Greater Manchester, Lancashire and South Cumbria
Clinical Senate

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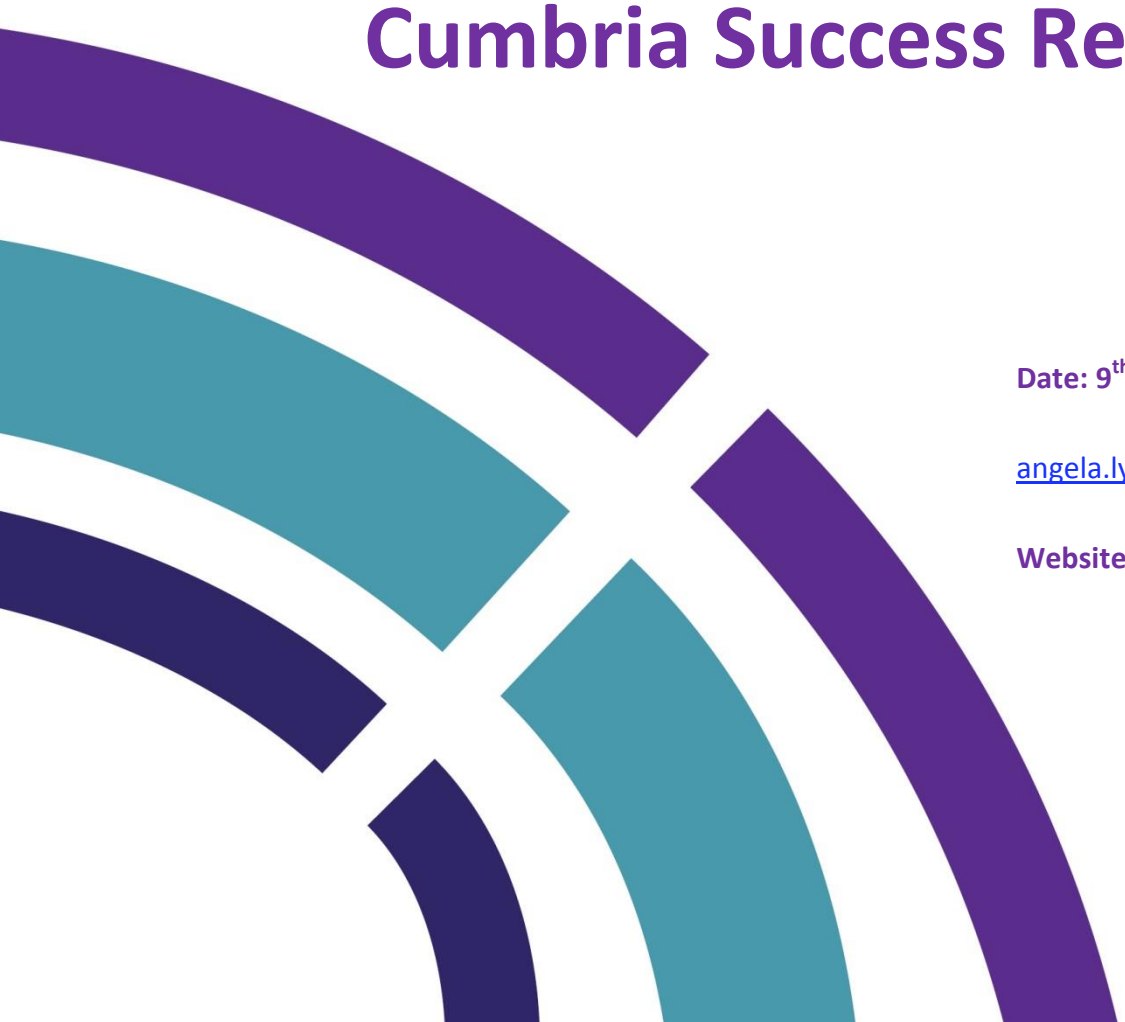
Independent Review of the Proposed Clinical Models for the North, West & East Cumbria Success Regime



Date: 9th May 2016

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Greater Manchester, Lancashire & South Cumbria Clinical Senate

The Clinical Senate brings together expertise from across care systems to promote improvements in the quality of services; providing leadership, advice and supporting assurance.

Clinical Senates comprise of a Senate Council that is made up of up to 30 health and care experts, including patients/citizen representatives and a Senate Assembly. The Senate Assembly is a wider group of up to 200 health and care professionals that will provide the Senate Council with ready access to a pool of experts that they can draw from.

The citizen representatives ensure that the Clinical Senate has patients, carers and citizens at the heart of their work. Our citizens are integral to high quality independent clinical advice and aim to complement local engagement, co-design and consultation etc. They provide invaluable insights, perspective and challenge.

Our offer

The Clinical Senate provides credible and robust independent clinical advice to commissioners in order to help them make the best decisions about health and care systems for the populations they serve.

We will do this by:

- Examining strategies and plans in order to identify and suggest to commissioners, possible areas where clinical evidence can support service improvements.
- Identifying, and suggesting to commissioners, aspects of health care where there is potential for commissioning to improve outcomes through analysis of evidence and best practice.
- Providing clinical advice as part of formal assurance processes.
- Providing clinical advice to use as part of planned or current service changes.

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Chair's Foreword

In March 2016, the Clinical Senate received a commission from Cumbria CCG on behalf of the North, West and East Cumbria Success Regime to review the proposed models of care for Integrated Care (including Community services), Mental Health, Elective Care, Proactive and Emergency Care, Children and Maternity.

The Clinical Senate agreed the Terms of Reference (*Appendix 1*) and convened an independent Review Team which was made up of clinical experts and Citizen Representatives (See *Appendix 2*) to review the information provided.

The Clinical Senate would like to stress that due to the stage of development of the proposed clinical models, the process that has been undertaken does not amount to a full clinical review for the purposes of assurance.

Based on the work submitted by the Success Regime ***at the start of the review***, the Clinical Senate focussed on the identification of clinical concerns or issues that need further examination or that should be considered by the CCG and other partners to inform the next steps in the development of the Success Regime programme.

I would like to thank the clinicians, patient representative and managers who have contributed to this review. The contributors to this process provide their commitment, time and advice freely. Without this we would have been unable to provide such a comprehensive report. I am forever grateful to the review team and members of the Clinical Senate for their ongoing support and commitment to the provision of robust clinical advice.

In addition, I would like to thank Stephen Singleton and the Success Regime Team for providing the additional information requested in a timely fashion, for open and transparent discussion at the workshop and for hosting the locality visit (which occurred on a beautiful spring day).

The clinical advice within this report is given in good faith and with the intention of supporting commissioners in further development of the models. This report sets out the methodology and findings of the review, and is presented to Cumbria CCG with the offer of continued support should it be needed.

Professor Donal O'Donoghue
Senate Chair
Greater Manchester, Lancashire & South Cumbria Senate

1. Executive Summary

The Clinical Senate has focussed this report on the identification of clinical concerns or issues that need further examination or that should be considered by the CCG and other partners to inform the next steps in the development of the Success Regime programme.

The proposed models of care which were in the scope of the review were as follows:

- Integrated Care Clinical Model (including Community services)
- Mental Health Clinical Model
- Elective Care Clinical Model
- Proactive and Emergency Care Clinical Model
- Children's Clinical Model
- Maternity Clinical Model

A number of common themes, where further work is required, were identified (see *section 4*):

- Vision, Clinical and Community Engagement and Communication
- Clinical Standards, Improving Outcomes and Implementing Best Practice
- Workforce *including recruitment, retention, education and continuing professional development (CPD)*
- Information Management and Technology
- Patient Transfer and Transport
- Parity of esteem between physical and mental health

The Citizens Panel expressed concerns about the lack of evidence of a robust and meaningful engagement process (with the notable exception of the excellent work undertaken for maternity and children's services). A number of engagement strategies are referenced, however, the documents lack details of events and there is little evidence of engagement with any groups.

The use of benchmarking of clinical outcomes using the NHS and Public Health and Social Care Frameworks is a fundamental omission from most of the proposed clinical models. In addition, there is little evidence of the consistent use of clinical, professional and service standards to underpin the proposed changes to pathways and systems of care.

The Summary and Conclusions in *Section 8* highlight areas of significant concern to the Review Teams, **where immediate action is required**. For example:

- The safety and sustainability of Children's and Maternity Services and the need to make concurrent decisions for both of these services as soon as possible.
- The need for Mental Health to have a higher priority and be an integral part of all clinical models and the overall Success Regime
- The need to demonstrate integration of Health and Social Care within the Success Regime to identify, develop and deliver integrated and holistic solutions for the population.

- The need to ensure that ongoing Clinical Leadership and engagement is supported throughout the development and implementation of the clinical models.

Specific recommendations for each clinical area are provided in *Section 7*. The recommendations summarise the actions for each clinical area. Although they are also included as a list in *Appendix 5*, they should be read in conjunction with the details provided in the full section.

Due to the stage of development of the clinical models, it was not possible to assess the interrelations, co-dependencies and implications of the Success Regime plans on the experience of care and delivery of Specialised Services. Specialised Services Commissioning was therefore not included in the scope of this Review.

Contents

2. Introduction

The Greater Manchester, Lancashire and South Cumbria Clinical Senate were pleased to receive a request in March 2016 from Cumbria Clinical Commissioning Group (CCG) to undertake a review of the proposed clinical models which have been developed as part of the North, West and East Cumbria Success Regime. The Clinical Senate accepted this commission in late March 2016. This report provides the background to the review, the methodology used and findings of the independent clinical Senate Review Teams.

It should be noted that this work was initially supported by the Northern Senate. As they have, however, been involved in the development of the models they requested that an independent Clinical Senate should lead on the provision of clinical advice that can be used for assurance purposes. The two initial reports which were produced by the Northern Senate have been shared with the Clinical Review Teams undertaking this review.

The Terms of Reference for the Review are shown in *Appendix 1*. Independent clinical review teams of clinical experts and citizen representatives were formed to review the information provided by commissioners (*Appendix 2*). The aims of the Senate Clinical review were as follows:

- To identify where the proposed models are credible and robust, highlight any areas of concern and make suggestions for improvement.
- To provide clinical advice on the emerging clinical models by assessing the supporting evidence and adherence to national guidelines. In addition, an assessment of the ability of the models to achieve patient choice and seven day working will be undertaken.
- To examine the clinical assumptions used when developing the models. This will inform a judgement on the feasibility of successful implementation in the North, West and East Cumbria context.
- To assess the extent to which the models have been clinically led and have included the perspectives and views of a wide range of clinicians.
- To consider the potential impact of service change proposals on interdependent services, e.g. implications for provision of other specialties or for specialised services

The Citizen Representatives assessed:

- The extent to which patients and carers have been involved meaningfully in the design of plans
- The diversity of service user views gained
- The extent to which commissioners have included the views and experience of patients and carers in plans

The proposed models of care which were in the scope of the review were as follows:

- Integrated Care Clinical Model (including Community services)
- Mental Health Clinical Model
- Elective Care Clinical Model

- Proactive and Emergency Care Clinical Model
- Children's Clinical Model
- Maternity Clinical Model
- Any identified potential interdependencies between specialised services and locally commissioned services (The strategic approach to the commissioning of specialised services is out of scope).

A facilitated workshop involving Clinical Senate Review Team members and the Programme Managers and Clinical Leads from the Cumbria Success Regime was held to discuss and further clarify the proposals. A series of teleconferences were also used to support clinical discussions by each of the Review Teams.

A locality visit (see *Appendix 4*) was also organised. This provided an invaluable opportunity to gain insights and better appreciate the challenges of the local geography, travel times and varied demography etc. It also provided an opportunity to talk with some front line staff and a few local residents/ service users. The visiting party saw several community hospitals and observed some joint working and also visited the 2 acute sites. Finally, a series of teleconferences were used to support clinical discussions by each of the Review Teams.

This final report has been reviewed from a Public Health perspective by Dr Peter Elton, the Clinical Director of the Senate. His detailed comments have been included in relevant parts of *Section 7* relating the individual clinical models. His feedback covers:

- The opportunities presented by secondary care to contribute to primary prevention and lifestyle changes, particularly by taking advantage of "teachable moments".
- The need to tackle mental health in people presenting with physical illness.
- The proposed expansion of the use of Midwife-Led Units (MLUs) and in particular the need to undertake research on whether categories presently excluded, could safely be managed on MLUs.

It is acknowledged that a great deal of work has been undertaken as part of the Success Regime Programme and that the development of the clinical proposals is an ongoing iterative process. Work has continued since the submission of the documents for review by the Senate. For the purposes of the review it was, however, necessary to draw a line at a point in time. None of the subsequent development of the proposed clinical models has therefore been considered as part of this review.

Due to the stage of development of the proposed Clinical Models, the process that has been undertaken does not amount to a full clinical review for the purposes of assurance. In addition, a considered view could not be formed on the inter-dependencies with Specialised Services.

The following report is solely based on the work submitted by the Success Regime ***at the start of the review*** and the supplementary reports and data which were provided at the request of the Review Teams.

The Clinical Senate has focussed on the identification of clinical concerns or issues that need further examination or that should be considered by the CCG and other partners to inform the next steps in the development of the Success Regime programme.

3 Overall Reflections

3.1 The Senate Review Team recognises the Cumbria Success Regime Leadership team's commitment to achieving improvements for their populations and were impressed by their willingness to demonstrate openness and transparency in this iterative process.

3.2 There is recognition that the commissioners must strike a balance between the responsibilities of providing services to the population they serve whilst acknowledging the significant challenges faced in relation to the geography and attracting a skilled workforce and talent to the area.

3.3 The application of traditional models of care and workforce models to this challenging geo-demography is unlikely to identify solutions for the future of N, W & E Cumbria. Public health efforts will postpone some of the burden. There is, however, a need for creative thinking to identify the models that will be required in the future. It is likely that more remote-system technology and more population self-management (which requires an enhanced level of engagement and education) could be approaches that may evolve into a new health and social care ecosystem. In addition, there may be lessons from other countries (Scandinavia, New Zealand, Canada) which share similar issues.

3.4 The current funding models for the NHS and social care are more designed for urban than rural models. A higher ambition, possibly towards the devolution of N, W and E Cumbria may be required to overcome this particular challenge.

3.5 A major challenge for the Success Regime is to win the 'hearts and minds' and commitment of the local people and the workforce to realise their ambitions. In particular, there is a need for inspirational clinical leadership and a clearly articulated and universally owned clinically-led vision for the proposed improvements.

3.6 The Review Teams encourage local clinical teams and community representatives to meet with clinicians and others who have been involved in successful major improvement programmes, for example, Greater Manchester's Healthier Together Programme and Healthy Liverpool. The methodology used by these change programmes was intrinsically based on ongoing clinician, patient and public involvement and included the identification of standards, improved quality and population outcomes which inspired the development of the vision for change.

3.7 The theme of "parity of esteem" and "no health without mental health" needs to be built into the mental health plans. In addition, Mental Health needs to be an integral part of **all** of the Success Regime clinical proposals.

3.8 The Success Regime covers different populations which have different needs and will require bespoke solutions. Where possible the local teams should, however, be encouraged and supported to identify solutions from elsewhere and adapt them to local circumstances. A systematic approach to spreading

best practice and quality improvement methodology across the system should also be pursued actively.

3.9 The scope and scale of the proposed changes is vast. It is therefore suggested that a number of key areas for improvement are identified as priorities for rapid and focussed further development. In addition the local team should be encouraged to identify areas where rapid progress could be made so that some "quick-wins" (within 6 months) can be achieved to provide encouragement for ongoing local engagement in further work.

3.10 It is important for the Success Regime to describe an approach that ensures consideration of the strategic plans of the STP, County Council and LEPs that examine health, employment, community development, transport, broadband and mobile technology in order to optimise overall strategic planning for the region. Partnership working with local government, third sector and Social Care colleagues can support future rural communities and sustainable service delivery.

3.11 Whilst primary prevention and lifestyle changes are mentioned in the clinical strategies, these activities should be addressed actively by more than public campaigns and primary and community services. Secondary care has many opportunities to help as there are a lot of teachable moments. Most contacts provide such opportunities. There are some heightened opportunities e.g. pre-operative assessment, patients referred for suspected cancer but then have negative results and acute episodes where lifestyle is a major risk factor.

3.12 It would be helpful for the strategy to clarify how public health needs and recommendations from joint strategic needs assessments (JSNA) have been considered in the development of the proposed models. This should be made clear in future iterations. Furthermore, it will be essential to include rural proofing impact assessments in the strategy.

4. General Recommendations

At the time of the review, the proposed Clinical Models were at different stages of development. The following ***general*** recommendations apply to the majority of the proposed clinical models. There are, however, some clinical models where some of the issues below have been addressed. This is reflected below and in *Section 7* where specific recommendations are made for each proposed clinical model.

