH

Renal: Context

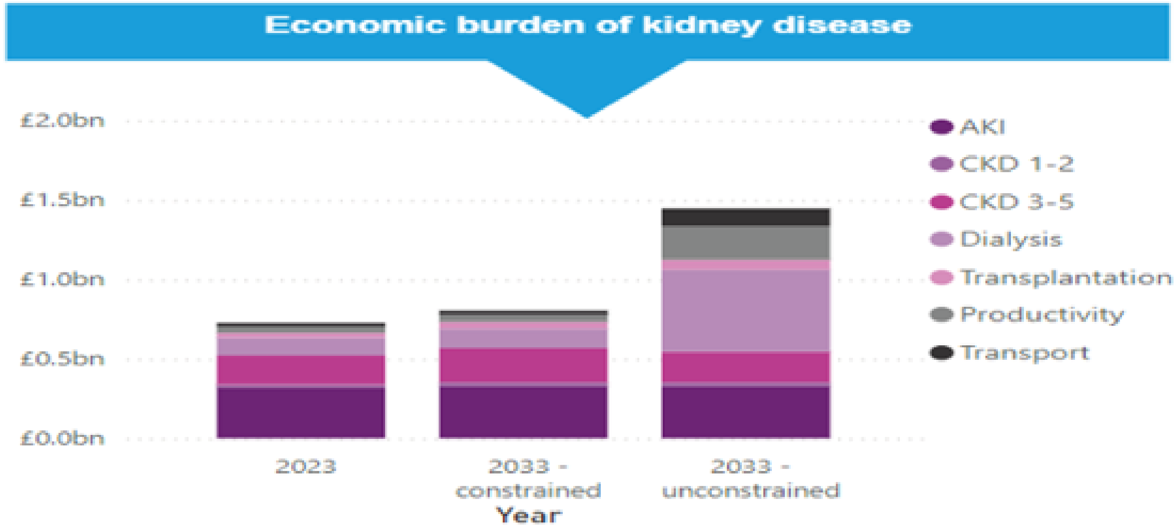
Kidney disease is projected to be the **fifth leading cause of premature deaths global by 2040**, with people living longer and having more comorbidities, the demand for dialysis and transplants is rising and exceeding capacity. Patients from ethnic minority groups are particularly at risk. The system is at full capacity for in-centre dialysis, requiring immediate action and a long-term strategy to optimise care.

East of England

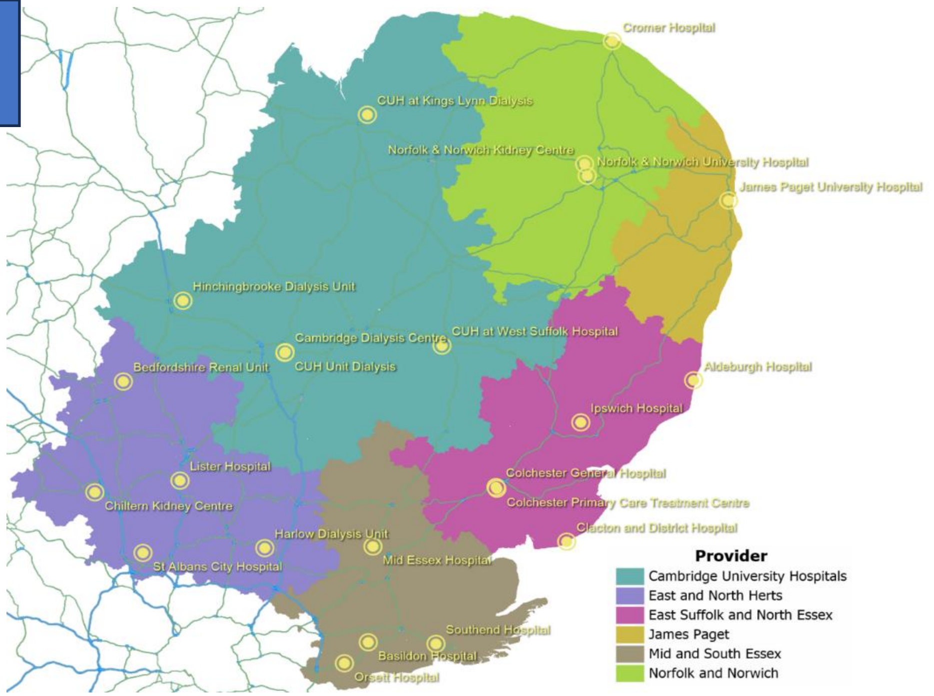


Current and future economic burden of kidney disease

- More than 3 million people live with moderate to severe chronic kidney disease (CKD) (stages 3-5). In 2023, the total cost of kidney disease to the UK economy is estimated at £7.0 billion including £6.4 billion in direct costs to the NHS.
- The £7.0 billion estimate also includes £372 million in productivity loss for people living with end-stage kidney disease and those who support them, in addition to £225 million of transport costs for patients receiving dialysis.
- To stay alive, people with kidney failure either need dialysis (regular treatment to filter waste products from the blood) or a kidney transplant. In 2022, more than 70,000 adults in the UK were receiving these treatments, including more than 30,000 on dialysis.
- The risk of kidney failure varies with ethnicity. Adults of Black, Asian or Mixed ethnicity are more likely to develop kidney failure, and at a younger age on average, than those of White ethnicity. People of Black and Mixed ethnicity are the youngest groups to start treatment.
- In the EoE we spent £70,460,132 on renal dialysis in 2024/25.

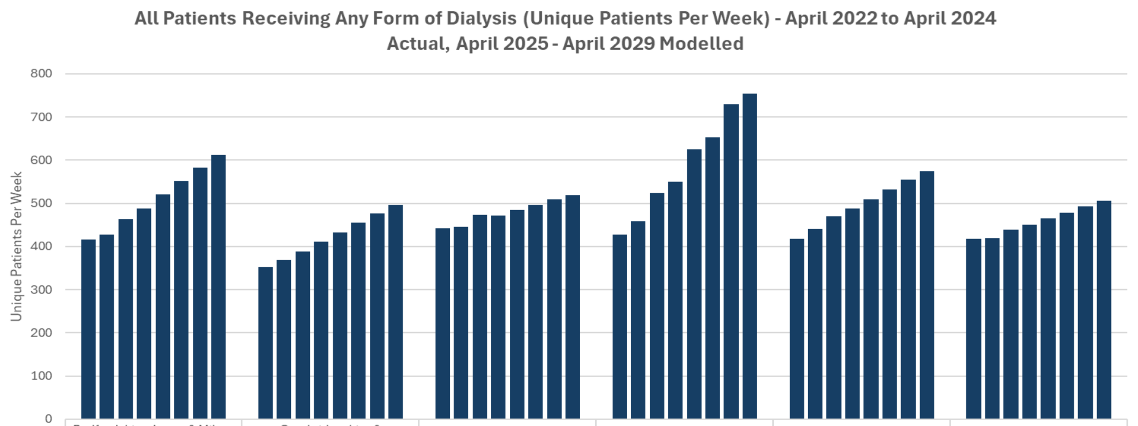


Renal: Opportunities and Priorities



Opportunities with Delegation:

- **Working across whole pathway** - ICBs now holds budget and responsibility for commissioning across the pathway including CKD and acute kidney injury services, and renal replacement therapy, including dialysis and transplantation, are specialised services. Opportunity to build in incentives for transformation and investment up front in the pathway to reduce incidence and exacerbation of these conditions as the cost of treating patients increases as their disease progresses.
- **Early identification** - CKD is often undiagnosed until the late stages due to a lack of symptoms, increasing the risk of kidney disease progression as well as cardiovascular events and hospitalisation.
- **New drugs approved by NICE can slow the progression** of CKD improving patient care and reducing costs for the NHS potentially saving £128.4m annually
- In the 'Getting It Right First Time' review of renal medicine (March 2021) it states 'ensure **home therapy** is promoted and offered for all suitable dialysis patients and that a **minimum prevalent rate of 20%** is achieved in every renal centre'. Current % receiving home dialysis as proportion of all patients dialysed varies between **7% - 19.7% in EoE**



	Bedfordshire, Luton & Milton Keynes	Cambridgeshire & Peterborough	Hertfordshire & West Essex	Mid & South Essex	Norfolk & Waveney	Suffolk & North East Essex
Apr-22	416	352	442	428	418	417
Apr-23	428	369	445	458	441	419
Apr-24	464	388	474	523	469	440
Apr-25	489	411	472	550	488	450
Apr-26	520	433	484	626	510	464
Apr-27	551	454	497	653	532	479
Apr-28	583	477	509	730	555	493
Apr-29	613	497	519	755	575	505

Integrated Care System

Apr-22 Apr-23 Apr-24 Apr-25 Apr-26 Apr-27 Apr-28 Apr-29

Immediate Priority – Focus on Dialysis

- EoE growth in dialysis – 4.9**%** - HWE 2.4% to MSE 8.5% per annum
- All ICBs are predicted to see an increase in demand for dialysis.
- Home dialysis availability varies across the region.
- Renal transplant numbers remain low due to limited doners
- **Current dialysis provision is at 100% usage** of staffed capacity and the experience of dialysis for some patients is poor.
- Plans for reprovision of dialysis as part of the New Hospital Programme are at different stages.
- Coordination on an ICB or multi-ICB footprint is required to establish adequate dialysis provision and improve the experience of care.
- In the East of England there is a pressing need to address renal dialysis capacity over the short-term (12-36 months) and for this expansion of provision to be aligned with strategic plans to address renal capacity demand (prevention and home-based therapies), and align with re-provision in the NHP, where the timeline for re-building is 5-7 years.

Neonatal and Paediatrics : Context

Around 10% of all births are admitted to neonatal services, meaning there are around 60 – 70,000 admissions to neonatal services each year (nationally).

2024 saw 5692 first admission episodes across the East of England equating to 9.5% of the births.

	2020	2021	2022	2023	2024
Number Live Births	61,724	63,502	58,889	60,107	59,358

The table above presents the number of live births from 2020 to 2024. There has been a slight increase in birth rate in 2023 however this figure still remains below 2019 numbers which were 64,271.

Projections for birth rates show a gradual increase over the next 15 years of 6%. Increasing births from 69,443 to 74,707.