4.1 Vision, Clinical and Community Engagement and Communication

The Success Regime Programme sets out a strategy with plans to deliver system changes. It is understood that communication materials are being developed to inform and engage local people and staff. As indicated above, there is a need for robust ongoing engagement to develop and implement a clearly articulated and universally owned vision for the proposed improvements.

The proposed clinical models are at different stages of development. Maternity and Women and Children's are, for example, further advanced. There are good examples of local engagement, for example engagement facilitated by HealthWatch on maternity services. **"I am Sam"** is also an excellent example of explaining the vision to achieve positive outcomes for children and families. This approach to engagement is not, however, universally evident across all of the clinical models.

It is understood that the engagement and support of NHS England will be essential to ensure alignment with national initiatives, as well as to ensure adequate resources are mobilised to allow for increased capacity and capability for Out of Hospital services. It is not clear within the plans how far NHS England, the commissioners and providers of primary care services have been engaged, to ensure implementation.

Organisational Development (OD) could be a significant risk and there may be an under-estimate of the ongoing support required to facilitate the behavioural and human requirements for change. It is recognised that the programme leaders acknowledge these observations and aspire to develop OD infrastructure to support the change agenda.

The Senate Citizen Review Team has reviewed the proposals for each of the clinical models. Their reflections and recommendations are captured throughout this report. Specifically, they expressed concerns about the lack of evidence of a robust and meaningful engagement process for the majority of the clinical models. A number of engagement strategies are referenced, however, the documents lack details of events and there is little evidence of engagement with any groups. The engagement process needs to inspire confidence and be meaningful. Clarity on how this is going to be achieved is required.

Recommendations: Vision, Clinical and Community Engagement and Communication The Success Regime Leadership Team is encouraged to:	
4.1.1	Commit significant and immediate effort to Identify clinical leaders, incentivise and support them throughout the development and implementation of the Success Regime programme. Strengthen the project management resources available to the programme.
4.1.2	Further develop the process for ongoing engagement to develop and implement a clearly articulated and universally owned clinically-led vision for improvement for all of the proposed clinical models.
4.1.3	Co-design and communicate a robust and meaningful clinically-led engagement process which supports all areas of the Success Regime, ○ HealthWatch Cumbria has led an excellent engagement process for maternity services. If possible, they should be involved in the other clinical areas, ○ Greater Manchester's Healthier Together Programme and Healthy Liverpool will also provide some useful insights into the improvement process.
4.1.4	Explore and further develop closer working, governance and budget arrangements with social care and other partners through an Accountable Care/ Partnership type arrangement.

4.2 Clinical Standards, Improved Outcomes and Implementation of Best Practice

The use of benchmarking of clinical outcomes using the NHS and Public Health and Social Care Frameworks is a fundamental omission from the strategy and proposed clinical models. In addition, there is little evidence of the consistent use of clinical, professional and service standards to underpin the proposed changes to pathways and systems of care.

It is widely recognised that these are key elements in developing and maintaining safe and sustainable services. The programme leaders recognise the importance of clinical ownership and consensus in identifying, developing and embedding standards in the clinical models and have acknowledged this is key to the progress of the whole work programme.

In order to achieve improvement in outcomes and patient experience, the standards need to be "owned" by the teams and local communities. Clinical leaders should be supported to work with their teams and service users to interpret, translate and customise national and other standards to their local environments.

The standards should inform the vision, improve quality and provide clarity for the local population. In time, the standards will then support performance management and the development of IT systems to measure achievement of the standards across pathways and settings of care. The latter will take up to 2 years and will require dedicated digital resourcing, staff support and adoption of system wide quality improvement (QI) methodology such as in NHS Scotland.

The reviewers advise that the pathway development work will provide an opportunity to rapidly compile a comprehensive suite of clinical standards relevant to each clinical model and care across the whole system. These can be drawn from available NICE guidance and quality standards, local clinical guidance, and professional standards. In addition, patient experience standards can be co-designed with patients, communities and the third sector. Identifying clinical and patient experience standards will in turn inform measures and data that can be used by clinical teams to drive learning and promote quality improvement and reliable care. Furthermore, the standards will form the basis of commissioning specifications that will support the necessary move to outcome based commissioning.

The Clinical Senate are confident that, where required, a portfolio of clinical standards, outcome measures and patient experience standards can be developed and agreed within the next few months and reporting systems developed within twelve months.
If required, the Clinical Senate can support the further development of clinical pathways and models, providing expert advice where required and facilitating the input of the Strategic Clinical Networks, Royal Colleges and professional bodies, as appropriate.

It is understood that the N, W & E Cumbria Success Regime has attempted to involve social care within its governance arrangements. It has, however, been set up fundamentally as a health care transformation programme. It should therefore consider how public health and social care can be involved actively and made jointly accountable for addressing the challenges, co-creating the vision, developing the plans, supporting and delivering the change. In particular, there is a need to strengthen the project management, clinical and social care resources available to the Success Regime.

Recommendations: Clinical Standards, Improved Outcomes and Best Practice The Success Regime Leadership Team is encouraged to:	
4.2.1	Support clinical leaders to work with their teams and service users to identify, interpret, translate and customise national and other standards to their local environments.

4.2.2	Identify how public health and social care can be involved actively and made jointly accountable for addressing the challenges, co-creating the vision, developing the standards and plans and delivering the change.
4.2.3	Collaboratively co-design and develop a portfolio of clinical and patient experience standards for each clinical model and the system of care and ensure that they are used to: ○ Articulate the case for change in terms of patient experience and outcomes, ○ Inform any clinical assumptions for workforce, activity and economic modelling.
4.2.4	Identify solutions from elsewhere and adapt them to local circumstances.
4.2.5	Adopt a systematic approach to spreading best practice and quality improvement across the system.
4.2.6	Identify and prioritise key areas for improvement for rapid and focussed further development.
4.2.7	Identify areas where rapid progress could be made so that some "quick-wins" (within 6 months) can be achieved to provide encouragement for ongoing local engagement in further work.
4.2.8	Oversee development of reporting systems and a quality dashboard that demonstrates achievement of clinical standards across North, West and East Cumbria.

4.3 Workforce - Education, Training, Recruitment and Retention

There is a desire to provide seven day and consultant led services throughout the NHS. Providing this across diverse populations some of which are rural and remote, affluent retired, socially deprived and isolated will be a particular challenge.

The recruitment and retention of staff is acknowledged as an ongoing problem. Robust strategic workforce planning seems to be hindered by a lack of creative thinking and detail in some of the clinical and workforce models. It is in the interest of the region, for example, to encourage medical and other trainees into the area to realise dual benefits. It provides a high quality training experience evidenced by deanery evaluation that show trainees enjoy time spent in N, W & East Cumbria *and* it enhances the likelihood of medical staff returning in the future as more senior clinical professionals.

The Senate Review Teams heard creative ideas during the facilitated workshop and the locality visits. These ideas have not, however, been captured or developed in the documentation reviewed.

Recommendations: Workforce: Education, Training, Recruitment and Retention The Success Regime Leadership Team is encouraged to:	
4.3.1	Work with local clinicians and communities to think creatively about how best to meet the workforce challenges through the development of bespoke arrangements.
4.3.2	Undertake more work with partners across the geography including local communities, schools, colleges and Health Education England North West and the Northern Deanery to design novel approaches to training and workforce development, recruitment and retention that includes both the medical and non-medical workforce.
4.3.3	Undertake detailed workforce analysis and modelling informed by creative thinking as well as the necessary professional standards that deliver the agreed clinical models and patient

	outcomes.

4.4 Information Management and Technology Adoption

The requirement for clinical engagement in the development of IMT solutions should not be underestimated. There is a critical co-dependency between IMT, clinical systems and patient care that can only be made seamless by the close working of IMT systems engineers and clinicians. Telemedicine and data sharing are two examples of IMT systems which can improve patient care.

The complexity of the proposed system changes will require a bespoke approach. The detail within the plans at this time is high level. Clarification will be required in relation to how the system will achieve the requirements for information governance, information sharing and set digital maturity goals. In addition, consideration will need to be given to training and support to achieve changes in practice.

Recommendations: Information Management & Technology Adoption The success Regime Leadership Team is encouraged to:	
4.4.1	Develop clear information governance and sharing agreements across the whole system.
4.4.2	Develop a business case to support the IMT strategy that is based on learning from others such as iLinks across Merseyside, 'Data Well' in Greater Manchester and Salford (which is the most digitally mature organisation in the NHS) and includes: ○ Routine use of technologies such as telemedicine etc., ○ Information sharing, ○ Information governance, ○ Resources for health and care professional training.

4.5 Patient Transfer, Transport and Repatriation

North, West and East Cumbria covers a wide and remote geographical footprint with pockets of post-industrial social deprivation and rural areas of sparse population. There may be increased patient movement across the footprint following any reform in acute care, the impact this will have on repatriation and access to specialist services for patients needs to be clarified. For example, it is understood that there are 1500 paediatric overnight admissions per year at Whitehaven. An independent review of patient notes would help to clarify the potential number of clinically required paediatric transfers to Cumbria.

Recommendations: Patient Transfer and Transport The success Regime Leadership Team ins encouraged to:	
4.5.1	Clarify the impact of any proposed clinical changes on repatriation and access to specialist and other services for patients.

5. Outline of the Success Regime & High Level Overview of System Challenges in West, North and East Cumbria – Context for the Review

The Success Regime is a national initiative, announced by the Secretary of State in June 2015. It is designed to support the most challenged health and care systems across the country. Due to its long-term difficulties in recruiting permanently to key clinical posts, a history of financial challenges, and the need to improve the quality of services, West, North and East Cumbria was one of the three areas included in the Success Regime. It is led by a partnership of three national NHS bodies - the NHS Trust Development Authority, Monitor and NHS England.

An outline strategy for local services – Together for a Healthier Future – was agreed following significant engagement with local people and health and care staff in 2014. The Success Regime provides local leaders with the ability to build on this strategy and approach, but to make progress at the pace and scale needed over the next five years.

Local health and care leaders continue to lead and own the improvement programme and the Success Regime provides them with access to support, expertise and resources at a national level.

The programme is based on the need for local health and care organisations to work more closely together as a 'system', united in a common purpose, approach and set of ambitions.

Geographically, the West, North and East Cumbria system is defined as the districts of:

- **Allerdale** 96,471 residents
- **Copeland** 69,832 residents approx. 11,000 in Lancs & SC STP area
- **Carlisle** 108,022 residents and
- **Eden** 52,630 residents.

This area is part of the wider region of Cumbria, which also includes the districts of Furness and South Lakeside. North Cumbria represents c.65% of the wider Cumbria population.

Health and social care services are delivered to the North Cumbria population by a wide variety of organisations:

- **Cumbria Clinical Commissioning Group (CCG) – whole county**
- **Cumbria County Council – whole county**
- **Cumbria Partnership NHS Foundation Trust – whole county**
- **North Cumbria University Hospitals NHS Trust – North Cumbria**

- **North West Ambulance Service – whole county and beyond**
- **Primary Care Organisations – Localised**
- **Tertiary and Network Providers (Newcastle-upon-Tyne NHS FT)**

5.1 The West, North & East Cumbria Context

It is recognised that the challenges for health care in W, N & E Cumbria are deep-rooted, long-standing and spread across the whole system as opposed to individual organisations. Local and national organisations have worked hard for some time to improve services for patients and the public, but have not made the progress needed.

Historically, there have been significant quality challenges across the W, N & E Cumbria local health and care system, and these persist today. Specifically, North Cumbria University Hospitals NHS Trust (NCUHT) has been in special measures since 2013 and the health system regularly fails to achieve the key waiting-time requirements in accident & emergency, time from referral to treatment, cancer, and diagnostics. Recently the number of delayed transfers of care has also increased significantly.

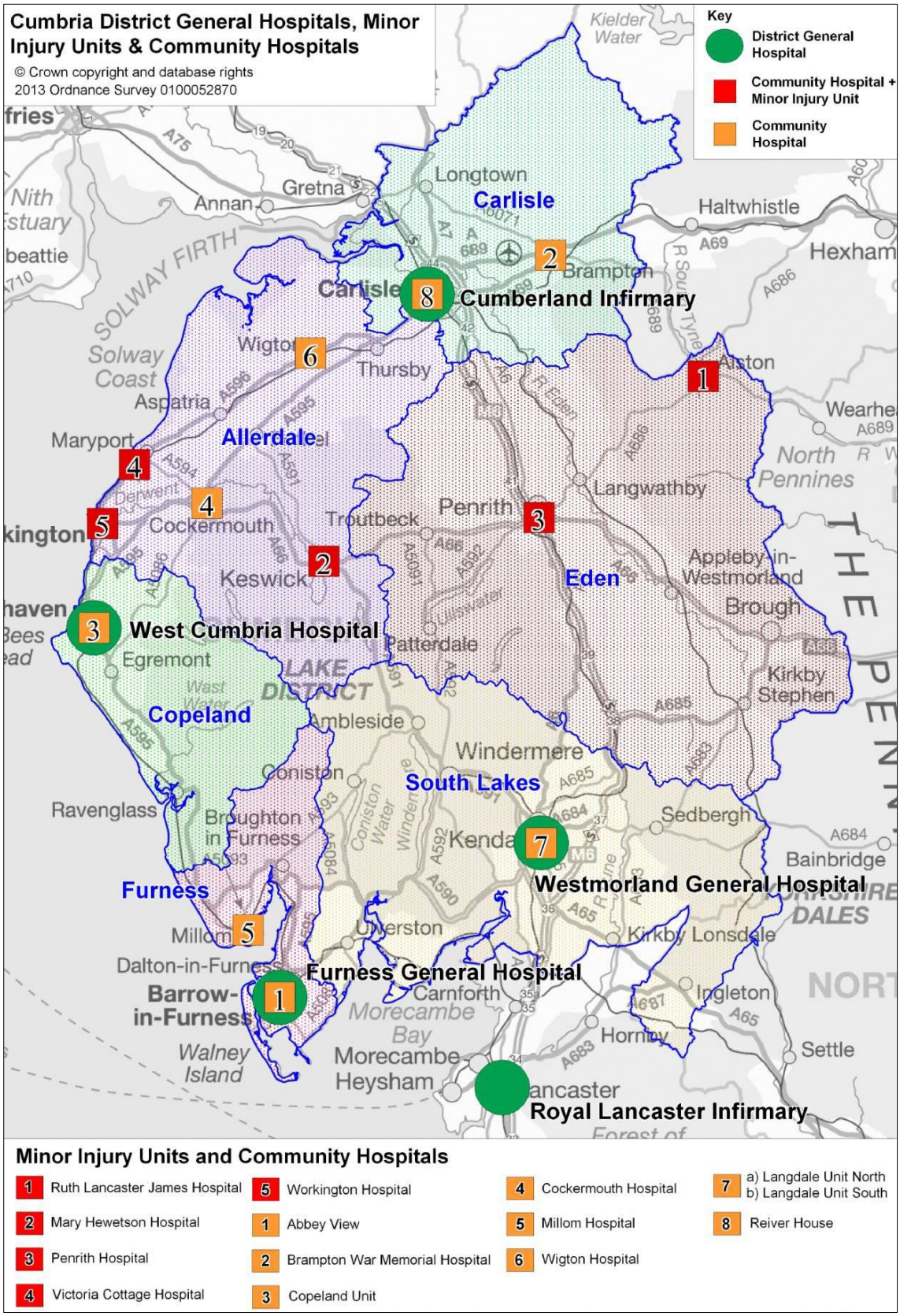
In September 2015 the CQC rated urgent and emergency services at NCUHT as "requiring improvement", with general medical services at West Cumberland Hospital (WCH) rated "inadequate".

As a consequence the Chief Inspector of Hospitals required the local health system to produce a clinical strategy by March 2016. The CQC recognised that the issues impacting on the Trust were in part due to the current

configuration of services provided across two acute hospital sites, each serving relatively small, rural and dispersed catchment populations. The Trust is therefore required to begin the move towards a new organisational form by September 2016.

In addition, while W,N & E Cumbria have historically benefitted from high quality primary care services (specifically general practice services), these too are experiencing significant pressure associated with increasing workload, a challenging resource outlook and increasing workforce difficulties.

Cumbria Partnership Foundation Trust (CPFT), which provides mental health, learning disability and community-based services across the area, is experiencing similar issues, as is Cumbria County Council. The recently published CQC report on CPFT gave an overall rating for the Trust as "requires improvement", with particular concerns identified in relation to services for children, young people and families.



5.2 High Level Overview of System Challenges

5.2.1 Culture and Leadership

It is understood that local organisations have, in the past few years, worked hard to improve the care and services they provide but progress has been too slow. Staff engagement and levels of confidence

from the people who use local health and care services remain low. In addition, the health and care economy is both challenged and fragmented.

The scale of change required will only be achieved if national and local leaders work together with a shared sense of purpose and focus on improving outcomes both with and for patients. Recognising where it has fallen short in the past and demonstrating the right leadership behaviours, developing the capability to learn and improve.

5.2.2 Health and Wellbeing

W, N & E Cumbria population is "super ageing", with a higher than average growth in the proportion of older people year-on-year compared to the rest of England. By 2020, nearly 25% of the Cumbria population will be aged over 65.

There are comparatively high levels of ill-health prevalence rates within the population, meaning that there is a high treatment burden in primary and secondary care. There is therefore a need to tackle primary prevention and address lifestyle risks, particularly in the more deprived pockets across W, N & E Cumbria. W, N & E Cumbria's overall performance on a range of health and wellbeing indicators disguises significant inequalities at district, lower layer super output area (LSOA) and ward level. There is a 19.5 year gap between the wards with the highest and lowest life expectancies in the county, with life expectancy in some wards being 8.4 years below the national average. Copeland has more than twice the prevalence rate for smoking as compared to Eden, implying an additional 9,500 smokers.

5.2.3 Access to Services

W, N & E Cumbria is one of the most rural counties in all of England, with a population density of 74 people per sq. km, compared to 413 across England and 255 people per sq. km in the UK. This varies across districts from Eden having 25 people per sq. km to Carlisle having 104 people per sq. km. Geography makes patient access and service delivery harder than average, with communities spread over large distances and isolation a key issue.

The low population density means there is a trade-off between providing easy access to essential services and running sub-scale services that are costly to provide. Distance to GP services highlights the issue – specifically the average distance for Eden is the highest among all districts nationally, with all four districts falling in the top quartile. The west coast of Cumbria (c.120,000 population) is especially isolated. For example, the towns of Whitehaven and Workington, with populations of c.25,000 each, are about 39 and 30 miles respectively from Cumbria's largest urban centre of Carlisle, and 100 miles from Newcastle. Geography and transport are therefore significant challenges especially when combined with adverse climatic conditions such as the recent floods.

It is in this context that a clinical strategy must give priority to strengthening public health, primary care and community based services to achieve a step change in population health.

5.2.4 Care and Quality

Historically, the quality of general practice services has been high and while this continues, the pressures on these services are increasing and recruitment and retention is now a significant risk. Some acute hospital services (e.g. urgent & emergency care, secondary care diagnosis & treatment) are not always provided sufficiently promptly and core constitutional standards are not consistently met.

It is recognised that more needs to be done to reduce the reliance on hospitals and care homes, providing better access to rehabilitation, enablement and support services which enable people to live more independently at home. This is especially the case for people who are frail or need multi-agency care, and people experiencing mental health distress.

Due to significant recruitment issues, the health and care system is currently using an expensive large temporary workforce of doctors and other key professionals. This is a major factor affecting the cost and quality of services in primary, secondary and social care, and feedback from staff is that they are often not working optimally.

5.2.5 Finance and Efficiency

It is recognised that the W, N & E Cumbria system is currently facing significant financial pressures with a projected underlying deficit of c£85m across providers and commissioners in 2015/6. In part, these pressures are due to a failure to drive efficiencies and productivity. There is, however, also evidence that the pressures are a result of the diseconomies of scale associated with the current configuration of services and the area's geographical rurality (which also contributes to the difficulties in staff recruitment and retention).

Inflationary pressures and increasingly complex population needs mean that the system will be even more stretched in the future, with the system challenge potentially increasing to £163.8m in 2020/21. NB/ it is understood that these figures do not include the position for Cumbria Council or primary care providers, which are experiencing similar challenges.

The scale of this challenge is such that a whole system approach is required. It is crucial that every opportunity to improve efficiency and productivity is explored, by reviewing the workforce, facilities, IT and purchasing activities in line with Lord Carter's recommendations.

5.3 Summary of Challenges

As indicated above, there are very considerable challenges facing North, West and East Cumbria, due to the geographic area covered the isolation of the significant population centre on the West Cumberland Coast in Whitehaven, Workington, Maryport and Egremont, poor staff morale and retention and a history of many management teams in the last 7 years. Recruitment of key medical staff is in a critical position with many services significantly reliant on locum/ agency staff. The CCG and local hospitals have made great efforts to improve things, despite severe financial constraints.

There is recognition that the CCG and local Trusts have a shared aim to ensure a safe and sustainable service for their patients, and that the current arrangements for hospital services are not satisfactory.

It is, for example, recognised that Medical Care at WCH was rated inadequate by the Chief Inspector of Hospitals, which gives urgency to the need for a change in the way patients are cared for. The Clinical Senate is therefore pleased to be asked to review and provide recommendations on the proposed clinical models of care.

6. Methodology

There were 4 key elements to the methodology:

- A desktop review of information
- Teleconferences and meetings with the working groups and SROs of each clinical area
- A Facilitated Workshop focussed on each proposed clinical model and
- A locality visit *[The purpose of the Locality visit was to better appreciate the geography and transport infrastructure rather than review the health system assets and capabilities].*

Relevant independent clinical experts were sourced from the four clinical senate areas (excluding the Northern Senate) that make up the North Region. The details of the independent clinical team that was convened to perform the review can be found in *Appendix 1*.

The information provided by the clinical and programme leaders of the Cumbria Success Regime is shown in *Appendix 4*. In some cases it included data used to inform the development of the proposed models and details of clinical pathways. The clinical leaders and Project Managers made themselves available during the review process to answer queries and clarify points, as necessary.

The questions for the review that were agreed with commissioners are shown in *Appendix 3*.

Review Team Members reviewed the information provided and a number of teleconferences were held to discuss and clarify information and identify key issues and recommendations. In addition a half-day facilitated workshop was convened with clinical and managerial members of the Cumbria Success Regime and Senate Review Teams on 18th April 2016 to discuss the proposed clinical models in further detail. A locality visit was held on 25th April, details of the participants and the itinerary are shown in *Appendix 4*.

The final report was written using an iterative process of initial drafting, review and comments between the Review Team members.

The initial draft report was shared with the Success Regime and the Senate Review Teams on 3rd May 2016 for immediate review and comment. It was subsequently updated before being shared electronically for review, ratification and signed off by the full Senate Council on Friday 7th May 2016.

The final report was sent to the Success Regime Team via email on 9th May 20016.

7. Summary of Key Recommendations from each Clinical Review Team

Clinical Review and Key Recommendations for the Proposed Models of Care

7.1 Mental Health Clinical Proposal Recommendations

The review team were concerned by the level of importance that appears to have been given to Mental Health. It needs to be an integral part of all of the Success Regime clinical proposals. For example, the team were disappointed that learning difficulties was only mentioned in passing and the focus appeared to be finance rather than clinical quality.

The proposed models for Mental Health are at an early stage of development. It is therefore not possible to answer comprehensively the Senate key questions in any depth. The following comments are based on the proposals submitted at the start of the Senate review. It is hoped that the clinical recommendations might guide further development of the mental health plans.

Scope and Content of the Proposed Model

Throughout the mental health documents, detailed references are made to examples of good practice nationally. In addition, there is evidence of early stage development of sub-areas of the clinical model. It is hoped that these will be included in the overall plan for Mental Health.

The focussed work on development of a multi-agency crisis response model is good. It is acknowledged that the modelling of patient flows through in-patient care is underway, although this needs significant further development. In particular, the review team suggest that the place to start co-design of Mental Health is at the population level and in the community. It would therefore also be helpful to model impact on demand for the new crisis model and enhanced primary mental health. Aggregated needs-based data and the inclusion of any summary clinical data would further enhance the development of the plans.

The theme of “parity of esteem” and “no health without mental health” has not so far been built into the mental health plans. It is acknowledged that there is a need to improve the physical health of patients with mental illness. There is also, however, a need to address mental health in people presenting with physical illness. This group, as well those with medically unexplained symptoms and others with health anxiety, will have better outcomes if there is a good liaison mental health service. There is also evidence suggesting that it will save costs.

It is important to ensure that wellbeing and mental health receive equal advocacy to physical health throughout life. There is therefore a need to describe methodology and outcome measures that will show how this will be achieved, particularly the impact on wellbeing. A greater focus on outcomes

that link to whole person care would be the ideal. This could be progressed as a key part of the cultural change programme. The inclusion of mental health professionals as equal partners within integrated care teams is important and any ongoing work also should also extend to Child and Mental Health Services (CAHMS).

Recommendations: Mental Health – Scope and content of mental health proposals The Success Regime Leadership Team for Mental Health is encouraged to:	
7.1.1	Focus on the acquisition, review and analysis of needs-based data across the system.
7.1.2	Ensure that Mental Health is integrated within the Success Regime programme and informs all other clinical plans. ○ Further develop work to achieve "parity of esteem", for example, by including primary mental health expertise within the physical health team integration development, ○ Ongoing work also should also extend to Child and Mental Health Services (CAMHS), ○ Consider and take account of how the strategy will impact on other health care providers including A&E, social services, carers, staffs, public health, ambulance services, and pharmacy.
7.1.3	Model flows through the crisis response model for all ages, to gauge impact on in-patient and primary care flows.
7.1.4	When developing the concept of more treatment at home, when undertaking the review of estates, there is a need to be sensitive to evidence where family pressures can exacerbate rather than support mental health difficulties. ○ It is important to identify how primary care or home care will address the complexities of patient care rather than seeing it as a solution to low staffing ratios, geographic complexities and limited finance.
7.1.5	Prioritise the building of resilience for services to children and families as part of overall mental health plans, particularly the transitional years.
7.1.6	Consider further the remodelling on in-patient flows as a direct response to primary mental health and crisis response outcomes, particularly where the re-distribution of funding may negatively impact elsewhere in care pathways. ○ For example, there is a need to ensure effective CAMHS and ED support at Whitehaven to avoid admissions.
7.1.7	Investigate the need to provide effective support for self-harming at Whitehaven to avoid admissions.

Delivery of Best Practice Clinical Outcomes

As indicated above, there has been considerable effort to understand both the current service position and best practice models. A key theme within the strategy document is service improvement both in terms of quality and outcomes. A number of service models are being developed. In so far as the documents reviewed describe good service principles, positive outcomes can be expected. Further work is, however, required to illustrate how the service standards will inform the evaluation of clinical outcomes and audit of performance.

Recommendations: Mental Health – Delivery of Best Practice Clinical Outcomes

The Success Regime Leadership Team for Mental Health is encouraged to:	
7.1.8	Develop system clinical outcome measures that will enable benchmarking of strategy roll out.
7.1.9	Use findings from past service challenges to understand their impact on clinical outcomes.
7.1.10	Where areas of strategy are built around "proof of concept", focus on clinical outcome measures in this proof.
7.1.11	Consider more critical analysis of existing practice and identify the changes that need to occur that will help both staff and patients.
7.1.12	Consider in greater depth how bed management strategies can address the needs of patients and their carers as well as the resourcing issues of the NHS.
7.1.13	Encourage hospital clinicians to work and/ or be involved more in the community care centres.
7.1.14	Build a core clinical governance theme based upon routine acquisition of patient/ carer/ family experience.

Clinical Workforce

Workforce data is absent from the mental health documents reviewed. As mentioned earlier, workforce is key to the successful implementation of any strategy simply because it determines whether or not the strategy is feasible. Nationally, the mental health workforce capacity is modest and geographically patchy. For Cumbria there is particular difficulty in recruiting medical and other staff. There is therefore a need to include a targeted and innovative recruitment strategy to address these challenges.

Recommendations: Mental Health – Workforce The Success Regime Leadership Team for Mental Health is encouraged to:	
7.1.15	Use a baseline workforce assessment to test the feasibility of new service models.
7.1.16	Evaluate innovative recruitment strategies e.g. The Millom Initiative.
7.1.17	As part of modelling new services, evaluate competency impact of moving staff into new roles and build an integrated training support model to mitigate skill gaps.
7.1.18	Exploit current initiatives to extend contribution of IT solutions and staff training to engage local populations.
7.1.19	Consider the training all staff in the management of challenging behaviours to promote parity of esteem. In addition, all staff should *make every contact count*, for example, smoking cessation and CVD risk reduction. This will ensure that Mental Health teams address basic medical issues as well as physical teams addressing basic mental health issues.
7.1.20	Consider a rapid response team for all mentally ill patients going through a crisis episode for all ages in A&E Departments.
7.1.21	Review further, initiatives to involve competencies for third and voluntary sectors in building workforce resilience.

Service Access Optimisation

The geography of Cumbria presents a significant challenge to the design and delivery of services. The documents clearly describe this and illustrate how influential this issue is in the design of the clinical plans. Due to the early stage of development, it is, however, unclear how the emerging mental health models will work in relation to the native population and geography. It is particularly important, given the challenges that the geography presents, that the "5 year forward view" influences local thinking to bring services to people rather than people to services.

Recommendations: Mental Health – Service access optimisation The Success Regime Leadership Team for Mental Health is encouraged to:	
7.1.22	Build on the existing strategy to ensure the general public are core to engagement processes that seek to understand preferences for how services should be delivered.
7.1.23	Consider how best to integrate communication systems into new models, particularly in relation to connecting people with services and supporting individuals and their families.
7.1.24	Test how the new models can be built around specific population areas with sensitivity to both native population, geography and skill recruitment.

Quality Measures

Unfortunately, due to its early stage of development, the mental health strategy documents do not currently show how new and emerging models, or their outcomes, will be measured. It is hoped that a range of measures will be developed covering an individual level from a health and wellbeing and illness recovery perspective and global level of care episode flows and system efficiencies.

7.2 Integrated Care Clinical (ICC) Model (including Community Services) Recommendations

General Comments

The papers reviewed were written at a high level and the vision for the proposed changes was unfortunately unclear. It is well recognised that integrated care is the key to optimise use of the acute sector (including mental health). The problems are understood and well described in the clinical strategy proposition. There is acknowledgement that investment in organisational development and community services such as care in the community and residential nursing homes is crucial. In addition, it is recognised that strong leadership and wider ownership among the workforce, communities and health and social care organisations will be needed. A single point of access and integration of IT systems including use of linked data sets, greater use of GP data to develop cohort-based techniques for tracking the care of individuals with long-term conditions that include analysis of the quality of care, as well as estimated cost and service use are also essential.

It is important to note that the overall success of the ICC project needs to be measured by the longer term resilience of the whole health and social care economy and its ability to adapt to the changing needs of the population and not based on the success or failure of an individual project.

Whilst the rationale for a locality based health care system appears robust, it would be helpful to understand how this will be achieved. Defining the service change and understanding the potential

barriers to change will be key. In particular, it would be helpful to understand what the ICC will achieve and how it will be implemented. The pace of change needs to be sustainable and requires organisational integration as well as standardisation of process and clinical pathways.

The Review Team understands that the early adopter sites have been asked to develop the clinical model for delivering integrated services. The timescale from the establishment of the pilots to full implementation is, however, very short. Consequently the benefits from the pilots may not be fully realised.

The Success Regime is encouraged to examine individual pathways to identify lessons to support change. In addition, it would be helpful to visit and learn from other health economies which have had success at achieving fuller integration e.g.

- The High Risk Patient Programme - Northumbria Healthcare NHS Foundation Trust
- North Lancs COPD Programme
- Collaborative care teams in Airedale
- Inner North West London and Trafford have attempted to develop more widespread integrated care across a whole health care economy.
- Merseycare NHS Trust - keeping people with dementia independent for longer.
- Oldham Local Authority has involved local communities and 3rd sector colleagues to help support integration. They have implemented an early intervention strategy using the same tools and assessments across all the teams in the Local Authority and Health within the community. It is based on a single point of referral online.

In addition some helpful references are shown below:

- Examples of integrated care: www.shiftingthebalance.scot.nhs.uk/improvement-framework/improve-access-to-care-for-remote-and-rural-areas/
- Examples from abroad, particularly Colorado, Pennsylvania, Georgia, New Mexico https://muskie.usm.maine.edu/Publications/rural/Integrated-Care-Rural-WorkingPaper.pdf
- https://www.gov.uk/government/news/integration-pioneers-leading-the-way-for-health-and-care-reform--2
- http://www.kingsfund.org.uk/publications/population-health-systems.

  70 community pharmacists in Wigan offer smoking cessation and sexual health advice services, as well as referring people to relevant services if they spot early signs of issues like isolation, dementia or the risk of falls. The approach is now being extended to dental practices in the area. Wigan Council has also established a community investment fund to provide support for ideas from the community sector that will improve people's health and wellbeing.