This data does not describe the difference in case mix across the region or for areas where transitional care is fully compliant. The table below shows the fluctuations in activity between 2020 to 2024

HRG	2020	2021	2022	2023	2024	Change over 5 years
HRG 1	10409	10047	10818	10568	10260	No change
HRG 2	19096	18480	19714	20501	21340	↑11%
HRG 1&2	29505	28527	30532	31069	31600	
HRG 3	40949	39312	41157	38254	39741	↓3%
HRG 4	2167	3165	3452	3879	3694	↑70%
HRG 5	4581	4375	4175	4067	3860	↓16%
Overall activity (excluding HRG 4)	75035	72214	75864	73490	75201	No change

It is understood that significant health inequalities exist in maternity and neonatal care in England. For example, outcomes for women and babies from minority ethnic groups are worse than for white women, and outcomes for those living in the most deprived areas are worse than for those in the least deprived (MBRRACE-UK, 2022).

National focus since the Better Births Review (2016) and the Neonatal Critical Care Review (2019) has described the **link between maternity and neonatal services** and the need for capacity to be understood across both in order to **best meet the needs of the population**. The 10-year Health Plan has announced a national independent investigation into maternity and neonatal services, to inform a new national maternity and neonatal action plan.

Drivers for change within neonatal services include:

- Specification changes for neonatal special care units
- Workforce does not meet the recommendations
- British Association of Perinatal Medicine minimum activity recommendations standards
- Reducing birth rate across the region impacting demand for specialist care
- Potential population increase due to housing developments
- New Hospital builds
- Changes to ways of work and opportunity to transform care
- Requests for redesignation of units
- Maternity reviews nationally

OUTCOME: Regional priority to ensure best alignment of maternity and neonatal capacity in the system

Neonatal and Paediatrics : Plans and Priorities

NHS
East of England Neonatal ODN
(Hosted by Cambridge University Hospitals)

Our Plans and Immediate Priorities

In Neonatal care,

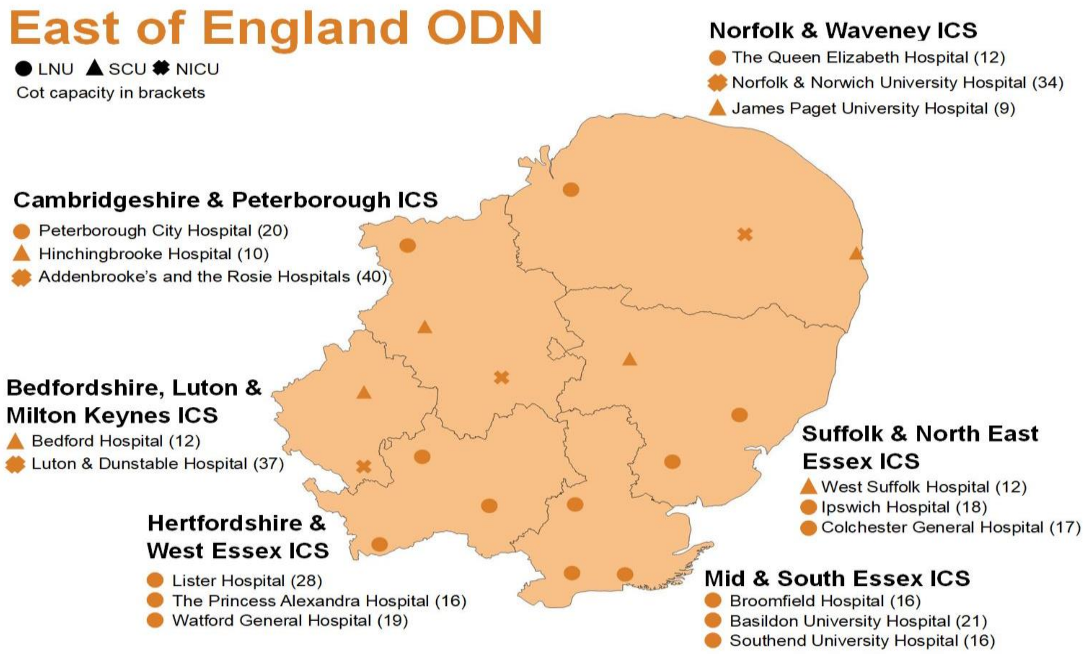
- Focus on understanding our demand and capacity to best plan for meeting the needs of the population and we will work with maternity system colleagues to best align this capacity.
- We will work with system partners to improve access to transitional care.

In Paediatric Critical Care, we will focus on:

- Improving the standard of education across the workforce
- Improving surge planning and improved collaboration with UEC
- Improve pathway for Long Term ventilation including better education for
- The wider workforce, support for repatriation to DGH's and timely proactive
- MDT discussion for complex children.

In Paediatric Surgery, we will focus on:

- Elective Recovery
- Increase day case numbers
- Monitoring and supporting response to variation i.e circumcision < 5 years
- Monitor and reduce readmission rates

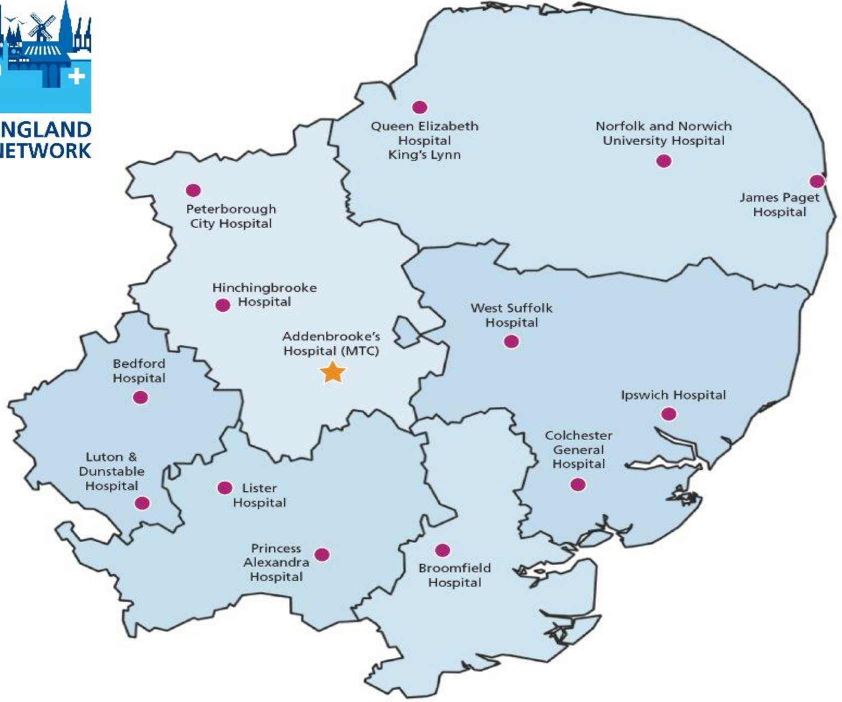


Opportunities with Delegation:

- Right size neonatal capacity and improve oversight of neonatal unit status to support flow
- Improve access to transitional care across the region
- Implement Retinopathy of prematurity provision across the region
- Implement Paediatric Critical Care strategy to skill up workforce to increase level of care that can be safely delivered within a DGH
- System approach to workforce challenges
- Regional priority to ensure best alignment of maternity and neonatal capacity in the system

Trauma and Rehabilitation : Context

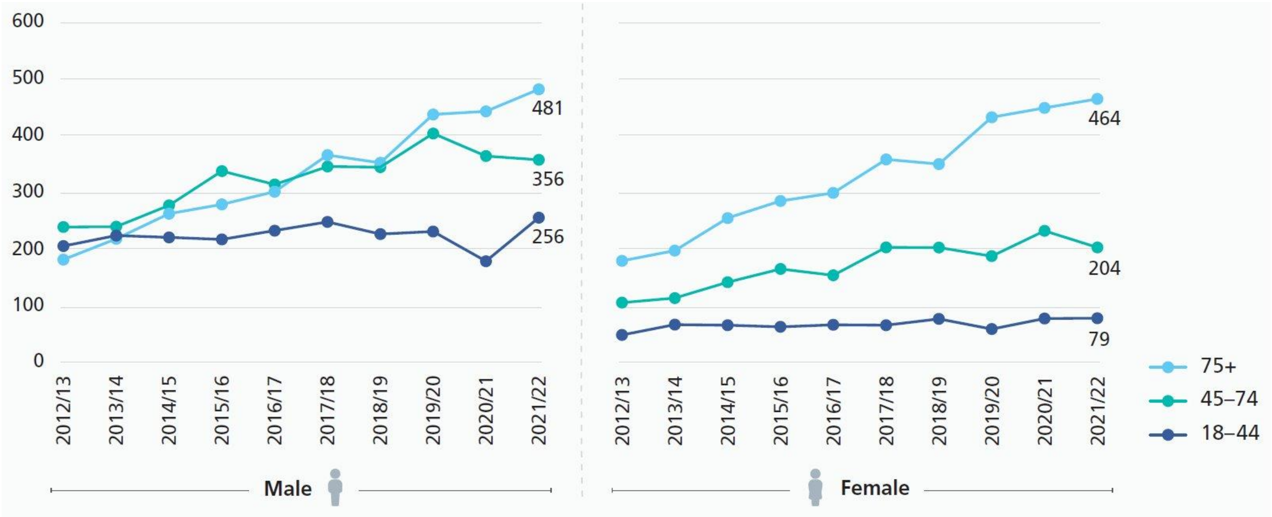
- Major trauma is the leading cause of death in people under the age of 40 and as such as serious public health problem. Major trauma affects 35% of all trauma patients presenting to East of England trauma services
- Within a trauma network, a trauma unit (TU) will deliver general care whilst a major trauma centre (MTC) will deliver more specialist care (hub and spoke).
- The number of major trauma patients has almost doubled since 2012/13 - more than less severe forms of trauma. Modelling predicts a threefold increase in all trauma patients by the end of 2026 compared to 2012
- Half of all major trauma is now in the elderly with a median age of 72 years.
- Vehicle incidents are the main cause of major trauma in the younger adult population and remain a major cause of preventable deaths in this population.
- Blows, stabbings, vehicle incidents together contribute greater than 50% of major trauma deaths in age 18-44y (see graph below right).
- A higher proportion of patients from the most deprived quintile suffer injuries by blows or stabbings compared to other causes resulting in major trauma