- In other parts of the country, programmes are being established that recognise the connections between people's health and their living environments. One example is

Liverpool City Council's Healthy Homes Programme. This uses targeted assessments of people's health needs and the conditions in their homes to identify interventions to improve health and wellbeing. Interventions include 'health-proofing' homes from damp and excess cold, removing hazards in the home to reduce accidents, and giving advice on fuel poverty and keeping homes warm, as well as referrals to a range of local partner organisations. The programme has achieved reductions in the number of excess winter deaths and financial savings for the NHS.

- In some areas, volunteers have been trained to become 'community health champions', supporting people in their neighbourhoods and broader communities to lead healthier lives,

as well as working with commissioners and providers to improve the quality of services available in their local area

- International case studies such as: Kaiser Permanente, USA; Nuka System of Care, Alaska; Gesundes Kinzigtal, Germany; Counties Manukau, New Zealand and Jonkoping County Council, Sweden.

Standards, Outcomes and Audit

The Success Regime is encouraged to ensure that standards are developed and potential interim and longer-term qualitative and quantitative outcomes identified for the current model. The Review Team recognise the desire for "quick wins". There may, therefore, be pressure to show a positive evaluation result in terms of activity and costs in a short period of time. In the first or second year, changes to structure and processes are interim outcomes which will not have an immediate positive impact on service use and patient outcomes but will support improvements at a later date.

The Review Team suggests that it would be helpful to implement an audit process which could be used to measure progress. The development of clear pathways to allow early assessment and potentially prevent admissions is essential and should be easy to audit. The North Lancs COPD pathway is a good example. A local baseline audit would be useful as the results will give details of current outcomes, gaps in the service and the standards which are currently being met. The audit can then form the basis of the evaluation as the initial data can be compared at the end with the pilot data.

Communication and Governance

The number of organisations and the fragmented nature of services between districts is a challenge which should be addressed through robust governance arrangements. This will ensure that duplication of effort and failure to respond to lessons learned is avoided. The Review Team therefore recommends the development of a communication plan and robust governance arrangements for the pilots and other adopters. It would also be helpful if the plan could include longer term plans for communicating public health messages and facilitating local change.

Workforce

Engagement and development of the workforce is crucial to achieve the identified standards and outcomes. The workforce needs to be motivated and supported to adopt new ways of working. Workforce planning should include the development of new roles and existing roles such as community practitioners i.e. Occupational Therapists, Physiotherapists, Pharmacists, Midwifes, Social Workers, Third Sector, Care home workers and carers. The plan will need to address practice isolation, for example, by developing rotations and/ or secondments. The development of new roles or new ways of working also needs to be underpinned by training programmes and included within a governance structure which describes the accountability of individuals and organisations. Plans to start recruitment in schools would also help to inspire younger individuals to train as health care professionals.

Population Access

It is suggested that the ICC team work with their estates teams to optimise access. The consolidation of services in the community will help as will the development of shared IT bundles.

Recommendations: Integrated Care Clinical (ICC) Model (including Community services) The Success Regime Leadership Team for ICC Services is encouraged to:	
7.2.1	Consider the creation of robust governance arrangements which include key stakeholders, for example through the use of an Accountable Healthcare System or other partnership model with all partner organisations.
7.2.2	Identify and stratify the risks across the health and social care system and use the results to inform the development of the ICC programmes and footprints. This could be achieved by creating a map of patient journeys to learn about and appreciate the existing problems and identify the improvements that will have the biggest positive impact for patients and staff.
7.2.3	Visit and learn from other health economies which have had success at achieving integration (examples above).
7.2.4	Develop and measure achievement of standards and improved outcomes, through the implementation of an audit programme to inform the ongoing changes. Also consider the use of other service evaluation tools such as patient reported outcome measures (PROMs) and clinician reported outcome measures (CROMs).
7.2.5	Engage with stakeholders to co-design plans and proposals to meet the needs of the population within the resources available. ○ Consider integrating services that offer a logical fit and where the impact will be greatest based on the local population and geography.
7.2.6	Develop a communication plan and robust governance arrangements for the pilots and other adopters.
7.2.7	Undertake further work to develop a robust and realistic workforce plan which addresses the following: ○ Models the proposed workforce roles and numbers and testing the assumptions regarding potential financial savings, ○ Clarifies the age profile and turnover of the staff,

	○ Clarifies the assumptions which have been made about the recruitment of new staff into the area and whether the anticipated numbers are realistic, ○ Clarifies the assumptions which have been made regarding the flexibility of the workforce and whether these are realistic, ○ Builds on the results of a risk assessment of staffing numbers and clarifies the proposed governance arrangements to manage the identified risks, ○ Outlines plans for the ongoing training and development of staff, ○ Describes how professional isolation will be addressed, ○ Embeds Quality Improvement into work force training and CPD, ○ Describes the extent that local commissioners have been engaged in the development of the workforce plan.
7.2.8	Develop an integrated IT plan (with appropriate training) which embraces telemedicine in order to address some of the patient access issues.

7.3 Children's Clinical Model Recommendations

General Comments

The Review Team recognise that significant previous work has been undertaken on Children's services in the form of the first Clinical Senate Review and the subsequent review by Dr Shortland. Despite this, the Children's clinical model is at a relatively early stage and the detail within it is insufficient to

provide full clinical assurance. In particular, the whole system approach needs further work, including the models of integrated care communities and integrated clinical teams, integration between community and secondary care and integration with general practice. Though the focus is likely to be on the configuration of acute hospital inpatient services, it should be noted that improved outcomes for children are most likely to be achieved through improving access to services, promoting health, and strengthening care within the community.

There is agreement that the present model of care is not sustainable in the future. The Review Team are concerned that the present situation will move from one of unsustainability to an unsafe service unless decisions are made in a timely manner and interim arrangements put in place.

The Review Team believe that the focus needs to be on improving health outcomes. This will ensure that health and the local communities' access to high quality services is the main consideration.

It should be noted that the transition to a new configuration of hospital based care would be faster if the APNP model was not the only route to remove the middle tier. Barrow, for example, is running a service with consultant with tier 1 trainees/ APNPs. This could work for Cumbria particularly if the SSPAU model was implemented.

The short term destabilising effect of any decision (apart from no change) needs to be factored into the planning process. The on-going lack of clarity will also not help the recruitment process.
Interim arrangements are an important aspect of any proposed model and may be in place for a number of years. This is particularly important if training of a 'middle tier' APNPs is required. This needs to be factored in when considering the achievability of the proposed models in terms of both

staff resources and financial costs particularly if APNPs need training before the middle grade is withdrawn.

It is important to understand the demography better to determine whether the proposed changes will be sustainable by the time implementation is complete. Additional information (e.g. an audit on the likely number of patient transfers with consultant review of notes at time of transfer) would therefore be helpful. In addition, further information on the changing demographics for those most likely to be admitted (infants) is required. It is recognised that the under 19 population is declining. It would also be helpful to understand changes in the under 2 year old population, which is a greater user of paediatric services.

Public and staff engagement is important. The successful implementation of any new model will require active and ongoing support from paediatricians and primary care to develop outreach paediatric clinics. The outcomes will need to be universally agreed so that the service is focussed on their achievement. Administrative support and clinic nurses will be vital to assist with these clinics but will also ensure that there is ongoing opportunity for shared learning.

The Sam's House work is an excellent foundation for engagement but it now needs to help the population understand pressures on the system. For example, the proposal states that 'People are mainly happy with paediatric services, they don't feel there is a need for root and branch reform'. This suggests that there has been little engagement on the real reason reforms are being considered.

The following documents were considered:

- for RCPCH Facing the Future Standards for Acute General Paediatric Services 2011 and 2015
- Department of Health Toolkit for High Quality Neonatal Services, 2009
- The British Association of Perinatal Medicine. Service Standards for Hospitals Providing Neonatal Care, 2010
- Paediatric Intensive Care Society, Quality Standards for the Care of Critically Ill Children, 2015
- In addition the team reviewing this work stream was augmented by a senior APNP to provide expert advice on the APNP aspect of the proposed model, given that solutions proposed heavily rely on this cadre.

It would be helpful for the Children's team to consider the following points in the further development of their plans:

- Any acute assessment unit at CIC should be fully integrated with the inpatient facilities to provide clear pathways of care.
- The co-dependency between paediatrics and maternity services is integral to the model of care provided.
- There needs to be parity of planning for CAMHS and integration within the proposed model.

The Review Team has significant reservations about whether the proposed model is deliverable.

It is dependent upon the recruitment and training of Advanced Paediatric Nurse Practitioners (APNPs) (8 at WCH and 10 at CIC), over the next 7 years. It is recognised that the training of APNPs requires significant time, 2023 is mentioned in the proposals. It is, however, unclear whether interim arrangements would be sustainable over this length of time.

As the majority of these trainees are likely to come from the existing nursing workforce there is a risk that not enough potential APNPS would be identified. In addition, the existing workforce would be destabilised as senior nurses move into APNP training. Furthermore, recruitment to the APNP programme will remove senior nurses from the nursing workforce thereby reducing the experience of that workforce at a time when a new model of care is being introduced – this needs to be considered and addressed by the nursing and Success Regime leadership.

It is also worth noting the proposed expansion of Children's community services. The stand-alone SSPAU would be closely linked to this community service and is a key component in the service's initial viability and ongoing safety and sustainability. However, this will put additional pressure on the pool of experienced nurses as recruitment to community nursing alongside that for the APNPs is likely to come from this same pool.

There is little information about how these APNPs will be retained in post. It is understood that a previous cohort has largely moved out from secondary care into primary care. Retention of APNPs therefore needs to be considered as does their banding which is below other ANPs. Finally, the development of an APNP role such as this requires a significant cultural change amongst parents and families and medical and nursing staff. This needs to be considered as well as the leadership required to implement the change in practice.

The RCPCH ***Facing the Future*** document suggests a requirement of 7.7 WTE consultants for a small unit such as WCH. This is included in the plan, however, at present, WCH only has one permanent consultant. The remaining posts are filled by long term locums. In addition, it is understood that a recent recruitment process has provided no reassurance that this number of consultants could be recruited. The proposals therefore need to address directly how consultant recruitment would be delivered. The difficulty in recruitment needs to be acknowledged more fully in the proposals (and potentially in local consultations). The Review Team suggest that consideration of whether a 14 hour SSPAU (this potentially could be extended to 16 hour) with no overnight consultant cover (e.g. no overnight beds at WCH) would be more attractive.

- The importance of consultant recruitment at WCH is that the preferred interim arrangement for middle tier posts will be gradually withdrawn with expansion in the number of Consultant posts. This may have a negative impact on consultant recruitment, particularly if required to be resident on call to cover gaps.
- It is understood that the move to APNPs was intended to 'replace' the middle tier. It is therefore not clear that in an SSPAU model this is needed if it is a consultant delivered model. A mix of tier 1 and APNPs might allow transition to be faster, and deals with the uncertainties of recruiting and retaining APNPs.
- The compliance of Tier 1 posts needs to be considered – these are to be retained but numbers are low – 5 going down to 4 at WCH, though APNPs might be an option here.

- The whole system approach is predicated upon a general practice workforce that has the resources to engage with and develop this new model of care. Our understanding is that this workforce is under significant strain with difficulties in recruitment.
- These changes can only be made with strong clinical leadership in order to achieve the whole system changes.

The model needs to consider long term retention of skills for staff at WCH where the number of patients (particularly sick/ critically ill children) will be small. Clarity about how the clinical skills of staff will be maintained is required, e.g. for the APNPs who have just completed their training. Are rotations to higher acuity sites being considered?

Consideration was made of Physicians Assistants. This is, however, a relatively new role and its introduction into a paediatric service would better be achieved from a position of strength rather than challenge, as is faced by the Success Regime. The Review Team felt this unlikely to be relevant as an option.

Recruitment is considered the major issue within this report. It is also important to consider the cost of successful implementation of the model in the light of funding and tariff for the relatively low number of patients for the service at WCH.

Best Practice Clinical Outcomes

Best practice outcomes are potentially deliverable based on the model of Sam's House which focuses on a whole system approach. Evidence was provided to support this. This does, however, require integration between teams and cross boundary working between organisations. As there is no plan for the acute and community trusts to merge, assurance is required about the commitment of both organisations to this model of care.

CAMHS is mentioned in the proposal but more detail would be helpful on pathways of care, e.g. 'Sam', the self-harming teenager admitted to WCH.

Proposed Quality Measures

Gaps still remain in the data on potential need for transport between WCH and CIC and the potential impact on the ambulance service:

- If WCH becomes an SSPAU with overnight accommodation for low acuity patients only
- If WCH becomes an SSPAU open 16/ 18 hours only

The review Team suggest a retrospective, semi-independent notes audit of patients on the ward at WCH at midnight based upon consultant presence until 22:00 would give a reasonable indication.

Quality measures for the whole system approach need to be considered including A&E attendance and unplanned admissions.

Population Access

The proposed model is designed to meet the needs of two distinct population centres approximately 40 miles apart with an additional rural population. If fully implemented, particularly the outward looking clinical care communities, then population needs can be met. There is, however, a real risk that the reconfiguration of paediatric (+/- maternity) services at WCH will overshadow the wider agenda both internally and in the public consultation.

There is therefore a lack of assurance that the whole model of integrated care will get the support required for success. There is therefore a significant risk that only a partial solution will be achieved (focussed on secondary care) which will not meet the population needs.

Service Interdependencies

Service interdependencies need to be considered in relation to:

- Maternity and neonatal care
- Anaesthesia
- A&E
- Ambulance – low acuity transfers/ by-pass criteria for WCH A&E
- CAMHS
- Surgery
- Community services/ General Practice
- The delivery of community paediatrics and paediatric care within primary care settings, acknowledging the recruitment problems in these areas – The Cumbria Health Out of Hours Service alongside A&E at WCH was noted as a model of integration

The pathways of care for the critically ill child attending WCH need to be tested for each option, in particular overnight care. Should there be by-pass criteria for the WCH A&E or stabilisation at WCH? (If stabilisation, how will the skills to undertake this be maintained when the numbers involved are low?)

There is a clear interdependency between maternity and children's services. It is noted that the preferred option considered by the maternity review team is for an obstetrician-led service at Whitehaven. However, this does not address the problems of sustaining neonatal cover.

This appears to be the most challenging issue in light of the significant reservations about whether the proposed model for children's services, which provides 24/7 neonatal cover, is deliverable. More thought therefore needs to be given to the scenarios that do not involve middle grade neonatal medical staff and innovative solutions need to be explored that can maintain neonatal capabilities within a model of limited or no overnight paediatric cover.

IT Innovations

The Review Team recognise that the Telemetry service in A&E can be used with access to Newcastle and Carlisle. Blood results are available on ICE across both sites. DMS has not yet been implemented in the Trust. This would be helpful for cross-site working.

Recommendations: Children's Services The Success Regime Leadership Team for Children's Services is encouraged to:	
7.3.1	Make timely decisions and decide concurrently on models of care for both maternity and children & families in order to maintain the viability of any future services. ○ The requirements of a consultant led obstetric unit are such that the paediatric model of care needs to be robust to support it. This was considered by Dr Shortland in his review. ○ The Senate Review Team recommend that his opinion is considered further i.e. a 14 hour SSPAU at the WCH site may be a more achievable and sustainable option.
7.3.2	Consider the following issues when modelling the effects of each option, reviewing achievability and making a decision: ○ Cross-border activity (e.g. the number of patients that would move to Barrow), ○ Interim arrangements in terms of both staff resources and financial costs and likelihood of meeting target configuration.
7.3.3	Further develop a robust and realistic workforce plan which addresses the following: ○ Models the proposed workforce roles and numbers and tests the assumptions regarding potential financial savings, ○ Clarifies the age profile and turnover of the staff, ○ Clarifies the assumptions which have been made about the recruitment of new staff into the area and whether the anticipated numbers are realistic, ○ Clarifies the assumptions which have been made regarding the flexibility of the workforce and whether these are realistic, ○ Builds on the results of a risk assessment of staffing numbers and clarifies the proposed governance arrangements to manage the identified risks, ○ Outlines plans for the ongoing training and development of staff, ○ Describes how professional isolation will be addressed, ○ Embeds Quality Improvement into work force training and CPD, ○ Describes the extent that local commissioners have been engaged in the development of the workforce plan. Also see General Recommendations in *Section 4.3*
7.3.4	Employ novel recruitment models once a clear vision for the future of the service has been established. Suggestions include: ○ Movement of clinical leaders between sites, ○ Secondments of senior well established clinicians who may also provide additional clinical leadership, ○ Working alongside universities to provide academic units.
7.3.5	Consider CAMHS and other service interdependencies throughout the decision making process and when putting in place transitional arrangements.
7.3.6	Ensure that a whole systems approach is maintained by considering community services and general practice at the heart of the decision making process.
7.3.7	Support the Trust to continue to build upon its exiting successes such as telemedicine.
7.3.8	Ensure that a robust engagement plan which builds on Sam's House is developed and implemented. It also needs to address and explain the reasons why changes are required.
7.3.9	Further develop the standards and quality measures for the service.
7.3.10	Undertake an audit of likely number of patient transfers if the SSPAU model was implemented.

7.4 Maternity Clinical Model Recommendations

General Comments

The Senate Review Team indicated that the expectations with respect to the speed with which the Success Regime can make progress and the timescales for Senate review are unrealistic.

The documents received for review were in the early stages of development which has made the systematic and comprehensive appraisal of the proposals in the light of the Senate Review questions very difficult.

Many additional documents had to be requested by the Senate Review Team in order to inform their appraisal of the proposals. Unfortunately, in the time available it was not possible to review all of these thoroughly. Evidence of innovative models was, however, noted in the RCOG report and its supporting evidence (requested by the Review Team).

The Review Team were impressed by the cross-Cumbria HealthWatch and MSLC engagement exercise on maternity Services. It is an excellent piece of work and should be used as an exemplar for engagement and listening across all of the Success Regime work streams.

Overall the proposed solutions could be more creative and challenging. The preferred option for maternity services does not address the problems of sustaining neonatal cover, which appears to be the most challenging issue. In this there is a clear interdependency between maternity and children's services. It is noted that the family and children's review team has significant reservations about whether the proposed model for children's services, which provides 24/7 neonatal cover, is deliverable. More thought therefore needs to be given to the scenarios that do not involve middle grade neonatal medical staff and innovative solutions need to be explored that can maintain neonatal capabilities within a model of limited or no overnight paediatric cover. In addition, risk assessments need to be undertaken.

The proposals indicate that the local population would like an obstetrician-led service at Whitehaven. If this is not possible there seems to be little appetite for a MLU as the HWB report indicates that only 20% of women feel that a Maternity Led Unit (MLU) is their preferred place of birth. The proposed model appears to maintain the status quo and population expectations appear to be very traditional e.g. expecting to stay overnight following an MLU birth.

The potential to expand birthing units should be explored further, although the Review Team urge caution in the light of population expectations as in Penrith the number of births is increasing. In addition, if a woman wants an epidural, this cannot be provided on an MLU. If, especially in remote areas, there is a desire to expand the use of MLUs, the Success Regime Team should be encouraged to review the literature to understand whether categories presently excluded, could safely be managed on MLUs.

Gaps still remain in the data on the potential need for transport between WCH and CIC and the potential impact on the ambulance service if a midwifery only model operated on the WCH site. Based on the learning from the Manchester reconfiguration of services and their stand alone MLU, the MLU

option would rely heavily on clear transfer polices/ governance arrangements covering the main unit. In addition a clear and simple communication strategy will be required for the population to explain transfer times in labour and the fact there will not be access to epidurals. Furthermore, there should be a degree of caution projecting births - the evidence nationally suggests that there will be fewer births than the predictor models forecast.

Finally, more assurance is required in relation to individual ownership and the system's commitment to change, especially given the pressures. Where confidence in the ability of the system to change is low, has this been fed back sufficiently robustly and how do the Cumbrian team intend to address this?

Recommendations: Maternity services The Success Regime Leadership Team for Maternity Services is encouraged to:	
7.4.1	Ensure that the proposed clinical models build on NICE guidelines and quality standards.
7.4.2	Consider the clinical co-dependencies involved during the development of the proposals for maternity services. Sources of useful information about the process for identifying clinical co-dependencies are: ○ The South East Senate report on clinical co-dependencies, ○ The Making It Better and Healthier Together Programmes, ○ The GM Devolution Specialised Services co-dependency assessment framework, ○ The Healthy Liverpool Programme.
7.4.3	Consider and take account of the critical interface between maternity services and paediatrics in the further development of the proposals.
7.4.4	Clarify how Cumbria responded to the concerns of the CQC. It would be helpful to see evidence of how the concerns raised from previous reports have or are being addressed.
7.4.5	Undertake further work to develop a robust and realistic workforce plan which addresses the following: ○ models the proposed workforce roles and numbers and testing the assumptions re potential financial savings, ○ Clarifies the age profile and turnover of the staff, ○ Clarifies the assumptions which have been made about the recruitment of new staff into the area and whether the anticipated numbers are realistic, ○ Clarifies the assumptions which have been made re the flexibility of the workforce and whether these are realistic, ○ Builds on the results of a risk assessment of staffing numbers and clarifies the proposed governance arrangements to manage the identified risks, ○ Outlines plans for the ongoing training and development of staff, ○ Describes how professional isolation will be addressed, ○ Embeds Quality Improvement into work force training and CPD, ○ Describes the extent that local commissioners have been engaged in the development of the workforce plan.
7.4.6	Clarify further the Enhanced Neonatal Nurse/ Midwife roles in terms of: ○ Training numbers, ○ Plans for supervision and ongoing training, ○ Proposed level of ongoing support from the wider staffing infrastructure to reduce professional isolation,

	○ Proposed level of professional responsibility and accountability etc.
7.4.7	Develop robust quality metrics and standards which can be used as a marker of progress and or success.

7.5 Proactive and Emergency Care Clinical Models Recommendations

General Comments

The documents received for review were in the early stages of development which has made the systematic and comprehensive appraisal of the proposals in the light of the Senate Review questions very difficult. In addition, it has not been possible to provide clinical assurance of the proposed models. The following comments are intended to help inform their further development.

The Review Team understands that the overarching model aims to achieve organisational and operational effectiveness. There is, however, a lack of a vision which describes the benefits for patients and carers. Future access for patients and carers to emergency and acute services needs to be clearly defined especially where it differs from existing models. The use of relevant clinical standards is paramount in framing the conversation with stakeholders including the public and Health and Well-Being Boards. These will provide valuable metrics for the programme of change.

The proposed model depends on the robust triage of patients and access to appropriately trained and skilled staff. It would be helpful to understand:

- Specific details of the plans for the management of a number of conditions including COPD, stroke, acute surgery, trauma and specialist cardiology.
- The extent of involvement of the Ambulance service (NWAS) in the joint development of policies.
- Links to Newcastle and proposal for the use of telemedicine

The big challenge in terms of number of patients and length of stay is older adults with long term conditions, especially if combined with cognitive impairment. This is where there whole system needs to work effectively together. Once people have deteriorated to the point where NWAS and senior hospital decision makers are involved, it may be too late. Early proactive and anticipatory care from Primary Care needs to prevent people even getting that far. This applies especially to COPD, diabetes and heart failure. There are good interventions (and NICE quality standards) that can help prevent hospitalisation, but these require early Primary Care input. It is therefore crucial that Primary Care i.e. General Practice has embraced the need to change to adopt new pathways and to be more proactive.

It would be good to see more robust evidence that the whole system including primary care, social care, mental health services, pharmacy, dentistry and the voluntary sector, NWAS is working together to keep people out of hospital. It is understood, for example, that the Success Regime has an enabling group for Transport. The management team is led by NWAS. In addition, NWAS are members of the Programme Board.

Workforce is a real challenge across the whole healthcare system and although it is understood that a work stream will be established it is not clear how engaged the current workforce are at all levels. In particular, it would be helpful to understand the level of engagement between primary care, social services, community services and the acute sector. It would also be helpful to understand if there is true understanding of the requirement of large-scale reallocation of workforce across Cumbria.

It is understood that new workforce skills are being considered e.g. Advanced Nurse Practitioner (ANP), Physician Assistant (PAs) and Advanced Clinical Practitioners (ACPs) who will originate from a variety of clinical backgrounds. The models for acute medical patient care initially focus upon ANPs being developed to work at CT2 and ST3 level and PAs will work at HO / FY1 level. It is also noted that at WCH a composite staffing model is proposed which draws non-consultant senior decision makers (ST3 level) from a range of different professional backgrounds both medical and non-medical. This will ensure ST3-level competencies will be available 24/7. The composite workforce strategy proposes the use of GP trainees and GPSIs and the continued recruitment of substantive Junior & Middle grade doctors. It would be helpful to have more detail relating to numbers requiring training, expected pass rates for different levels of competence, accreditation, sustainability, timescales and governance arrangements.

True integration of health and social care should be demonstrated as part of the proposed change. This needs to include infrastructure (e.g. IT) and a culture and environment for continual development, innovation and research e.g. consistent use of new technologies such as telemedicine. Furthermore, it would be helpful to understand how the emerging clinical plans are drawing on the knowledge and expertise of the local System Resilience Group (SRG).

Pathways need to have a clear definition e.g. the acute surgery pathways do not clearly define high risk, complex and major surgery. Also some of the general surgical pathways are combined with T&O, where the evidence is different and hence the metrics used may not be truly reflective.
There is a need to provide details of the Leadership, Governance and risk assessment frameworks for this work stream and clarify how they fit with the overarching Success Regime.

Finally, there may be increased patient movement across the footprint following any reform in acute care. The impact this will have on repatriation and access to specialist services for patients is not apparent and needs clarifying.

Recommendations: Proactive and Emergency Care The Success Regime Leadership Team for Proactive and Emergency Care Services is encouraged to:	
7.5.1	Co-design and communicate a clear vision which focuses on future development, quality improvement and the achievement of clinical standards that will ensure reliable care and includes a much stronger evidence base with identified safety, quality and effectiveness metrics. o Focus communications on high level aspirations which describe how best to improve the outcomes for the population and describe what the system could look like in the future, o Communicate the ongoing benefits for the population which will result from service change e.g. improvements in mortality and morbidity should be monitored and reported

	regularly by the Success Regime.
7.5.2	Ensure that the proposed clinical models build on relevant guidelines and quality standards, suggestions as follows: o Recent NICE guidelines, o The Keogh report (which identifies evidence-based robust emergency care pathways), o College guidelines and standards for ED, o Greater Manchester Primary Care standards, o NICE quality standards addressing hospital admission outcomes, o The South East Clinical Senate and the GM Devolution Specialised Services clinical co-dependencies frameworks, o Reference evidence and learning from other sparsely populated areas.
7.5.3	Further develop a robust and realistic workforce plan which addresses the following: o Models the proposed workforce roles and numbers and testing the assumptions re potential financial savings, o Clarifies the age profile and turnover of the staff, o Clarifies the assumptions which have been made about the recruitment of new staff into the area and whether the anticipated numbers are realistic, o Clarifies the assumptions which have been made re the flexibility of the workforce and whether these are realistic, o Builds on the results of a risk assessment of staffing numbers and clarifies the proposed governance arrangements to manage the identified risks, o Outlines plans for the ongoing training and development of staff, o Describes how professional isolation will be addressed, o Embeds Quality Improvement into work force training and CPD, o Describes the extent that local commissioners have been engaged in the development of the workforce plan. Also see General Recommendations in *Section 4.3*
7.5.4	Further clarify the role of Physician Associate in terms of: o Training numbers, o Plans for supervision and ongoing training, o Proposed level of ongoing support from the wider staffing infrastructure to reduce professional isolation, o Proposed level of professional responsibility and accountability etc.
7.5.5	Develop an integrated IT plan (with appropriate training) which embraces telemedicine in order to address some of the patient access issues.
7.5.6	Clarify how the emerging clinical plans are drawing on the knowledge and expertise of the local System Resilience Group (SRG).
7.5.7	Provide more clarity in relation to patient transport across the system. In particular, the triage and decision-making process for transfer to an acute centre for surgery. The access to services should also describe how patients will be repatriated.
7.5.8	Identify solutions which are more creative.
7.5.9	Clarify plans for the development of infrastructure e.g. 24/ 7 radiology access which will support local diagnostics to inform access to Specialised and other services.

7.6 Elective Care Clinical Model Recommendations

The Elective Care clinical models are at a relatively early stage and the detail within it is insufficient to provide full clinical assurance. It is noted that the elective care work-stream covers proposals for an Elective Care Centre plus new integrated pathway work in Musculoskeletal (MSK) care and ophthalmology. Due to the expertise within the Review Team, the following comments relate solely to the plans for the Elective Care Centre.

It is understood that there is an aim to improve quality, outcomes and patient experience by making WCH a "world class centre of excellence" for elective surgery. There is, however, no detail of many of the requirements for the development of an elective surgery centre and how this will be achieved. In addition, there is no evidence on the benefits to patients and carers and whether their views have been considered. In addition, there appears to be a lack of clinical engagement.

The development of WCH as a "world class centre of excellence" for elective surgery is likely to be the correct reconfiguration for elective surgery provision. It is recognised that if elective care is high quality with good outcomes and is accessible for patients, this could attract patients who are currently choosing to go outside of the area. It would also be attractive to the workforce. It is, however, not possible for the Review Team to judge the practicality, efficacy and safety of the proposal from the information supplied. In addition, as indicated above, if the proposal for the elective surgical centre is to be successful, it will require significantly more stakeholder engagement and clinical involvement in the planning and execution.

In terms of proposed use of the facilities, the documents identify possible subspecialties but there is a lack of clarity on case mix and case selection and whether the unit is day case, 5-day or 7-day. Furthermore, there is no detail of critical co and interdependencies for surgical provision including anaesthetic staffing and availability, critical care, cross-sectional imaging, access to interventional radiology and gastroenterology, and transfer arrangements. There are tables on the recent change of elective activity in CIC and WCH in various subspecialties: e.g. Upper GI surgery but unfortunately it is not possible to extrapolate future usage as there is no indication of case mix.

The review team recognise the quality of the existing facility at WCH which has the estates capacity to support elective surgery delivery. However, co-dependencies, staffing and travel times for patients need to be considered as well as quality of the estate in considering locations for elective surgery.

Further work is required to develop the workforce. This will require a creative approach to ensure patient safety and improved recruitment. There is currently no clear approach to future recruitment and retention, types and grades of staff required, skill mix and future development. It is understood that staffing of the unit is currently problematic: Clinical nursing and professions allied to medicine all having difficulties in recruitment and retention. Any proposals for innovative rostering of staff to meet these challenges will, however, need to meet required safety standards. The Review Team expressed particular concern in relation to comments in the proposal relating to staffing the surgical on call rota at night.

Recommendations: Elective Care

The Success Regime Leadership Team for Elective Care is encouraged to:	
7.6.1	Meet with the Manchester Healthier Together Team and the Healthy Liverpool team to explore their approaches to the identification of evidence-based clinical standards, patient and clinical engagement, communicating the vision for future improvements in patient outcomes and reduction in mortality etc.
7.6.2	Consider the clinical and operational co-dependencies involved during the development of the proposals for elective care including, *inter alia*, Primary Care and the Ambulance Service. Sources of useful information are: ○ The South East Senate co-dependencies report, ○ The Healthier Together Programme, ○ The GM Devolution Specialised Services co-dependency assessment framework, ○ The Healthy Liverpool Programme, ○ Reshaping Surgical Services: Principles for Change, The Royal College of Surgeons of England January 2013.
7.6.3	Ensure that the proposed clinical model build on NICE guidelines and quality and safety standards, RCS and GMC Recommendations. Develop robust quality metrics and standards and a performance framework which can be used as a marker of progress and/ or success.
7.6.4	Co-design coherent pathways for referral (with primary care) and for transfer and transit. Involve actively the Ambulance Service in the development of the proposals.
7.6.5	Undertake further work to develop a robust and realistic workforce plan which addresses the following: ○ models the proposed workforce roles and numbers and testing the assumptions regarding potential financial savings, ○ Clarifies the age profile and turnover of the staff, ○ Clarifies the assumptions which have been made about the recruitment of new staff into the area and whether the anticipated numbers are realistic, ○ Clarifies the assumptions which have been made re the flexibility of the workforce and whether these are realistic, ○ Builds on the results of a risk assessment of staffing numbers and clarifies the proposed governance arrangements to manage the identified risks, ○ Outlines plans for the ongoing training and development of staff, ○ Describes how professional isolation will be addressed, ○ Embeds Quality Improvement into work force training and CPD, ○ Describes the extent that local commissioners have been engaged in the development of the workforce plan.
7.6.6	Clarify how the IT infrastructure will support the operation of the centre, particularly access to radiology and other imaging results.
7.6.7	Clarify the subspecialty use, case mix and transfer and transit arrangements for the proposed centre. Use this information to assess whether the proposed model is fully optimized to serve the population.

8. Summary and Conclusions

8.1 This section identifies **in bold** areas of significant concern to the Senate Review Teams **where immediate action is required.**

8.2 The Review Team welcomes the fact that Mental Health is part of the strategy. It, however, needs to have a higher level of priority and underpin and influence the whole Success Regime programme. Furthermore, the proposals are at a very early stage of development and require significant further work.