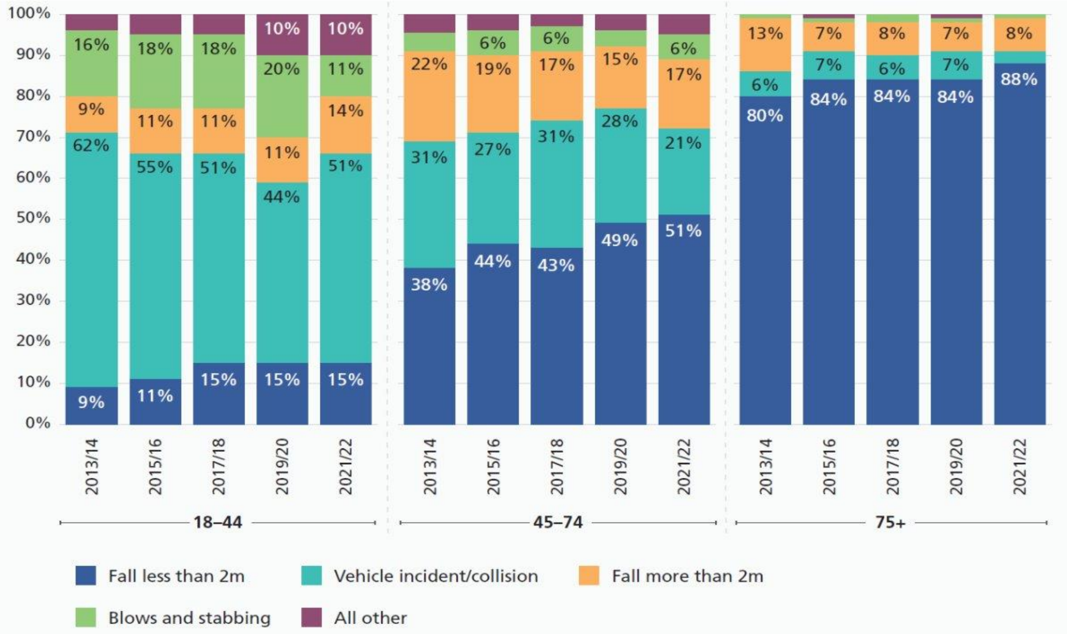


East of England Network: Established 2012, serves 6.2 million population

Current Configuration: 1 MTC (Addenbrooke's Hospital) + 12 TUs across large geographic area

Major trauma growth by age group and sex, EoE

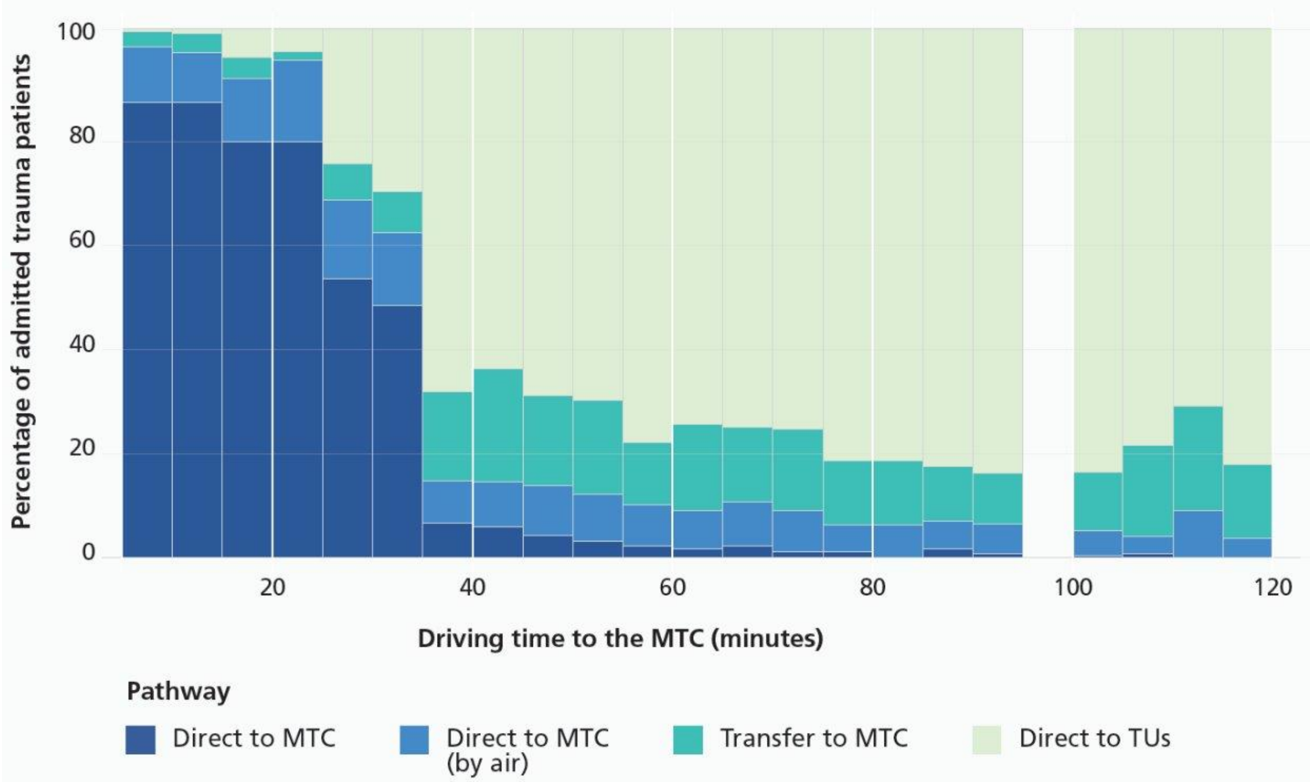




Trauma and Rehabilitation : Opportunities and Priorities

EAST OF ENGLAND TRAUMA NETWORK

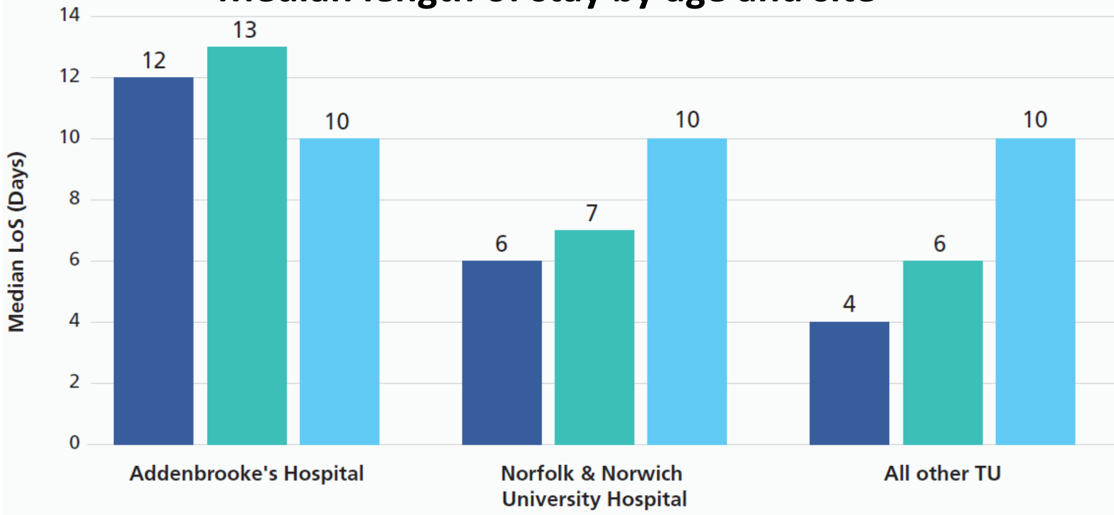
- Deprived and coastal communities are located furthest distance from MTC.
- Patients are more likely to remain in TU if incident is more than 35 minutes drive from MTC – even more so for age 75+ years.
- **Only 5% of most deprived 20% of population** are within a 45-minute drive to the MTC (see right).
- **Rehabilitation** – a service understanding and gap analysis project by the EoE Trauma Network (2024), identified regional inequalities in provision of care. Despite meeting UKROC recommendations for service provision in L2, there is only 1 L1 service, meaning L2 may be stretched to cope with some L1 intended care. Further work is underway analysing the rehabilitation provision in the community.



Opportunities and Priorities with Delegation:

- Half of all major trauma is now in the elderly – median age is 72 years. Low level falls are now over half of all major trauma – incidence rates have doubled to 22 persons per 100k – **falls prevention and long-term conditions management prioritisation** is essential
- Repatriation delays due to process and availability of pathway
- LOS impacts across all parts of the pathway.
- **Rehabilitation planning and coordination** across region – establishing live dashboard showing where spare beds, and collaborating to establish clearer pathways and links to commissioners, including introducing clinical facing trauma & rehab coordinators in acute hospitals
- Expand service capacity in a way that ensures equitable geographic coverage
- **Enhance capabilities** in areas outside specialist service (MTC) reach
- Develop protocols to address need of most disadvantaged groups and track inequality metrics alongside activity data

Median length of stay by age and site



Mental Health : Context

- Mental health conditions are common, with one in four adults and one in ten children experiencing mental illness. According to Mind, the economic burden of poor mental health is estimated in England reaching £300 billion annually. Individuals with severe mental illness may experience a reduced life expectancy, sometimes by 15-20 years, compared to those without. The allocation for East of England population is £0.2bn (against a total allocation of £2.5bn)
- Identified specialised mental health and learning disability and autism (MHLDA) services (note slide 12) were delegated to ICBs from April 2025. These are delivered via the MHLDA Provider Collaborative (PC) model, working with ICBs.
- Specialised MHLDA PCs have responsibility for local pathway delivery of the services lines within their portfolio for the defined population. These responsibilities are set out in contracts with the Lead Provider (LP) for the PC. The LP is responsible for the sub-contracting of its partners to support the range of services required for their cohort of patients, and for the quality oversight and assurance of the delivery of these services.