8.3 The current model of care for children's and maternity services is not sustainable. It is recognised that the decisions for maternity and paediatrics are intricately linked. The Review Teams are concerned that the present situation will move from one of unsustainability to unsafe children's services and unviable obstetric-led services unless decisions are made in a concurrent and timely manner and interim arrangements put in place.

8.4 The Review Team suggest that the Success Regime considers the development of an Accountable Care type or other Partnership Arrangement which includes Local Authorities and other key stakeholders. This will ensure that Public Health, Social Care and the wider determinants of health i.e. jobs, poverty, education and access (public transport) are linked into the plans and governance arrangements for the Success Regime.

8.5 The review team acknowledge the specific challenges relating to attracting workforce to the area and understand the need to design services that meets the needs of the population in the most effective way possible. The development of a robust workforce will, however, be crucial to the success of the programme. Creative and innovative ideas will be required to address this long term problem.

8.6 The size, scale and challenge of the transformation which drives the Success Regime work programme is significant. It requires ongoing dedicated support from many clinicians, project managers, patients, carers and volunteers. The Success Regime Leadership Team is encouraged to meet with and learn from the leaders of other major transformation programmes such as Greater Manchester's Healthier Together and Healthy Liverpool to ensure that ongoing and future project management and other support needs are identified and addressed.

8.7 The review team suggest that the Success Regime focus on the General Recommendations as an immediate priority. In addition, it would be helpful to prioritise the development of a quality metric system that will provide on-going quality measures that can be used for assurance and to drive improvement of the service.

8.8 A number of common themes, where further work is required, were identified (*section 4*):

- **Vision, Clinical and Community Engagement and Communication**
- **Clinical Standards, Improving Outcomes and Implementing Best Practice**
- **Workforce *including recruitment, retention, education and continuing professional development (CPD)***
- **Information Management and Technology**
- **Patient Transfer and Transport**

- **Parity of esteem between physical and mental health**

8.9 Although Specialised Services were not included as part of this review, the Senate Review Teams suggest that Specialised Services are incorporated into the governance arrangements for the Success Regime. In addition, account should be taken of specialised services when generating clinical options. It would be helpful if the planning and modelling of pathways is done in conjunction with Specialised Services Commissioners, clinicians delivering Specialised Services, representative service users and the Third Sector.

8.10 The report provides a number of recommendations and highlights a number of areas where consideration is needed in the further development of the clinical models:

- ***Section 4*** identifies General Recommendation (based on the above themes) which apply to the majority of the proposed clinical models.
- Specific Recommendations for each clinical model are covered in ***Section 7*****.**

8.11 A full list of recommendations is included in ***Appendix 5*****.**

8.12 The advice within this report is given in good faith and is correct at the time of writing. Moving forward the Clinical Senate extends the offer of further support should commissioners request it.

Appendix 1 – Terms of Reference for the review

North Region Clinical Senate

Independent Clinical Review of North, West and East Cumbria Success Regime Clinical Strategy and Proposed Models of Care

Final Draft Terms of Reference 06.04.16

1. Stakeholders

Sponsoring Commissioning Organisation: Cumbria CCG

Lead Clinical Senate: Greater Manchester, Lancashire & South Cumbria Clinical Senate on behalf of the North Region Clinical Senate System

Terms of reference agreed by: Professor Donal O'Donoghue and Dr David Rogers, Medical Director [on behalf of Cumbria CCG]

Date: 30th March 2016

Clinical Senate Review Chair: Professor Donal O'Donoghue

Lead Citizen Representatives:

- Kate McNulty

Lead Clinical Senate Review Team Members

- Dr Patrick McDowell, Consultant Renal Physician and Deputy MD, LTHT
- Dr Graham Spratt, Consultant Clinical Psychologist, 5 Boroughs Partnership
- Mr Jon Ausobsky, General Surgeon, Bradford Teaching Hospitals
- Dr Irfan Chaudry, Consultant Intensivist, LTHT
- Dr Jeff Perring, Director of Intensive Care and Vice Senate Chair Yorks and Humber, Sheffield Children's Hospital
- Miss Helen Scholefield, Consultant Obstetrics, Liverpool Women's Hospital

2. Aims, scope and objectives of the review

2.1 Aim of Review:

To provide independent clinical advice on the emerging clinical models from the work streams of the Cumbria Success Regime programme.

The advice will take account of the demographic, geographical and population context. It will provide an assessment of the ability of the proposed models to deliver good clinical outcomes and positive experiences for service users.

2.2 Scope of the review:

- Integrated Care Clinical Model (including Community services)
- Mental Health Clinical Model

- Elective Care Clinical Model
- Proactive and Emergency Care Clinical Model
- Children's Clinical Model
- Maternity Clinical Model
- Any identified potential interdependencies between specialised services and locally commissioned services (The strategic approach to the commissioning of specialised services is out of scope).

2.3 Objectives

For each of the clinical areas that are 'in scope', the assurance review will:

- Identify where the proposed models are credible and robust, highlight any areas of concern and make suggestions for improvement.

- Provide clinical advice on the emerging clinical models by assessing the supporting evidence and adherence to national guidelines. In addition, an assessment of the ability of the models to achieve patient choice and seven day working will be undertaken.

- Examine the clinical assumptions used when developing the models. This will inform a judgement on the feasibility of successful implementation in the North Cumbria context

- Assess the extent to which the models have been clinically led and have included the perspectives and views of a wide range of clinicians.

- Consider the potential impact of service change proposals on interdependent services, e.g. implications for provision of other specialties or for specialised services

The Citizen Representatives will assess:

- The extent to which patients and carers have been involved meaningfully in the design of plans
- The diversity of service user views gained
- The extent to which commissioners have included the views and experience of patients and carers in plans

3. Outline methodology

There are 4 key elements to the methodology:

- A desktop review of information
- Teleconferences/WebEx/ meetings with the working groups and SROs of each clinical area
- A Facilitated Workshop focussed on each proposed clinical model
- And a locality visit *[The purpose of the Locality visit is to better appreciate the geography and transport infrastructure rather than review the health system assets and capabilities].*

Relevant independent clinical experts will be sourced from the four clinical senate areas (excluding the Northern Senate) that make up the North Region.

Information will be provided by the clinical and programme leaders of the Cumbria Success Regime. It will include data used to inform the development of the proposed models, relevant clinical standards and details of clinical pathways. The clinical leaders will make themselves available throughout the review process to answer queries and clarify points, as necessary.
The information will be appraised and used to inform the clinical advice given. Clinical advice will focus on quality and potential clinical outcomes that can be reasonably delivered as a result of implementation of the proposed clinical models within the context of wider proposed system changes.

4. **Timeline**:

Late March – Early May 2016

5. Reporting arrangements, Public Communication and Media Handling

The clinical review team working groups will report to Professor Donal O'Donoghue, Lead Senate Chair, on behalf of the North Region Clinical Senate. He will agree the report and be accountable for the advice contained in the final report.

The report will be given to the sponsoring commissioner. It is understood that it will subsequently be shared with NHS England as part of the assurance process for the Success Regime.
The report will be made publicly available by the CCG as part of the pre-consultation business case. The process for handling publication will be undertaken by the Success Regime Communication and Engagement team in partnership with the CCG and the Clinical Senate.

6. Key Milestones

- Discussion with North Region Clinical Senate Chairs and Medical Director – W/C 28th March 2016
- Discussion with Clinical Senate Chair, Commissioner and Review Team Lead to finalise Terms of Reference – W/C 30th March 2016
- Review team established, Conflict of Interest and confidentiality agreements received – W/C 4th April
- Information for review submitted by Commissioner and distributed to review team [6th April]
- Review Team WebEx/Teleconferences with working groups [week beginning 11th April]
- Requests for clarification and/or further information from Commissioners [18th April]
- Meeting of Senate members of each working group and local Clinical Representatives
- Panel teleconferences [week beginning 18th April]
- Panel submit final edits and report writing for submission [25th April]
- Final report drafted & sent to commissioners for comment [by 4th May]
- Commissioners response by 5th May
- Sign off of final report by Chairs of North Clinical Senate [6th May]

7. Report production

A draft clinical senate report will be provided to the sponsoring organisation for fact checking by 4th May 2016.

Comments/ corrections received from commissioners by 5th May 2016 will be incorporated into the final report.
The final report will be ratified by the North Clinical Chairs on **6th May** and submitted by the Clinical Senate to the sponsoring organisation by **9TH May 2016.**

8. Resources

The Clinical Senate will provide administrative support to the review team, including setting up the meetings and other duties as appropriate.
The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

9. Accountability and Governance

The clinical review team is part of the North Region Clinical Senate accountability and governance structure.
The Clinical Senate is a non-statutory advisory body and will submit the report to the sponsoring commissioning organisation.
The review report will identify any risks that the sponsoring organisation may wish to consider and address before progressing their proposals. The sponsoring organisation will, however, remain accountable for decision making.

10. Roles and Responsibilities

10.1 The sponsoring organisation will:

- Provide the clinical review panel with relevant information such as:
    - Background information e.g. relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and population projection, evidence of alignment with national, regional and local strategies and guidance (e.g. NHS Constitution and outcomes framework, Joint Strategic Needs Assessments, CCG two and five year plans and commissioning intentions).
    - Relevant best practice guidance and service specifications
    - The case for change
    - Options appraisal
    - The sponsoring organisation will provide any other additional background information requested by the clinical review team.
- Respond within the agreed timescale to the draft report on matters of factual inaccuracy.
- Undertake not to attempt to unduly influence any members of the clinical review team during the review.
- Submit the final report to NHS England for inclusion in its formal service change assurance process.

10.2 The Clinical senate council and the sponsoring organisation will

- Agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

10.3 The Clinical Senate council will

- Appoint a clinical review team [This may be formed by members of the senate, external experts, and / or others with relevant expertise]. It will appoint a chair or lead member.
- Advise on and endorse the terms of reference, timetable and methodology for the review
- Consider the review recommendations and report (and may wish to make further recommendations)
- Provide suitable support to the team
- Submit the final report to the sponsoring organisation

10.4 The Clinical review team will

- Undertake its review in line the methodology agreed in the terms of reference
- Follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies
- Submit the draft report to clinical senate council for comments and consider any such comments and incorporate relevant amendments into the report. The team will subsequently submit final draft of the report to the Clinical Senate Council.
- Keep accurate notes of meetings
- Clinical review team members will undertake to
  - Commit fully to the review information and attend all briefings, meetings, interviews that are part of the review (as defined in methodology).
  - Contribute fully to the process of writing and reviewing the final report
  - Ensure that the report accurately represents the consensus of opinion of the clinical review team
  - Comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it.
  - Declare any conflicts of interest to the chair.

Appendix 2 - Contributors to the Review

Chair: Professor Donal O'Donoghue, Chair of Independent Clinical Review Team, Consultant Renal Physician, Salford Royal Foundation Trust and Greater Manchester, Lancashire & South Cumbria Clinical Senate Chair

Lead Citizen Representative:

- Kate McNulty, Patient Representative and member of the Greater Manchester, Lancashire & South Cumbria Clinical Senate Council

Lead Clinical Senate Review Team Members

Clinical Models	Lead of clinical review team
Integrated Care (including Community services)	**Dr Patrick MacDowall,** Consultant Renal Physician and Deputy MD, Lancashire Teaching Hospitals NHS Trust
Mental Health	**Dr Graham Spratt**, Consultant Clinical Psychologist, 5 Boroughs Partnership
Elective Care	**Mr Jon Ausobsky**, General Surgeon, Bradford Teaching Hospitals
Proactive and Emergency Care	**Dr Irfan Chaudry,** Consultant Intensivist, Lancashire Teaching Hospitals NHS Trust
Children's	**Dr Jeff Perring**, Director of Intensive Care and Vice Senate Chair Yorks and Humber, Sheffield Children's Hospital
Maternity	**Miss Helen Scholefield,** Consultant Obstetrics, Liverpool Women's Hospital

Clinical Review Team Members:

Clinical Models	Clinical review team members
Integrated Care (including Community services)	**Dr Patrick MacDowall**, Consultant Nephrologist, Lancashire teaching Hospital NHS Foundation Trust, **Vats Patel**, Pharmacist & Manchester Local Pharmaceutical Committee Member **Dr Helen Hurst**, Advanced Nurse Practitioner **Dr Naresh Kanumilli**, Clinical Lead Long Term Conditions & Clinical Network Lead for Diabetes, **Dr Mehran Javeed**, Trainee in Old Age Psychiatry, **Mohammed Sarwar**, CEO of Multicultural Arts & Media Centre & Patient Representative.
Mental Health	**Dr Graham Spratt**, Clinical Psychologist, **Paul French**, Associate Director, GM West Trust **Cathy Wright**, AHP Lead and CAHMS OT & Participation Lead, **Joan Hutt**, Volunteer Patient's Cabinet in Bury

Elective Care	**Mr Jon Ausobsky**, General Surgeon, Bradford Teaching Hospitals FT **Mrs Jane Ooi**, Breast Surgeon, Bolton FT **Dr Niall Lynch**, Consultant Radiologist, Stockport NHS FT. **Mr Ken Johnson**, Public Representative on the Neurology group for the NHS in the North
Proactive and Emergency Care	**Dr Irfan Choudry**, Critical Care Intensivist, Lancashire Teaching hospitals FT **Dr Ivan Bennet**, GP & Clinical Director, Central Manchester CCG **Dr Robert Coward**, Consultant Physician & Nephrologist, Lancashire Teaching Hospitals (Retired) **Kate McNulty**, Patient Representative Strategic Clinical Network Clinical Senate, Oversight & Planning Group & Patient, Carer Public Advisory Group GMLSC
Children's	**Dr Jeff Perring**, Director of Intensive Care and Vice Senate Chair, Sheffield Children's Hospital **Dr James Bunn**, Consultant Paediatrician, Alder Hey Children's Hospital **Angela Douglas**, Scientist and Genomic Lead, Liverpool Women's Hospital **Kate McNulty**, Patient Representative Strategic Clinical Network Clinical Senate, Oversight & Planning Group & Patient, Carer Public Advisory Group GMLSC
Maternity	**Dr Helen Scholefield**, Consultant Obstetrics, Liverpool Women's Hospital, **Dr Ngozi Edi-Osagie**, Consultant Neonatologist, Central Manchester FT, **Dr David Rowlands**, FROG, Associate Medical Director, Arrowe Park Hospital, **Kathy Murphy**, Deputy Director of Nursing & Head of Midwifery , Central Manchester FT, **Judith Shaw**, Volunteer Patient Cabinet member.

Appendix 3: Questions Addressed During the Review Process

Key questions	Considerations	Source
1. The scope and content of the proposed model is clinically safe and effective	Is there robust evidence to underpin the clinical case for change and the proposed clinical model? Has the available evidence been applied to the specifics of the proposed model? Have the clinical benefits, evidence for service change and underlying assumptions been clearly set out? Is there alignment with national, regional and local intentions? Has advice been sought from authoritative sources, e.g. relevant networks and professional bodies?	Desktop review Clinical expertise ICRT discussion Interview with clinical lead Locality visit*
2. The model will deliver best practice clinical outcomes	Is there a clear focus on improving quality and outcomes? Will the model deliver real benefit to patients and carers? Does the model reflect relevant clinical guidelines and best practice? Have patient and carers' views been considered and incorporated into the design of the model of care? Does the model have clear standards, measurement and reporting systems for quality control, contracting, performance management and quality improvement? Is there a programme of audit and a plan for publication of quality metrics?	Desktop review Clinical expertise ICRT discussion Interview with clinical lead
3. The clinical workforce proposed is adequate to support and sustain the model	Is there a Health and Social Care system OD plan? Is there a Health and Social Care HR plan? Are the proposals clinically viable and is there clinical capacity to implement them? Are there transition plans? Do the plans identify mechanisms to address organisational and cultural challenges? Has the workforce impact, including impact on education, recruitment, retention been considered? Have the clinical staff that may be affected by the changes been involved in their development? Is the proposed workforce adequate for the service needs? Are there minimum skills and competencies for roles? Is there sufficient provision for CPD? Will minimum safe staffing levels be met? Is there physical capacity and infrastructure at the sites where the services will be concentrated? Have the proposals considered a networked approach, with co-operation from other sites and/ or organisations including the 3rd Sector?	Desktop review Clinical expertise ICRT discussion Interview with clinical lead

4. The model has been fully optimised to serve the population	Is the model able to deliver the current and future needs of the target population? Do the proposals improve access to services for the population? E.g. have waiting times and travel for patients and their families been considered? Will the proposals support a reduction in health inequalities? Does the model support better integration of services? Is there an integrated IT plan? Is there a sufficiently resourced deployment and training plan? Have innovations and improvements that would improve quality and outcomes been considered? For example, remote video-enabled consultations, email consultations?	Desktop review Clinical expertise ICRT discussion Interview with clinical lead Locality visit*
5. The proposed quality measures used are appropriate	Is current service performance understood? Is it clear how the service would sustain, improve or achieve standards? Are the anticipated outcomes and quality improvements clear? Have recommended standards for the service been considered? Do quality measures include a focus on clinical outcomes, PROMS and patient experience measures? Is there an accompanying health literacy, patient activation and supported self-care plan?	Desktop review Clinical expertise ICRT discussion Interview with clinical lead Locality visit*
6. Any unintended consequences and service interdependencies are highlighted	Have potential trade-offs and unintended consequences of the model been identified and articulated? Are there plans in place for future improvements? Has a thorough analysis of the risks and consequences of implementing the model of care been carried out? Are there mitigating actions and monitoring arrangements for risks? Have organisational mechanisms to manage such risks been considered/ put in place? Service interdependencies - What is the potential impact on other services as a result of the proposed changes?	Desktop review Clinical expertise ICRT discussion Interview with clinical lead

*** The purpose of the Locality visit was to better appreciate the geography and transport infrastructure rather than review the health system assets and capabilities.**

5.6 The questions addresses by the Citizen Representatives were as follows:

- How extensively have patients and carers have been involved meaningfully in the design of plans?
- What is the level of diversity of service user views gained?
- To what extent have commissioners included the views and experience of patients and carers in plans?