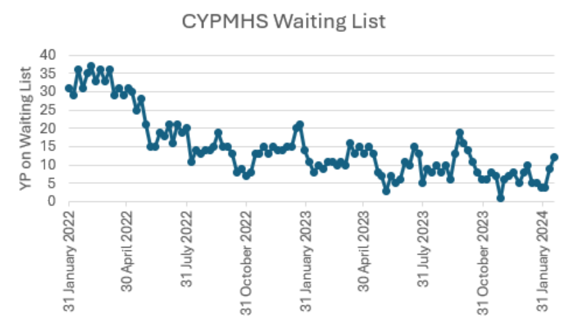
The collaborative is driven by these shared goals and significant progress has been made in each of these areas:

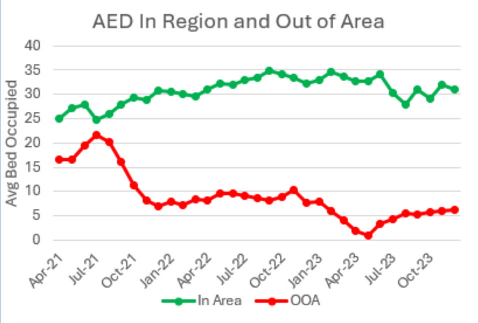
EAST OF ENGLAND PROVIDER COLLABORATIVE BETTER CARE CLOSER TO HOME

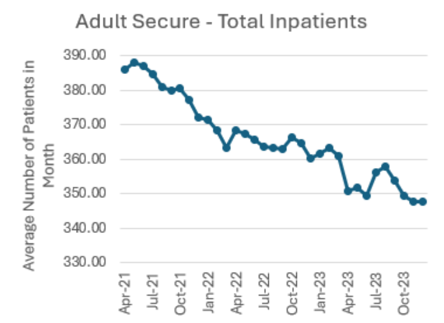
Care closer to home

Treatment outside of hospital where possible

Delivering high quality care







Opportunities with Delegation:

- The Provider Collaborative predominantly commissions inpatient care, although does commission alternatives to admission and day hospitals. Delegation provides the opportunity to **co-commission entire pathways** with ICBs to jointly plan future models
- Right size and type system capacity to meet demand and changes to pathways
- Eliminating inappropriate placements that are outside of natural clinical flows (NCF)
- Implementation of the Developmental Children's and Young People's Intensive Mental Health Service (CYPMHS) Specification.
- Women's Secure Pathway Transformation

Mental Health: Key Challenges

Key Challenges

Adult secure

- **Workforce** - Providers continue to report issues relating to workforce, recruitment, and retention of skilled staff.
- **Capacity** - Beds in the region are closed due to planned refurbishment and damage, impacted in some areas by workforce issues. In addition, there is an ongoing theme of access to seclusion suites affecting admissions (there are a number of males requiring seclusion facilities awaiting transfer from prison) to medium secure wards, with some of these having exceeded the recommended timescale guidelines.

Children and Young People

- **Age** - The Provider Collaborative have identified that a third of children and young people in in-patient settings are 17 years old or over, many of whom have high complex needs in terms of clinical presentation and require system input to support safe discharge. Heads of Nursing have been involved, and a report highlights the challenges faced within each system. A 'transitions' review is planned.
- **Capacity –**
  - Issues remain around workforce, bed closures, and reduced regional PICU capacity due to staffing capacity and environmental damage, with an increased demand for beds.
  - There is also an increased demand for eating disorder beds. The Enhanced Eating Disorders pathway being implemented through eating disorder beds in GAUs and Eating Disorder Intensive Day and Virtual Services.

Immediate Priorities

- **Women's Secure Pathway Transformation -** The pathway into and out of adult secure services differs for men and women. Significant work to date has identified the need for transformation of the adult secure pathway for women.
- **Implementation of the Developmental Children's and Young People's Intensive Mental Health Service (CYPMHS) Specification -** The intention is to redevelop regional, specialist wards into more flexible, local services that can better meet the individual needs of all children and young people in their local area, in line with the evidence-base, under the national Quality Transformation Programme.
- **Reducing inappropriate out of area placements (OAPs)/outside of natural clinical flows (NCF) -** The NHS is committed to reducing inappropriate OAPs/ONCFs for patients receiving mental health care and treatment. Following approval at the National Leadership Group in early June, EPUT and NSFT's bids have been successful for refurbishment of the seclusion facilities in two of their adult secure wards. The next stage is for DHSC to issue an MOU for the funding draw down and for the works to be completed.
- **Bed reconfiguration -** There is a historic mismatch between capacity and demand within the East of England inpatient units, with reduction in demand exceeding current capacity in some service lines. Bed closures, both planned and unplanned further reduce capacity, but offer new opportunities. EPUT and HPFT business cases have been approved supporting changes in the adult secure mental illness and learning disability services. This will also consider a 'civil section panel' (to offer additional scrutiny to referrals); and exploring creation of a medium secure single point assessment ward for males with a mental illness
- **Secure bed repricing** – The Provider Collaborative are proposing to rebase the contract Occupied Bed Day (OBD) rate for adult secure services, recognising the prices are historic, and in the main have remained unchanged for many years other than the application of annual inflation uplifts. Providers have highlighted the rising delivery costs and the difficulty of establishing and maintaining safe staffing levels, noting that current funding fails to cover actual expenses.

Specialised Mental Health Transformation Plan

EAST OF ENGLAND
PROVIDER COLLABORATIVE
BETTER CARE CLOSER TO HOME

CYPMH	AED	Secure	Perinatal
Current Transformation Schemes			
• Crisis Sanctuary (CNWL) • Peripatetic dietician • Bed reconfiguration 24/25 (training for Naso-gastric feeding) • Eating Disorders pathway • Complex Systems Case Manager	• Regional Intensive Community support teams (ICS) • Virtual Intensive Service (VIT) • Autism assessment and diagnosis pilot	• Bed reconfiguration in HPFT • Bed reconfiguration in EPUT • Intensive support Mental Health Case Manager	• Developing a standardised outreach approach
Upcoming Transformation Schemes			
• Transitions review (17 years+) • Bed reconfiguration • Improving the experience of those with Learning Disabilities and Autism	• Establish a regional AED advisory panel • Bed reconfiguration	• Community Forensics MI & LD • Bed reconfiguration	• Education and upskilling of staff / training partners • Health inequalities
Future Transformation Schemes			
• Review of the Home Treatment Teams • Out of hours detentions • ICU / HDU pathway review • Consultant Psychiatrist resource • Eating Disorders review • Assertive Outreach	• Out of hours telephone line for alternative to admission • Improving transition from children and young people's services to adult services • Development of pathway for patients with emotional dysregulation	• Bed reconfiguration – single point admissions; civil section panel • Women's pathway • Staff counsellor • ASD pathway • Discharge pathway / Step down pilot • Access criteria for Woodlea Clinic • Trauma informed recovery / upskilling staff	• CAMHS early school age • Develop system wide engagement plan • Smoking and pregnancy • Co-working/joint projects • Review of referral and allocation process

Neurology/Neurosciences: Context

NHS East of England Specialised Services Provider Collaborative

- There are an estimated 14.7 million cases of neurological disorder in the UK, which equates to **one in six people having a neurological** condition. The NHS spends £4.4bn per year on neurological conditions. *(Neurology GIRFT Programme; 2021*)
- Neuroscience is the **study of the nervous system**, from structure to **function**, development through to **degeneration.** It applies to the **whole nervous system,** with core focus on brain. Cognitive function, damage and degeneration are key.
- **Over 600** known neurological **disorders,** triggered through genetics, infection, **degeneration, acquisition** (stroke or TBI), **trauma or, unknown.**
- Neuroscience services are under **immense pressure** nationally. In the East of England, most patients must travel outside their ICB to either Cambridge or London for specialist neurological care with significant variation in access to specialist therapies and long waits for repatriation to local hospitals.
- NHS England has launched a national **Neuroscience Services Transformation Programme (NSTP)** aimed at addressing long-term delivery challenges and improving patient and service outcomes
- EoE SPC has identified neurosciences as a priority area and are currently developing an EoE wide Strategy, focussing on key clinical areas:
  - General neurology
  - Epilepsy
  - Multiple Sclerosis
  - Migraine
  - Functional Neurological Disorder
  - Dementia
  - Parkinson’s Disease
  - Neuro-rehabilitation
  - Research, innovation and development

Actions identified

- Developing a standardised formulary
- Community led PTL
- Supra MDT
- Consistent referral pathways for equity of access
- PIFU
- Community hubs
- Wearables informing PIFU
- Integrated Workforce model
- Integrated patient dashboard

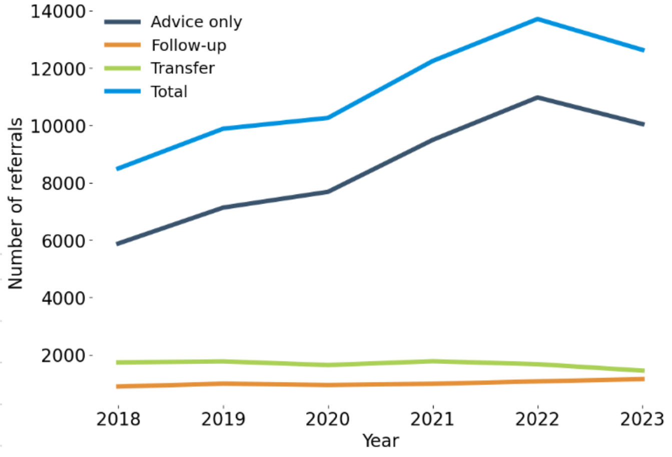
Opportunities with Delegation:

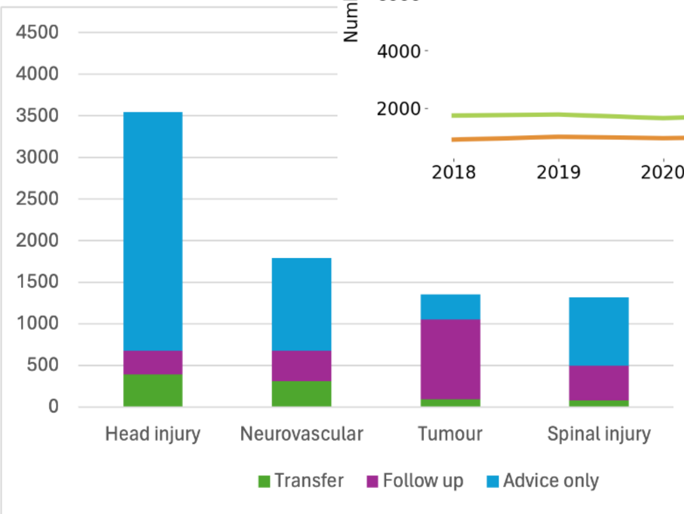
- **Pathway -** developing an integrated model of care enabling delivery of the right service at the right time and providing care closer to home
- **Vertical integration with new models of care -** to enable delivery closer to home through developing across Primary Care, community care and specifically with Integrated Neighbourhood Teams, supported by acute partnership
- **Virtual neuro hubs -** optimising resources across the system; pooling workforce around appropriate conditions and services
- **VCSE partnerships -** developing the patient ability and confidence to self manage and adopting a social prescribing/community-based support structure to support self management

Neurosurgery: Context and Focus Areas

East of England Neurosurgery Network

- **Neurosurgery** is a specialised service for management of patients with disorders of the **central and peripheral nervous systems**. At the region's sole neurosurgical centre (CUH), all neurosurgical subspecialties are represented: neurotrauma, neurovascular, neuro-oncology, skull base and pituitary surgery, spine surgery (including care of patients with spinal cord injury), hydrocephalus, and functional neurosurgery. Pertinent national neurosurgical initiatives include Low Volume High Complexity (**LVHC**), Repatriation, **Rehabilitation**, **Patient-centred care**, High-flow patient pathways (including brain tumour, sub-arachnoid haemorrhage (SAH), pituitary and head injury) and **Theatre efficiency**.
- One of the most prescient challenges is the **rising number of referrals** (far right; 8,000pa in 2018 to ~13,000pa in 2022) with static transfer figures (~2000pa); "*advice only*" contributes 75% of all referrals. "Head injury" contributes ~30% (right).





Prioritised focus areas:

Work with main networks (cranial neurosurgery – EoE NN, spinal neurosurgery – Spinal Network) and network sub-groups (EoE NN Patient Community Voice) and focus on:

- **Years 1-3: Traumatic brain injury** (**TBI**) – pilot of digital imaging triage for mild TBI, outpatient management of sport-related concussion in adolescents/adults, regional mapping of local management of non-operative adult TBI, support for expansion of neurosurgery provision to a second centre within the region (Norwich).
- **Year 2: Epilepsy** – commissioning of epilepsy surgery.
- **Year 2: Intraoperative imaging** – installation of intra-operative MRI ("io-MRI").
- **Year 3: Neurorehabilitation** (co-review of regional Level; 2 provision with Trauma).
- **Years 1-5: Spinal surgery** – review of the Cauda equina syndrome (CES) pathway, tackling disparities in access to services (**Year 5 -** creation of a spinal injuries centre).
- **Year 5+: Neurosciences Institute** (development and building; truly multi-disciplinary – including neurosurgery and neurology, in collaboration with University of Cambridge).

Opportunities with Delegation:

- **Innovate:** Leverage partnership working (ICBs, neurosurgery clinical networks) to support development of personalised, preventative models of care for the entire, varied, Eastern region to align with the 10-year plan.
- **Harmonise local management** of non-operative mTBI, including SRC (significant negative sequelae for return-to-work/education), regionally.
- **Maximise regional neurosurgical provision;** bring care closer to home, reduce health inequalities (most acutely felt by coastal communities).
- **Collaborate with Cambridge Children's**; Improve access to transitional care across the region (paediatric neurosurgery is a network "orphan").
- **Efficient use of resources:** Enact a long-term, **specialised neurorehabilitation plan** for the region, across all specialised services.

Delivering On Our Ambition

Foundations for Delivering the Ambition

Delivering the Strategy is based on evidence of successful transformation efforts in comparably complex settings and the approach is built on the following key foundations:

Good Governance

The Strategy has been agreed by the JCC and the JCC will receive regular reports on the implementation programme's content, progress, key risks and benefits realisation

A Theory of Change

Achieving such an extensive and ambitious programme of improvement requires a clear understanding of how to bring about change in the NHS environment. The JCC has adopted four core principles which will enable it to secure professional and public support for its strategic goals and importantly they enshrine the important role that clinical leadership plays in transforming NHS services. The 3 Rs approach has been based on evidence of successful improvement techniques and aligns closely with NHS Impact 's improvement methodology. The drive to improved productivity and scale of financial challenge in the NHS environment will support the strategy's aims

Bringing about improvement through commissioning

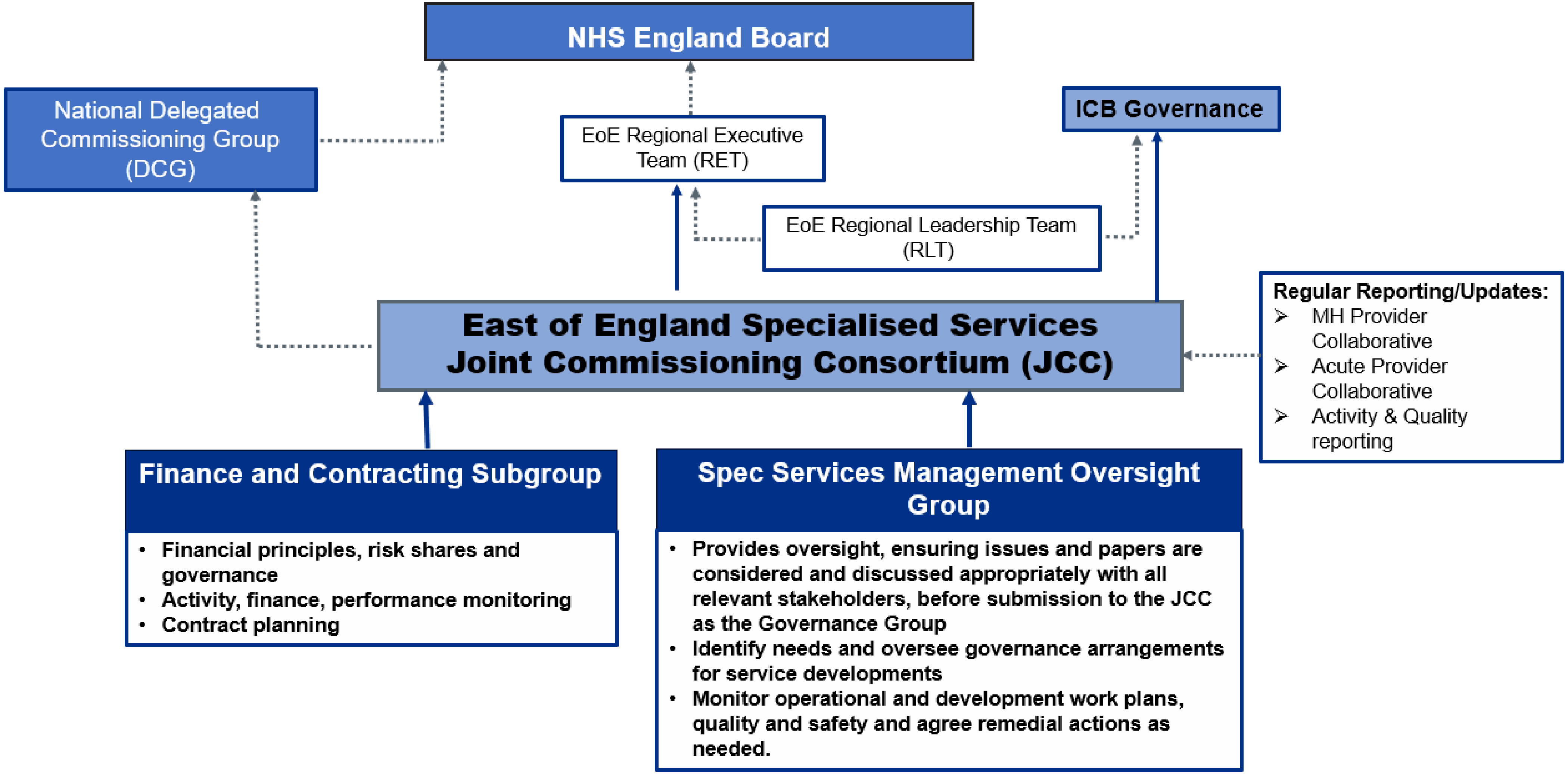
Requires a clear framework including but by no means restricted to, successful contracting, integration of quality measures and full transparency of financial data flows. The JCC has adopted such a framework and achieving transformational change which is contracted, monitored and measured is a key part of this.

Co-ordination and reporting

Are central to ensuring that improvement work initiated through the strategy complements the work already under way by providers, Clinical Networks and others. Subject to organisational change it is envisaged that the SCT's Transformation Function will lead on coordination and reporting based on open sharing of improvement initiatives and outcomes

EoE JCC Governance Arrangements

Governance and risk management arrangements via the JCC and Collaboration Agreement have been in place during 2024/25, and this will continue to provide the forum for **collective decision-making and oversight** of the implementation of the strategy



Our Approach to Improvement – the 3 Rs

Review

Take a systematic approach to reviews, focusing our analysis on the specialised commissioned element of a pathway whilst engaging with the whole system to fully understand the opportunity and deliver transformation

Deep Dives: Establishing a Single Version of the Truth incorporating activity and financial data, demand and capacity modelling, productivity measures including asset utilisation, population health intelligence, quality and outcomes data, use of Spending and Outcomes tools, audit reports and patient experience using an ICB lens

Horizon scanning for improvement activity within each clinical priority area, identifying sources of UK and international innovation and good practice

Reality testing with clinicians and patients to identify focus areas

Identification of which changes, at any part of the pathway including prevention, will bring about the greatest benefit

Reimagine

Co-designed - transformation across complex pathways with multiple stakeholders will not be easy and will require robust leadership and collaboration to ensure **proactive recognition and understanding of impacts** and avoidance of unintended consequences.

The approach is underpinned by the continuous improvement principles outlined in the **NHS IMPACT**.