Appendix 4: Locality Visit Agenda

Cumbria Success Regime Clinical Senate Visit
Monday 25th April 2016, 9:30am – 16:30pm

Time	*Itinerary*	*Timings*	*Venue*
9.30am	Meet at MO Meeting Room, The Bungalow, Tynefield Drive.	15mins	Penrith Community Hospital, Bridge Lane, Penrith, CA11 8HX
9.45am	Welcome and Introduction led by Dr Stephen Singleton, Medical Director, Cumbria Success Regime	15mins	Penrith Community Hospital, Bridge Lane, Penrith, CA11 8HX
10.00am	Travel to Cockermouth Community Hospital	45mins	
10.45am	Site Visit of Cockermouth Community Hospital	30mins	Cockermouth Community Hospital, 1 Isel Road, Cockermouth, CA13 9HT
11.15am	Comfort Break	15mins	
11.30am	Travel to Workington Community Hospital	20mins	
11.50am	Site Visit of Workington Community Hospital	30mins	Workington Community Hospital, Park Lane, Workington, CA14 2RW
12.20pm	Lunch	30mins	
12.50pm	Travel to West Cumberland Hospital, Whitehaven	30mins	
1.20pm	Site Visit of West Cumberland Hospital, Whitehaven	30mins	West Cumberland Hospital Homewood Rd, Whitehaven, CA28 8JH
1.45pm	Travel to Cumberland Infirmary, Carlisle	1.25 Hours	
3.00pm	Comfort Break	15mins	Cumberland Infirmary, Newtown Road, Carlisle, CA2 7HY
3.15pm	Site Visit of Cumberland Infirmary, Carlisle	30mins	Cumberland Infirmary, Newtown Road, Carlisle, CA2 7HY
3.45pm	Travel to NHS Cumbria CCG, Lonsdale	30mins	
4.15pm	Final Briefing, Meeting Room 1, Lonsdale	15mins	Penrith Community Hospital, Bridge Lane, Penrith, CA11 8HX
4.30pm	Close and Depart		

A lot of interest was expressed by Review Team members to participate in the locality visit. Unfortunately, on the day, there were significant delays on the trains and the motorway system. This meant that some of the intended participants were unable to join the visit. The following participated in the Cumbria locality visit:

Dr James Bunn	Patrick MacDowall	Donal O'Donoghue
Kate McNulty	Helen Scholefield	
Ken Johnson	Cathy Wright	

Appendix 5: List of all Recommendations

General Recommendations: Vision, Clinical and Community Engagement and Communication The Success Regime Leadership Team is encouraged to:	
4.1.1	Further develop the process for ongoing engagement to develop and implement a clearly articulated and universally owned clinically-led vision for improvement for all of the proposed clinical models.
4.1.2	Co-design and communicate a robust and meaningful clinically-led engagement process which supports all areas of the Success Regime ○ HealthWatch Cumbria has led an excellent engagement process for maternity services. If possible, they should be involved in the other clinical areas, ○ Greater Manchester's Healthier Together Programme and Healthy Liverpool will also provide some useful insights into the improvement process.
4.1.3	Identify and resource the ongoing clinical leadership, organisational and system development support requirements.
4.1.4	Explore and further develop closer working, governance and budget arrangements with social care and other partners through an Accountable Care/ Partnership type arrangement.

General Recommendations: Clinical Standards , Improved Outcomes and Best Practice The Success Regime Leadership Team is encouraged to:	
4.2.1	Support clinical leaders to work with their teams and service users to identify, interpret, translate and customise national and other standards to their local environments.
4.2.2	Identify how public health and social care can be involved actively and made jointly accountable for addressing the challenges, co-creating the vision, developing the standards and plans and delivering the change.
4.2.3	Collaboratively co-design and develop a portfolio of clinical and patient experience standards for each clinical model and the system of care and ensure that they are used to: ○ Articulate the case for change in terms of patient experience and outcomes, ○ Inform any clinical assumptions for workforce, activity and economic modelling.
4.2.4	Identify solutions from elsewhere and adapt them to local circumstances.
4.2.5	Adopt a systematic approach to spreading best practice and quality improvement across the system.
4.2.6	Identify and prioritise key areas for improvement for rapid and focussed further development.
4.2.7	Identify areas where rapid progress could be made so that some "quick-wins" (within 6 months) can be achieved to provide encouragement for ongoing local engagement in further work.
4.2.8	Oversee development of reporting systems and a quality dashboard that demonstrates achievement of clinical standards across North, West and East Cumbria.

General Recommendations: Workforce: Education, Training, Recruitment and Retention The Success Regime Leadership Team is encouraged to:	
4.3.1	Work with local clinicians and communities to think creatively about how best to meet the workforce challenges through the development of bespoke arrangements.
4.3.2	Undertake more work with partners across the geography including local communities, schools, colleges and Health Education England North West and the Northern Deanery to design novel approaches to training and workforce development, recruitment and retention that includes both the medical and non-medical workforce.
4.3.3	Undertake detailed workforce analysis and modelling informed by creative thinking as well as the necessary professional standards that deliver the agreed clinical models and patient outcomes.

Recommendations: information Management & Technology Adoption The success Regime Leadership Team is encouraged to:	
4.4.1	Develop clear information governance and sharing agreements across the whole system.
4.4.2	Develop a business case to support the IMT strategy that is based on learning from others such as iLinks across Merseyside, data well in Greater Manchester and Salford (which is the most digitally mature organisation in the NHS) and includes: o Routine use of technologies such as telemedicine etc., o Information sharing, o Information governance, o Resources for health and care professional training.

Recommendations: Patient Transfer and Transport The Success Regime Leadership Team is encouraged to:	
4.5.1	Clarify the impact of any proposed clinical changes on repatriation (i.e. transfer back to local hospital) and access to specialist and other services for patients.

Recommendations: Mental Health – Scope and content of mental health proposals The Success Regime Leadership Team for Mental Health is encouraged to:	
7.1.1	Focus on the acquisition, review and analysis of needs-based data across the system.
7.1.2	Ensure that Mental Health is integrated within the Success Regime programme and informs all other clinical plans. o Further develop work to achieve "parity of esteem", for example, by including primary mental health expertise within the physical health team integration development, o Ongoing work also should also extend to Child and Mental Health Services (CAMHS), o Consider and take account of how the strategy will impact on other health care providers: A&E, social services, carers, staffs, public health, ambulance services,

	pharmacy, etc.
7.1.3	Model flows through the crisis response model for all ages, to gauge impact on in-patient and primary care flows.
7.1.4	When developing the concept of more treatment at home, when undertaking the review of estates, there is a need to be sensitive to evidence where family pressures can exacerbate rather than support mental health difficulties. o It is important to identify how primary care or home care will address the complexities of patient care rather than seeing it as a solution to low staffing ratios, geographic complexities and limited finance.
7.1.5	Prioritise the building of resilience for services to children and families as part of overall mental health plans, particularly the transitional years.
7.1.6	Consider further the remodelling on in-patient flows as a direct response to primary mental health and crisis response outcomes, particularly where the re-distribution of funding may negatively impact elsewhere in care pathways. o For example, there is a need to ensure effective CAMHS and ED support at Whitehaven to avoid admissions.
7.1.7	Investigate the need to provide effective support for self-harming at Whitehaven to avoid admissions.

Recommendations: Mental Health – Delivery of Best Practice Clinical Outcomes The Success Regime Leadership Team for Mental Health is encouraged to:	
7.1.8	Develop system clinical outcome measures that will enable benchmarking of strategy roll out.
7.1.9	Use findings from past service challenges to understand their impact on clinical outcomes.
7.1.10	Where areas of strategy are built around “proof of concept”, focus on clinical outcome measures in this proof.
7.1.11	Consider more critical analysis of existing practice and identify the changes that need to occur that will help both staff and patients.
7.1.12	Consider in greater depth how bed management strategies can address the needs of patients and their carers as well as well as the resourcing issues of the NHS.
7.1.13	Encourage hospital clinicians to work and/ or be involved more in the community care centres.
7.1.14	Build a core clinical governance theme based upon routine acquisition of patient/ carer/ family experience.

Recommendations: Mental Health – Workforce The Success Regime Leadership Team for Mental Health is encouraged to:	
7.1.15	Use a baseline workforce assessment to test the feasibility of new service models.
7.1.16	Evaluate innovative recruitment strategies e.g. The Millom initiative.
7.1.17	As part of modelling new services, evaluate competency impact of moving staff into new roles and build an integrated training support model to mitigate skill gaps.

7.1.18	Exploit current initiatives to extend contribution of IT solutions and staff training to engage local populations.
7.1.19	Consider the training all staff in the management of challenging behaviours to promote parity of esteem. In addition, all staff should *make every contact count*, for example, smoking cessation and CVD risk reduction. This will ensure that Mental Health teams address basic medical issues as well as physical teams addressing basic mental health issues.
7.1.20	Consider a rapid response team for all mentally ill patients going through a crisis episode for all ages in A&E Departments.
7.1.21	Review further, initiatives to involve competencies for third and voluntary sectors in building workforce resilience.

Recommendations: Mental Health – Service access optimisation The Success Regime Leadership Team for Mental Health is encouraged to:	
7.1.22	Build on the existing strategy to ensure the general public are core to engagement processes that seek to understand preferences for how services should be delivered.
7.1.23	Consider how best to integrate communication systems into new models, particularly in relation to connecting people with services and supporting individuals and their families.
7.1.24	Test how the new models can be built around specific population areas with sensitivity to both native population, geography and skill recruitment.

Recommendations: Integrated Care Clinical (ICC) Model (including Community services) The Success Regime Leadership Team for ICC Services is encouraged to:	
7.2.1	Consider the creation of robust governance arrangements which include key stakeholders, for example through the use of an Accountable Healthcare System or other partnership model with all partner organisations.
7.2.2	Identify and stratify the risks across the health and social care system and use the results to inform the development of the ICC programmes and footprints. This could be achieved by creating a map of patient journeys to learn about and appreciate the existing problems and identify the improvements that will have the biggest positive impact for patients and staff.
7.2.3	Visit and learn from other health economies which have had success at achieving integration (examples above).
7.2.4	Develop and measure achievement of standards and improved outcomes, through the implementation of an audit programme to inform the ongoing changes. Also consider the use of other service evaluation tools such as patient reported outcome measures (PROMs) and clinician reported outcome measures (CROMs).
7.2.5	Engage with stakeholders to co-design plans and proposals to meet the needs of the population within the resources available. o Consider integrating services that offer a logical fit and where the impact will be greatest based on the local population and geography.
7.2.6	Develop a communication plan and robust governance arrangements for the pilots and other adopters.
7.2.7	Undertake further work to develop a robust and realistic workforce plan which addresses

	the following: ○ Models the proposed workforce roles and numbers and testing the assumptions regarding potential financial savings, ○ Clarifies the age profile and turnover of the staff, ○ Clarifies the assumptions which have been made about the recruitment of new staff into the area and whether the anticipated numbers are realistic, ○ Clarifies the assumptions which have been made re the flexibility of the workforce and whether these are realistic, ○ Builds on the results of a risk assessment of staffing numbers and clarifies the proposed governance arrangements to manage the identified risks, ○ Outlines plans for the ongoing training and development of staff, ○ Describes how professional isolation will be addressed, ○ Embeds Quality Improvement into work force training and CPD, ○ Describes the extent that local commissioners have been engaged in the development of the workforce plan.
7.2.8	Develop an integrated IT plan (with appropriate training) which embraces telemedicine in order to address some of the patient access issues.

Recommendations: Children's Services The Success Regime Leadership Team for Children's Services is encouraged to:	
7.3.1	Make timely decisions and decide concurrently on models of care for both maternity and children & families in order to maintain the viability of any future services. ○ The requirements of a consultant led obstetric unit are such that the paediatric model of care needs to be robust to support it. This was considered by Dr Shortland in his review, ○ The Senate Review Team recommend that his opinion is considered further i.e. a 14 hour SSPAU at the WCH site may be a more achievable and sustainable option.
7.3.2	Consider the following issues when modelling the effects of each option, reviewing achievability and making a decision: ○ Cross-border activity (e.g. the number of patients that would move to Barrow), ○ Interim arrangements in terms of both staff resources and financial costs and likelihood of meeting target configuration.
7.3.3	Further develop a robust and realistic workforce plan which addresses the following: ○ Models the proposed workforce roles and numbers and tests the assumptions regarding potential financial savings, ○ Clarifies the age profile and turnover of the staff, ○ Clarifies the assumptions which have been made about the recruitment of new staff into the area and whether the anticipated numbers are realistic, ○ Clarifies the assumptions which have been made re the flexibility of the workforce and whether these are realistic, ○ Builds on the results of a risk assessment of staffing numbers and clarifies the proposed governance arrangements to manage the identified risks, ○ Outlines plans for the ongoing training and development of staff, ○ Describes how professional isolation will be addressed, ○ Embeds Quality Improvement into work force training and CPD, ○ Describes the extent that local commissioners have been engaged in the development of the workforce plan.

	Also see General Recommendations in *Section 4.3*
7.3.4	Employ novel recruitment models once a clear vision for the future of the service has been established. Suggestions include: ○ Movement of clinical leaders between sites, ○ Secondments of senior well established clinicians who may also provide additional clinical leadership, ○ Working alongside universities to provide academic units.
7.3.5	Consider CAMHS and other service interdependencies throughout the decision making process and when putting in place transitional arrangements.
7.3.6	Ensure that a whole systems approach is maintained by considering community services and general practice at the heart of the decision making process.
7.3.7	Support the Trust to continue to build upon its exiting successes such as telemedicine.
7.3.8	Ensure that a robust engagement plan which builds on Sam's House is developed and implemented. It also needs to address and explain the reasons why changes are required.
7.3.9	Further develop the standards and quality measures for the service.
7.3.10	Undertake an audit of likely number of patient transfers if the SSPAU model was implemented.

Recommendations: Maternity services The Success Regime Leadership Team for Maternity Services is encouraged to:	
7.4.1	Ensure that the proposed clinical models build on NICE guidelines and quality standards.
7.4.2	Consider the clinical co-dependencies involved during the development of the proposals for maternity services. Sources of useful information about the process for identifying clinical co-dependencies are: ○ The South East Senate report on clinical co-dependencies, ○ The Making It Better and Healthier Together Programmes, ○ The GM Devolution Specialised Services co-dependency assessment framework, ○ The Healthy Liverpool Programme.
7.4.3	Consider and take account of the critical interface between maternity services and paediatrics in the further development of the proposals.
7.4.4	Clarify how Cumbria responded to the concerns of the CQC. It would be helpful to see evidence of how the concerns raised from previous reports have or are being addressed.
7.4.5	Undertake further work to develop a robust and realistic workforce plan which addresses the following: ○ Models the proposed workforce roles and numbers and testing the assumptions re potential financial savings, ○ Clarifies the age profile and turnover of the staff, ○ Clarifies the assumptions which have been made about the recruitment of new staff into the area and whether the anticipated numbers are realistic, ○ Clarifies the assumptions which have been made re the flexibility of the workforce and whether these are realistic, ○ Builds on the results of a risk assessment of staffing numbers and clarifies the proposed governance arrangements to manage the identified risks,

	○ Outlines plans for the ongoing training and development of staff, ○ Describes how professional isolation will be addressed, ○ Embeds Quality Improvement into work force training and CPD, ○ Describes the extent that local commissioners have been engaged in the development of the workforce plan.
7.4.6	Clarify further the Enhanced Neonatal Nurse/Midwife roles in terms of: ○ Training numbers, ○ Plans for supervision and ongoing training, ○ Proposed level of ongoing support from the wider staffing infrastructure to reduce professional isolation, ○ Proposed level of professional responsibility and accountability etc.
7.4.7	Develop robust quality metrics and standards which can be used as a marker of progress and or success.