Multi-disciplinary Process Mapping applying an end-to-end lens; Construction of Programme Budgets to model shifts in investment to yield optimum benefit

Stakeholder engagement

Success metric identification and testing with clinicians and patients

Identifying workforce implications

Generation of the case for change

Develop a shared purpose and vision

Realise

Utilise the **collaborative commissioning cycle** to realise service improvement and transformation changes. The specialised Services Commissioning Framework is outlined on the next page

Short Term:

Creation of commissioning and Operating Plan propositions

Establish improvement metric collection

Review capacity and timescales for implementation

Medium Term:

Development of business cases for resource shift including workforce, technology, estates within flat cash environment

Adoption of contractual innovation to incentivise transformation for example Outcomes Based Contracting

Our Approach to Engagement, Participation and Co-production

We recognise the importance of involving patients who use specialised services, their carers and the public in planning, service change- including that emerging from applying the 3Rs model, decision making and information sharing.

Our approach to engagement, participation and co-production is outlined in this process chart.

Engagement in service improvements and changes are reported through to the JCC or one of its subgroups.

Planning

- Involve patient groups, ODNs, Cancer Alliances
- Include patient experience data from providers
- Embed population need early in service planning

→

- Involve stakeholders from the start of planning, including intent to undertake needs assessments, demand and capacity reviews, and service planning
- Invite Healthwatch, or patient group representative onto project team
- Develop patient experience and engagement metrics and introduce regular reporting of patient experience using contracts to require providers to provide data
- Standardised check-list / evaluation criteria

Service Change

- Early engagement with patients, public, scrutiny committees
- Monitor via project dashboards and impact statements
- Evaluation and iterative continuous improvements

→

- Develop toolkit / checklist for commissioners to ensure appropriate engagement is planned / has taken place
- Include involvement metrics on project and evaluation dashboards

Decision-Making

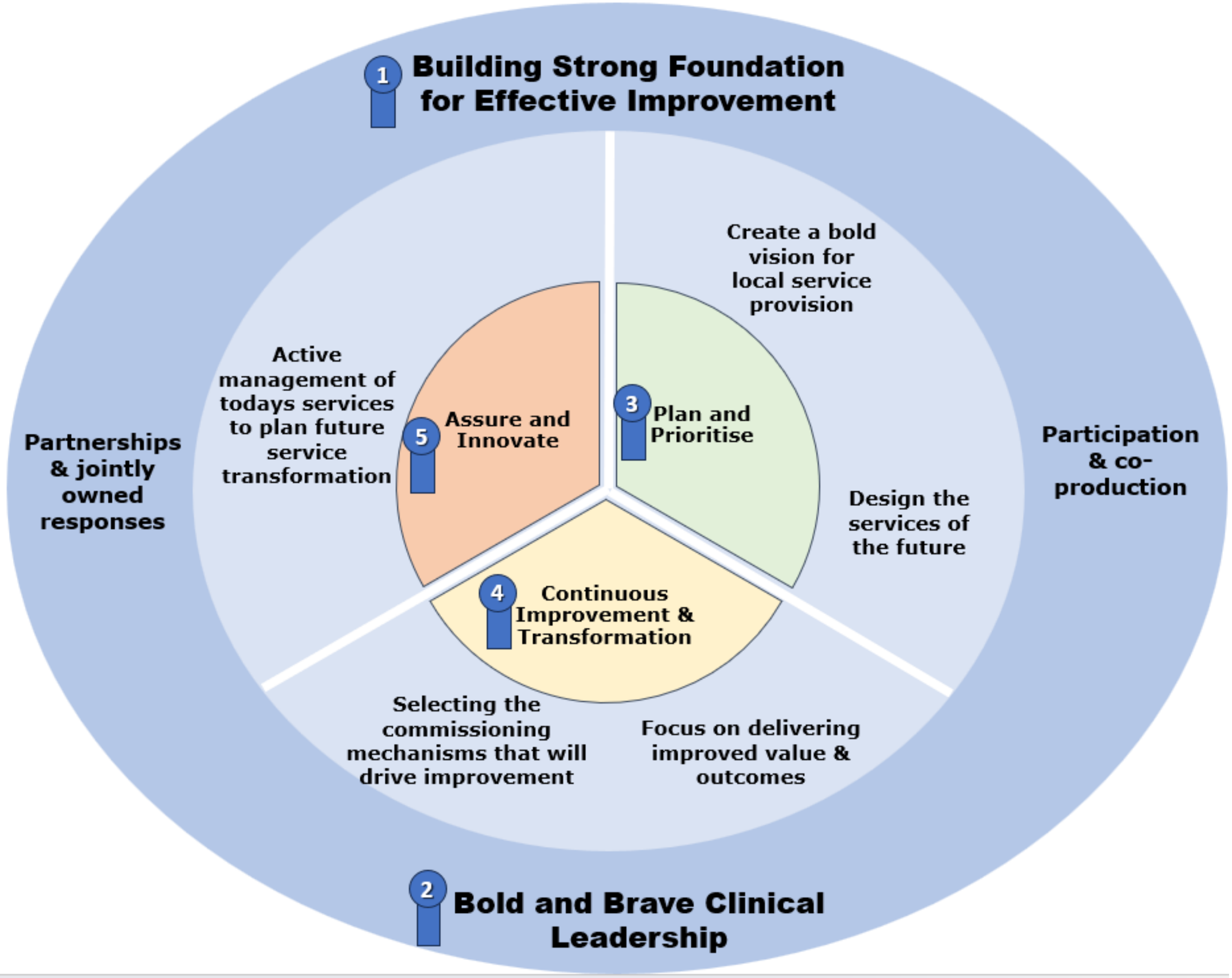
- Regional patient reference group
- PPI captured in meeting cover sheets
- Regular meetings with key patient groups
- Annual reporting to scrutiny committees

→

- Consider establishment of a regional patient reference group / citizen's panel with a role to consider if the patient voice has been heard prior to a decision being taken.
- Use cover sheets to provide assurance to JCC
- Quarterly meetings with Healthwatch and lead commissioners
- Produce short annual report to be distributed scrutiny committees summarising activity and plans. No surprises.

EoE Specialised Services Commissioning Framework and Strategy Integration

The 3Rs Delivery Approach will feed into the specialised services collaborative commissioning cycle, with a focus on continuous improvement and transformation, as set out in the EoE Specialised Services Commissioning Framework in February 2025



1. **Building Strong Foundation for Effective Improvement**

   *Work with system partners to create **proactive approach** and **drive delivery of transformation programmes** with local adaption of how services are delivered to suit their populations across pathways of care*

2. **Bold and Brave Clinical Leadership**

   ***Courageous clinical leaders** work with the system to take managed risks, create an environment which is **open to change, drive plans forward and create the energy and direction to deliver them**. Working with ODNs and other Networks on leading continuous improvement and transformation programmes*

3. **Plan and Prioritise**

   *Design the services of the future and build **jointly owned responses** to rectify unwarranted variation in outcomes and experience and inequalities in access. Imbed into contracts agreed approach. Agreement of a prioritisation approach for driving the transformation agenda*

4. **Continuous Improvement and Transformation**

   *Using the contracting process to **identify opportunities** and **monitor impact**.*

   Working together across the system to facilitate improved outcomes through:

   - ***Productivity** – efficiencies and effectiveness,*
   - ***Equity of Access** - decisions on spend are based on the needs of a local population*
   - ***Transformation Process of whole pathways of care**: Review, Reimagine and Realise*

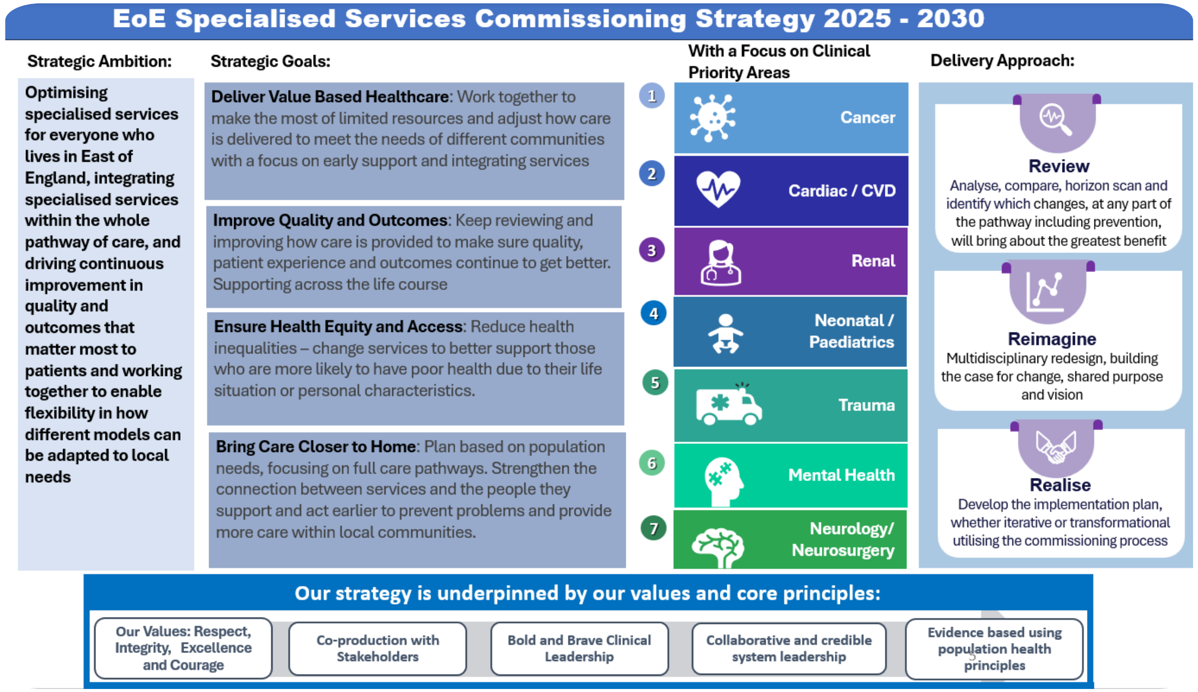
5. **Assure and Innovate**

   Active management of today's services to plan future service transformation – end-to-end care pathway reviews and patient engagement

Coordination and Reporting

One of our core principles is co production with stakeholders and the immense programme of existing transformation work being undertaken by providers, Clinical Networks and Collaboratives is highly valued. Our approach is that further work will be in collaboration with stakeholders to ensure that the next steps are complementary to, and considerate of, the work already in progress. This means that achievement of the strategy will be a complex endeavor and the JCC will need to be supported by high levels of coordination to assure delivery.

- The Specialised Commissioning Team is currently establishing a map of current improvement initiatives within each of the clinical priority areas, categorised by the four strategic goals as outlined in the opportunities matrix; this map will be the foundation of effective reporting and sharing of strategic actions with stakeholders
- The Specialised Commissioning Team's Transformational function (TF) will lead the reporting of progress on the strategy to its Working Groups and the SSMOG and thence to the JCC itself
- The TF will establish a register of key timelines and improvement initiative measures to enable the JCC to assure itself on benefits realisation across the clinical priority areas, liaising with Senor Responsible Owners in providers, Clinical Networks, Collaboratives and other contributors to ensure an authoritative account of what the current and additional programs are designed to deliver
- The TF will establish a Risk Register for strategy implementation, enabling the JCC to assure itself that principle risks have been identified and are being mitigated
- The TF will co ordinate the co-production of a Prioritisation Framework with partners, to ensure that priorities are systematically and transparently agreed



Implementing the Strategy

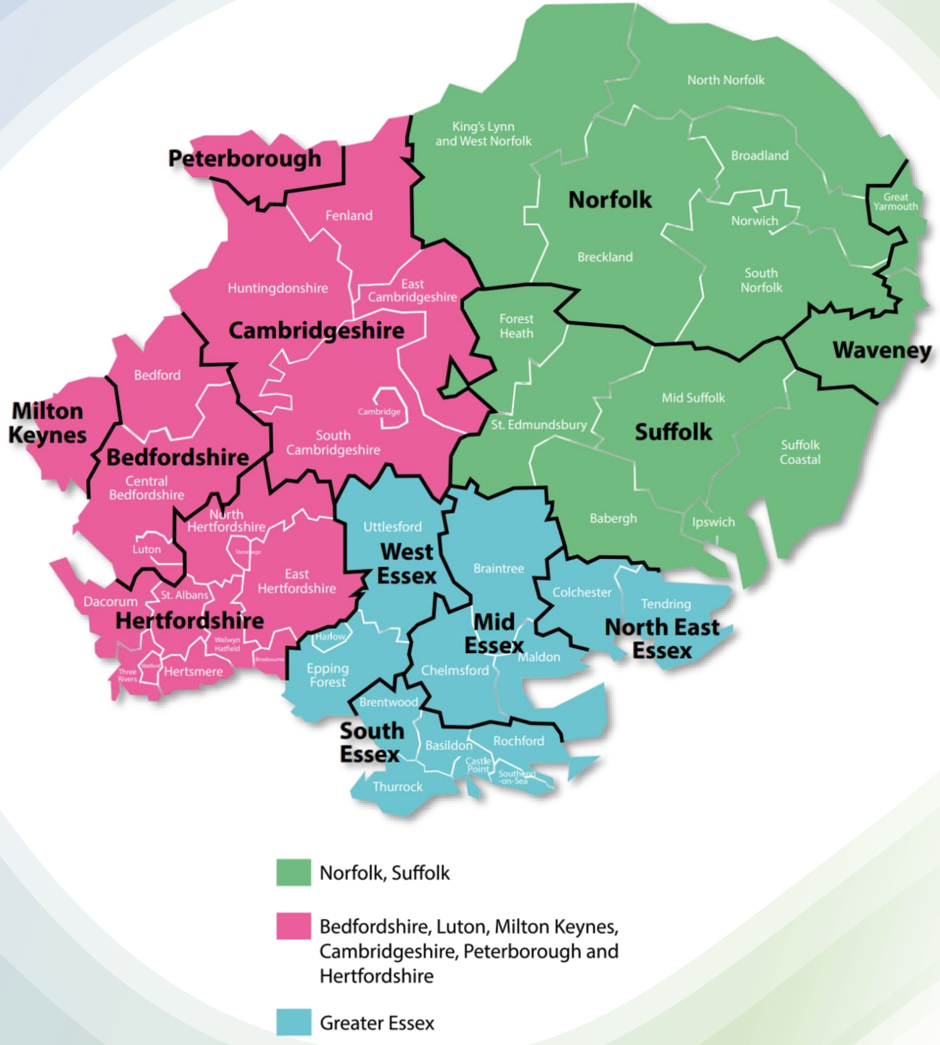
We need to evolve with the changes that come out of the **10-year plan** and the reorganisation of DHSC, NHSE, ICBs and Provider Services to ensure we remain focused on our ambition.

Given the scale of organisational change, the transformation programme emerging from the strategy will need to be considered against likely capacity constraints emerging from turbulence and key risks arising from this will need to be reflected in the Strategy's Risk Register.

In particular, the establishment of three new Integrated Care Boards in the East of England, will require further work to map the identified specialised commissioning initiatives within the place footprints.

To realise our Specialised Services Commissioning Strategy, we will **develop a detailed implementation plan**, outlining the key tasks for the first 18 months of the strategy. In the mean-time the high-level road map for the strategy sets out key milestones over the strategic period including:

- Adoption of a Prioritisation Framework and generation of the first cycle of Deep Dives in the Review Phase
- Co-design and project planning of the Re-imagine Phase for the prioritised Reviews, including building the case for change and working with partners to agree re designed pathways, repatriation proposals, activity shifts and their consequences
- Translation of agreed re-design proposals into business cases and commissioning and contracting proposals

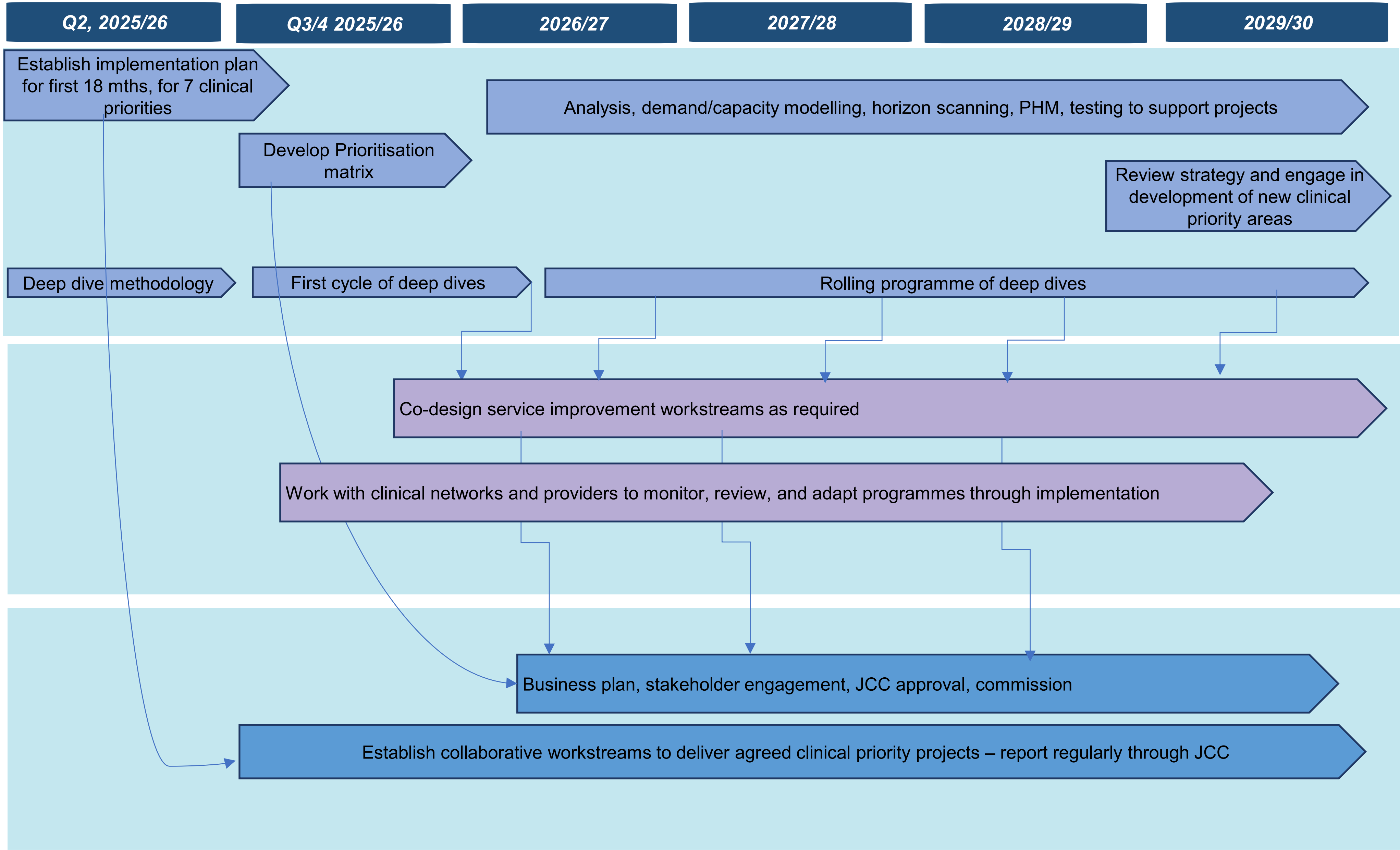


Specialised Commissioning Strategy High level Roadmap

1 REVIEW:
Analyse, compare, horizon scan and identify which changes, at any part of the pathway will bring about the greatest benefit

2 REIMAGINE:
multi-disciplinary redesign, building the case for change, shared purpose and vision

3 REALISE:
Develop the plan, whether iterative or transformational utilising the commissioning process



Appendices

Appendix One : Productivity Improvement:

National Pillars

NHS productivity remains 7-8% below the pre-pandemic levels with many opportunities to apply proven productivity measures in a consistent manner across the service, including in specialised services*

Five pillars for improved productivity have ben set out nationally*:

1. Clinical and operational productivity
2. Workforce
3. Shifting care
4. Transformation and
5. Reducing waste

It is expected that systems will be supported over a five-year period, matching that of the E of E strategy, to achieve improvements in each of these areas

The five pillars align closely with our strategic goals if productivity work already under way in providers is used within the Review Phase and Re-imagine phases of the 3 Rs approach

Measuring productivity can be problematic and specifically in specialised services a particular confounder is the identification and definition of specialised activity, where the same treatment can be classified as specialised because of where it is delivered not because of its clinical content

* Emerging national productivity programme NHSE July 2025

East of England Specialised Perspective

An NHSE commissioned analysis of 2022*, part of the wider Regions and ICB productivity toolkit, focused particularly on two key sources of productivity for specialised services :

Regional or ICB Level Redesign:

- Re-design through *upstreaming* using secondary prevention or moving interventions earlier in the pathway,
- Consolidation of resources including *specialised teams and delivery sites*

Provider Collaboration:

- Improved efficiency of operational delivery in which there is significant variation
- Reduction of unwarranted variation, particularly in high-cost drugs and devices

The toolkit identified potential focus areas for the East of England:

Upstreaming:

- **Prevention**: Cardiology, renal, cancer
- **Repatriation**: spinal, neurosciences, rehabilitation and disability

Consolidation of resources:

- **Integration of sites**: PPCI, Vascular, Cardiac surgery (IP), Access for renal dialysis
- **Integration of teams**: Ophthal., Paed. & young people cancer

Improved operational efficiency

- **Providers of focus:** Cambridge ,Norfolk and Norwich and Royal Papworth

Reduction of unwarranted Variation

- **Drug volumes/mix:** Infectious diseases, colorectal services, HIV, cancer
- **Device volumes/mix:** Cardiac services

* N.B This analysis remains subject to validation; sources such as PLCM data 2019/20 are used

Appendix One : Productivity Improvement

Variation in East of England Specialised Services

- Reducing unwarranted cost variation is about fairness, equity and sustainability
- The 2022 toolkit presented a number of detailed analyses which can provide a useful contribution to the Review Phase once they have been validated and updated by clinicians and business intelligence, as part of a single version of the truth for each prioritised deep dive .
- For example, in three areas where secondary prevention is regarded by NICE as having high potential, namely cancer, cardiac care and renal care (in order of spend) median ICS spend varies seven-fold in renal services and specialised cancer diagnostics amongst all ICS's; and within E of E ICS's this pattern of variation is similarly marked at seven and five -old respectively
- There will be many reasons why this variation is clinically warranted, not least health demographics, but it must be interrogated and understood before this assumption is made. This is the critical work of the 3Rs review phase and there follow lines of enquiry recommended by the tool kit

Recommended checklist of analyses in Specialised Services

Levers	Recommended set of analyses
Upstreaming of care	• Benchmark activity across whole pathways to identify if opportunities exist for pathway redesign • Compare referral rates per population vs. peers • Review key literature and guidance to identify if there are opportunities for prevention and earlier intervention
Consolidation of resources	• Assess the geographic spread of the service, considering patient travel times • Explore the tail of activity within a specialty to identify whether low-volume sites are performing at par with larger providers • Assess cost metrics (for example PLICS) to identify if there is variation in cost between HRGs
More efficient operational delivery of care	• Assess operational metrics, including LOS, first to follow-up attendance ratios, coverage of consultants per patient
Reduction in unwarranted care	• Compare drug prescription rates vs. national benchmarks

Glossary of Terms

Accronym	Meaning	Department
3R's	Review, Reimagine, Realise	Generic
AAD	Acute Aortic Dissection	Cardiac
ACCEND	Aspirant Cancer Career Education Development	Cancer
ACS	Acute Coronary Syndrome	Cardiac
AED	Adult Eating Disorder	Mental Health
AI	Artificial Intelligence	Generic
AKI	Acute Kidney Injury	Cardiac
ASD	Autsim Spectrum Disorder	Mental Health
ATLAS	Ambulatory Transient Outpatient Monitoring System	Cardiac
AVR	Surgical Aortic Valve Replacement	Cardiac
BLMK	Bedfordshire, Luton and Milton Keynes ICB	Generic
C&P	Cambridge & Peterborough ICB	Generic
CAG	Coronary Angiogram	Cardiac
CAMHS	Children and Adolescent Mental Health Service	Mental Health
CDC's	Community Diagnostic Centres	Mental Health
CES	Cauda Equina Syndrome	Neurosurgery
CKD	Chronic Kidney Disease	Cardiac
CNWL	Central and Northwest London NHS Foundation Trust	Generic
COPD	Chronic Obstructive Pulmonary Disease	Chronic Conditions
CTCA	Computerised Tomography Coronary Angiography	Cardiac
CTYA	Children, Teenagers and Young Adults	Mental Health
CUH	Cambridge University Hospital	Generic
CVD	Cardiovascular Disease	Cardiac
CWT	Communications Toolkit	Cancer
CYP	Children and Young People	Mental Health
CYP	Children and Young Persons	Mental Health
CYPMHS	Children and Young People's Menhal Health Services	Mental Health
CVD	Cardiovascular Disease	Cardiac
D&C	Demand & Capacity	Generic
DCG	Delegated Commissioning Group	Generic
DGH	District General Hospital	Cardiac
DHSC	Department of Health and Social Care	Cancer

Accronym	Meaning	Department
EEAST	East of England Ambulance Service NHS Trust	Generic
EoE	East of England	Generic
EP	Emergency Presentation	Cancer
EPUT	Essex Partnership University NHS Foundation Trust	Generic
GAUs	General Adolescent Units	Mental Health
GIRFT	Get It Right First Time	Generic
HDU	High Dependency Unit	Mental Health
HPFT	Hertfordshire Partnership University NHS Foundation Trust	Generic
HRG	Healthcare Resource Groups	Neonatal & Paediatrics
HWE	Hertfordshire and West Essex ICB	Generic
ICB	Integrated Care Board	Generic
ICS	Integrated Care Systems	Mental Health
ICU	Intensive Care Unit	Cardiac
IMD	Index of Multiple Deprivation	Generic
io-MRI	Intra-operative MRI	Neurosurgery
JCC	Joint Commissioning Committee	Generic
LD	Learning Disability	Mental Health
LINAC	Linear Accelerator	Cancer
LNU	Local Neonatal Unit	Neonatal & Paediatrics
LOS	Length of Stay	Cardiac
LP	Lead Provider	Mental Health
LSOAs	Lower Layer Super Output Area	Generic
LVHC	Low Volume High Complexity	Neurosurgery
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries	Neonatal & Paediatrics
NCDR	National Commissioning Data Repository	Generic
MD	Managing Director	Generic
MDT	Multi-disciplinary Team	Neonatal & Paediatrics
MHLDA	Mental Health and Learning Disability and Autism	Mental Health
MI	Mental Illness	Mental Health
MOU	Memorandum of Understanding	Mental Health
MSE	Mid and South Essex NHS Foundation Trust	Generic
MTC	Major Trauma Centre	Trauma and Rehabilitation

Glossary of Terms

Accronym	Meaning	Department
NCF	Natural Clinical Flows	Mental Health
NHC	Northgate Hospital	Mental Health
NHP	New Hospital Programme	Neonatal & Paediatrics
NHS	National Health Service	Generic
NHSE	NHS England	Generic
NHSI	NHS Improvement	Generic
NIC	Neonatal Intensive Care	Neonatal & Paediatrics
NICU	Neonatal Intensive Care Unit	Neonatal & Paediatrics
NMTR	National Major Trauma Registry	Trauma and Rehabilitation
NN	Neurosurgery Network	Neurosurgery
NSFT	Norfolk and Suffolk NHS Foundation Trust	Generic
NSTEMI	Non-ST segment elevation Myocardial Infarction	Cardiac
NSTP	Neuroscience Services Transformation Programme	Neurosurgery
N&W	Norfolk & Waveney ICB	Generic
OAPs	Out of Area Placements	Mental Health
OBD	Occupied Bed Day	Mental Health
ODN	Operational Delivery Network	Cancer
OHCA	Out of Hospital Cardiac Arrest	Cardiac
ONCFs	Outside of Natural Clinical Flows	Mental Health
OOA	Out of Area	Mental Health
ONS	Office for National Statistics	Generic
OPEL	Operational Pressures Escalation Levels	Generic
OPTICS	Optimising People to Imprve Cancer Services	Cancer
PC	Provider Collaborative	Mental Health
PCI	Percutaneous Coronary Intervention	Cardiac
PHM	Public Health Management	Generic
PIC	Psychiatric Intensive Care	Mental Health
PIFU	Patient Initiated Follow Up	Generic
PPCI	Primary Percutaneous Coronary Intervention	Cardiac
PPI	Patient and Public Involvement	Generic
PPV	Patient and Public Voice	Generic
PSFU	Personalised Stratified Follow Up	Cancer

Accronym	Meaning	Department
PTL	Patient Tracking List	Neurosurgery
RET	Regional Executive Team	Generic
RLT	Regional Leadership Team	Generic
ROP	Retinopathy of Prematurity	Neonatal & Paediatrics
RPH	Royal Papworth Hospital NHS Foundation Trust	Cardiac
RTD	Referal to Diagnosis	Cardiac
RTT	Referal to Treatment	Cardiac
SACT	Systemic Anti-cancer Therapy	Cancer
SAH	Sub-Arachnoid Haemorrhage	Neurosurgery
SC	Specialised Commissioning	Generic
SCT	Specialised Commissioning Team	Generic
SCU	Special Care Unit	Neonatal & Paediatrics
SDA	Same Day Access	Generic
SDIP	Service Development and Improvement Plan	Generic
SLGs	Service Line Groups	Generic
SN	Spinal Network	Neurosurgery
SNEE	Suffolk and Northeast Essex ICB	Generic
SPC's	Specialised Services Provider Collaborative	Generic
SRC	Sport-related Concussion	Neurosurgery
SSMOG	Specialised Services	Generic
SSMOG	Specialised Services Management Oversight Group	Generic
STEMI	ST-elevation Myocardial Infarction	Cardiac
SUS	Secondary Uses Service	Generic
TAVI	Transcatheter Aortic Valve Implantation	Cardiac
TBI	Traumatic Brain Injury	Neurosurgery
TU	Trauma Unit	Trauma and Rehabilitation
UEC	Urgent Emergency Care	Generic
UKROC	The UK Rehabilitation Outcomes Collaborative	Trauma and Rehabilitation
VCSE	Voluntary, Community and Social Enterprise sector	Neurosurgery
VIT	Virtual Intensive Service	Mental Health
WT&E	Workforce, Training & Education	Cancer
YP	Young People	Mental Health