Recommendations: Proactive and Emergency Care The Success Regime Leadership Team for Proactive and Emergency Care Services is encouraged to:	
7.5.1	Co-design and communicate a clear vision which focuses on future development, quality improvement and the achievement of clinical standards that will ensure reliable care and includes a much stronger evidence base with identified safety, quality and effectiveness metrics. ○ Focus communications on high level aspirations which describe how best to improve the outcomes for the population and describe what the system could look like in the future, ○ Communicate the ongoing benefits for the population which will result from service change e.g. improvements in mortality and morbidity should be monitored and reported regularly by the Success Regime.
7.5.2	Ensure that the proposed clinical models build on relevant guidelines and quality standards, suggestions as follows: ○ Recent NICE guidelines, ○ The Keogh report (which identifies evidence-based robust emergency care pathways), ○ College guidelines and standards for ED, ○ Greater Manchester Primary Care standards, ○ NICE quality standards addressing hospital admission outcomes, ○ The South East Clinical Senate and the GM Devolution Specialised Services clinical co-dependencies frameworks, ○ Reference evidence and learning from other sparsely populated areas.
7.5.3	Further develop a robust and realistic workforce plan which addresses the following: ○ Models the proposed workforce roles and numbers and testing the assumptions re potential financial savings. ○ Clarifies the age profile and turnover of the staff. ○ Clarifies the assumptions which have been made about the recruitment of new staff into the area and whether the anticipated numbers are realistic. ○ Clarifies the assumptions which have been made re the flexibility of the workforce and whether these are realistic.

	○ Builds on the results of a risk assessment of staffing numbers and clarifies the proposed governance arrangements to manage the identified risks. ○ Outlines plans for the ongoing training and development of staff. ○ Describes how professional isolation will be addressed. ○ Embeds Quality Improvement into work force training and CPD. ○ Describes the extent that local commissioners have been engaged in the development of the workforce plan. Also see General Recommendations in *Section 4.3*
7.5.4	Further clarify the role of Physician Associate in terms of: ○ Training numbers, ○ Plans for supervision and ongoing training, ○ Proposed level of ongoing support from the wider staffing infrastructure to reduce professional isolation, ○ Proposed level of professional responsibility and accountability etc.
7.5.5	Develop an integrated IT plan (with appropriate training) which embraces telemedicine in order to address some of the patient access issues.
7.5.6	Clarify how the emerging clinical plans are drawing on the knowledge and expertise of the local System Resilience Group (SRG).
7.5.7	Provide more clarity in relation to patient transport across the system. In particular, the triage and decision-making process for transfer to an acute centre for surgery. The access to services should also describe how patients will be repatriated.
7.5.8	Identify solutions which are more creative.
7.5.9	Clarify plans for the development of infrastructure e.g. 24/ 7 radiology access which will support local diagnostics to inform access to Specialised and other services.

Recommendations: Elective Care The Success Regime Leadership Team for Elective Care is encouraged to:	
7.6.1	Meet with the Manchester Healthier Together Team and the Healthy Liverpool team to explore their approaches to the identification of evidence-based clinical standards, patient and clinical engagement, communicating the vision for future improvements in patient outcomes and reduction in mortality etc.
7.6.2	Consider the clinical and operational co-dependencies involved during the development of the proposals for elective care including, *inter alia*, Primary Care and the Ambulance Service. Sources of useful information are: ○ The South East Senate co-dependencies report, ○ The Healthier Together Programme, ○ The GM Devolution Specialised Services co-dependency assessment framework, ○ The Healthy Liverpool Programme, ○ Reshaping Surgical Services: Principles for Change, The Royal College of Surgeons of England January 2013.
7.6.3	Ensure that the proposed clinical model build on NICE guidelines and quality and safety standards, RCS and GMC Recommendations. Develop robust quality metrics and standards and a performance framework which can be used as a marker of progress and/ or success.

7.6.4	Co-design coherent pathways for referral (with primary care) and for transfer and transit. Involve actively the Ambulance Service in the development of the proposals.
7.6.5	Undertake further work to develop a robust and realistic workforce plan which addresses the following: ○ Models the proposed workforce roles and numbers and testing the assumptions re potential financial savings, ○ Clarifies the age profile and turnover of the staff, ○ Clarifies the assumptions which have been made about the recruitment of new staff into the area and whether the anticipated numbers are realistic, ○ Clarifies the assumptions which have been made re the flexibility of the workforce and whether these are realistic, ○ Builds on the results of a risk assessment of staffing numbers and clarifies the proposed governance arrangements to manage the identified risks, ○ Outlines plans for the ongoing training and development of staff, ○ Describes how professional isolation will be addressed, ○ Embeds Quality Improvement into work force training and CPD, ○ Describes the extent that local commissioners have been engaged in the development of the workforce plan.
7.6.6	Clarify how the IT infrastructure will support the operation of the centre, particularly access to radiology and other imaging results.
7.6.7	Clarify the subspecialty use, case mix and transfer and transit arrangements for the proposed centre. Use this information to assess whether the proposed model is fully optimised to serve the population.

Appendix 6: Information Submitted for the Independent Senate Review for the WNE Cumbria Success Regime

Clinical Model	Document	Date/Version
Background and Context		
	Public Progress Report	Feb-16
	Key Challenges and Baseline facts and figures	Mar-16
	Previous Senate Review Reports	Phase 1 report Nov 2014 Phase 2 July 2015
	Allerdale Health profile	
	Carlisle Health Profile	
	Copeland Health Profile	
	Cumbria Health Profile	
	Eden Health Profile	
	Main site location maps	
Children & Families		
	Background Presentation	Background Presentation
	Proposition Document with Appendices (including QIAs)	Proposition Document with Appendices

	Cumbria CAMHS Transformation Plan	
Elective Care		
	Background Presentation	16th December 2016
	Diagnostics Proposition	V0.2 22nd February 2016
	MSK Proposition	V0.3 15th February 2016
	Ophthalmology Proposition	v0.2 20th February 2016
	WCH Centre of Excellence Proposition	V0.2 15th February 2016
	QIA for prioritised pathways	12th February 2016
Maternity		
	Background Presentation	29th March 2016
	Summary of RCOG Options	16th January 2016
	Options Appraisal – Reconfiguration of Obstetric and Maternity Services in Cumbria (RCOG)	February 2015
	Maternity Clinical Strategy Proposition with Appendices (including QIAs)	V0.5 19th February 2016
	Maternity Matters - HealthWatch Cumbria working in partnership with the Maternity Services Liaison Committee - Engagement Report	March 2016
	Maternity Travel Analysis	October 2015
	NCUH Feasibility Report	April 2016
	Evaluation Process North Cumbria	April 2016
	NCUH Care in labour	
	NCUH Labour risk assessment	
	NCUH Antenatal risk assessment	
	NCUH Homebirth	
	NCUH Maternal transfer	
	NCUH Midwifery workforce report	March 2016
	RCOG Maternity Review Evidence Base	November 2015
Mental Health		
	Background Presentation	
	Proposition Document	V1.5 24h March 2016
	References and Bibliography	
Pro-active and Urgent Care and ICC		
	Background Presentation	17th December 2015
	Community Hospitals Proposition	V0.6 9th March 2016
	QIA for CH options	18th January 2016
	COPD Proposition	16th February 2016
	QIA for COPD	9th February 2016
	Frailty Proposition	v0.3 15th February 2016
	QIA for Frailty	26th January 2016

	Integrated Care Communities	v0.3 18th February 2016
	ICC QIA	22nd January 2016
	Pro-active and urgent care - Clinical Standards Reference	
	Social Care Proposition (for context)	v0.1 January 2016
	Stroke (ESSD & HASU)	v2
	QIA Stroke	12th February 2016
	WCH Medical Staffing Proposition	V6.1 February 2016
	QIA WCH	8th February 2016
	Acute Medicine Workforce	v4
	Clinical standards reference	
	North Cumbria Review Report	Dec-16
Additional Information Requested		
	Workforce 10 point plan and WraPT plan	31st March 2016
	Estates Proposition	22nd February 2016
	IT proposition (Enabling Strategy)	Feb-16
	Mental Health Modelling Proposal	5th February 2016
	Connecting Cumbria Link	
	JSNA Overview 2015-17	
	JSNA Health inequalities	
	Cumbria population January 2015	
	Health profile 2015 Cumbria	

Appendix 7: Maps of Locality Showing Health and Social Care Facilities

Community hospitals:

Brampton War Memorial Hospital
Tree Road Brampton
Brampton, CA8 1TX
01228 608345

Penrith Community Hospital
Bridge Lane, Penrith, CA11 8HX
01768 245555

Ruth Lancaster James Hospital
Alston, CA9 3QZ
01434 381218

Mary Hewetson Cottage Hospital
Crosthwaite Road, Keswick, CA12 5PH
01768 245678

Wigton Community Hospital
Cross Lane, Wigton, CA7 9DD
016973 66600

Workington Community Hospital
Park Lane, Workington, CA14 2UF
01900 705000

Cockermouth Community Hospital
Isel Road, Cockermouth, CA13 9HT

Millom Hospital
Lapstone Road, Millom, LA18 4BY
01229 772631

Victoria Cottage Hospital
Ewanrigg Road, Maryport, CA15 8EJ
01900 812634

Step-Up Step-Down Units:

Copeland Unit
West Cumberland Hospital
Hensingham, Whitehaven
Cumbria, CA28 8JG
01946 693181

Langdale Unit
Westmorland General Hospital
Burton Road, Kendal, LA9 7RG
01539 732288

Abbey View
Furness General Hospital
Patterdale Drive, Barrow-in-Furness, LA14 4LS
01229 870870

M

Mental Health Sites:

Hadrian Unit
Carleton Clinic,
Cumwhinton Drive
Carlisle, Cumbria
CA1 3SX

01228 602000

Oakwood
Carleton Clinic,
Cumwhinton Drive
Carlisle, Cumbria
CA1 3SX

01228 602000

Rowanwood
Carleton Clinic
Cumwhinton Drive
Carlisle, Cumbria
CA1 3SX

01228 602000

Ruskin
Carleton Clinic
Cumwhinton Drive
Carlisle, Cumbria
CA1 3SX

01228 602000

Dova Unit
Dane Garth
Furness General Hospital
Dalton Lane
Barrow-in-Furness
Cumbria
LA14 4LF

01229 404355 / 57

RAMSEY UNIT
OPENING
JUNE 2012

Gill Rise
Stanley Street,
Ulverston, Cumbria
LA12 7BT

01229 484000

Kentmere
Westmorland General Hospital
Burton Road,
Kendal, Cumbria
LA9 7RG

01539 716711

Yewdale Ward
West Cumberland Hospital
Hensingham
Whitehaven, Cumbria
CA28 8JG

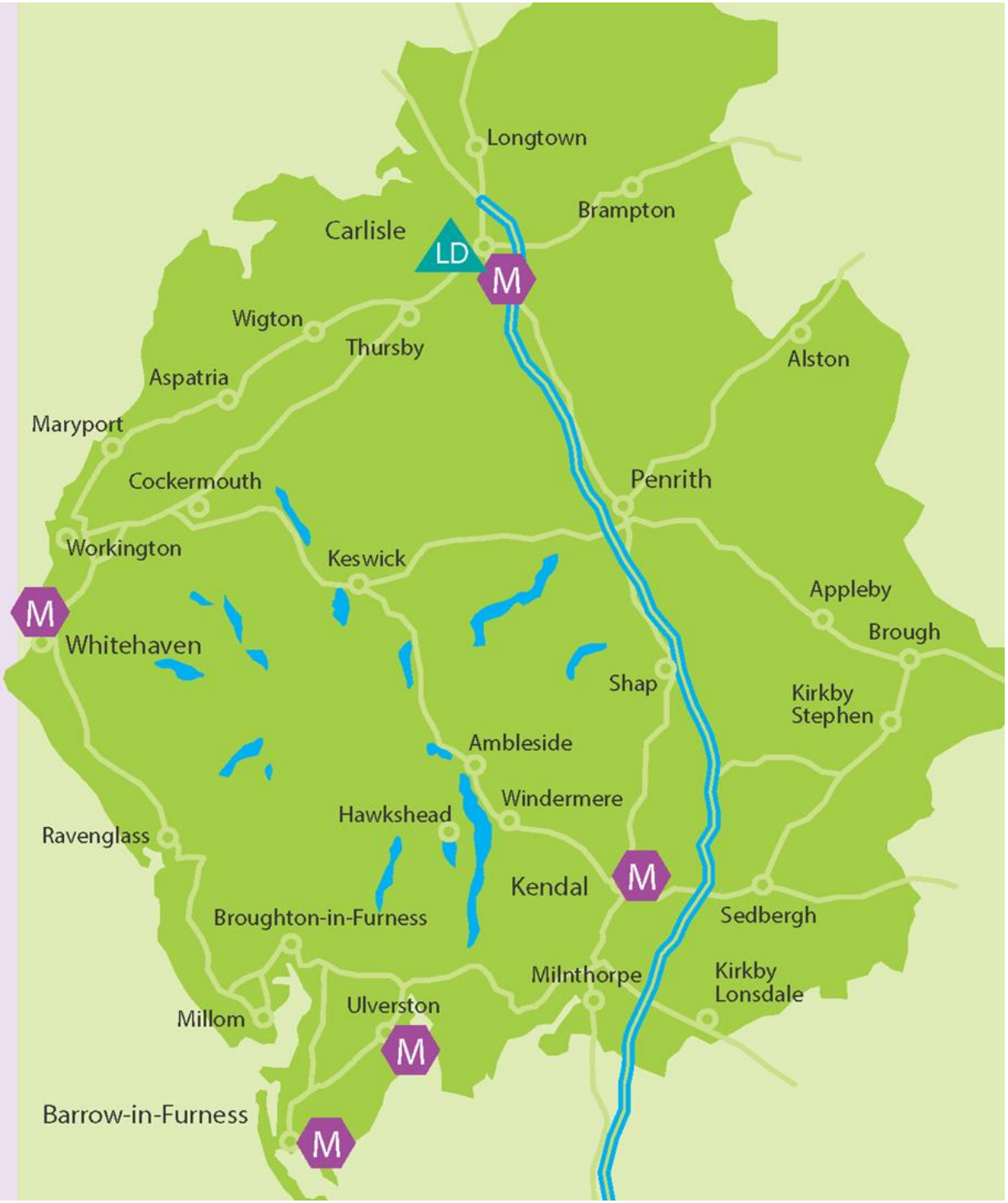
01946 693181 (ext 4137)

LD

Learning Disabilities:

Edenwood
Carleton Clinic
Cumwhinton Drive
Carlisle, Cumbria
CA1 3SX

01228 602000



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Locations:

Abbey View
Furness General Hospital
Barrow, LA14 4LS
01229 870870 ext 1176
01229 491176 (direct)

Dane Garth
Furness General Hospital
Dalton Lane, Barrow, LA14 4LF

Brampton War Memorial Hospital
Tree Road, Brampton
01228 608345

Cockermouth Community Hospital
Isel Road, Cockermouth
01900 705776

Copeland Unit
West Cumberland Hospital
Whitehaven, CA28 8JG
01946 693181 ext 2013

Edenwood
Carleton Clinic, Carlisle
01228 602000

Gill Rise
Stanley Street, Ulverston, LA12 7BT
01228 602000

Hadrian Unit
Carleton Clinic, Carlisle
01228 602000

Kentmere Ward
Westmorland General Hospital
Burton Road, Kendal, LA9 7RG
01539 716711

Langdale Unit
Westmorland General Hosptial
Kendal, LA9 7RG
01539 795209 (north)
01539 795210 (south)

Mary Hewetson Cottage Hospital
Crosthwaite Road, Keswick
01768 245678

Millom Hospital
Lapstone Road, Millom
01229 772631

Oakwood Unit
Carleton Clinic, Carlisle
01228 602000

Penrith Community Hospital
Bridge Lane, Penrith
01768 245555

Reiver House
Newton Road, Carlisle, CA2 7HY
01228 608174

Ruth Lancaster James Hospital
Alston
01434 381218

Rowanwood Psychiatric Intensive Care Unit
Cumwhinton Drive, Carlisle
01228 602000

Ruskin Unit
Carleton Clinic, Carlisle
01228 602000 (Main) 01228 608080 (direct)

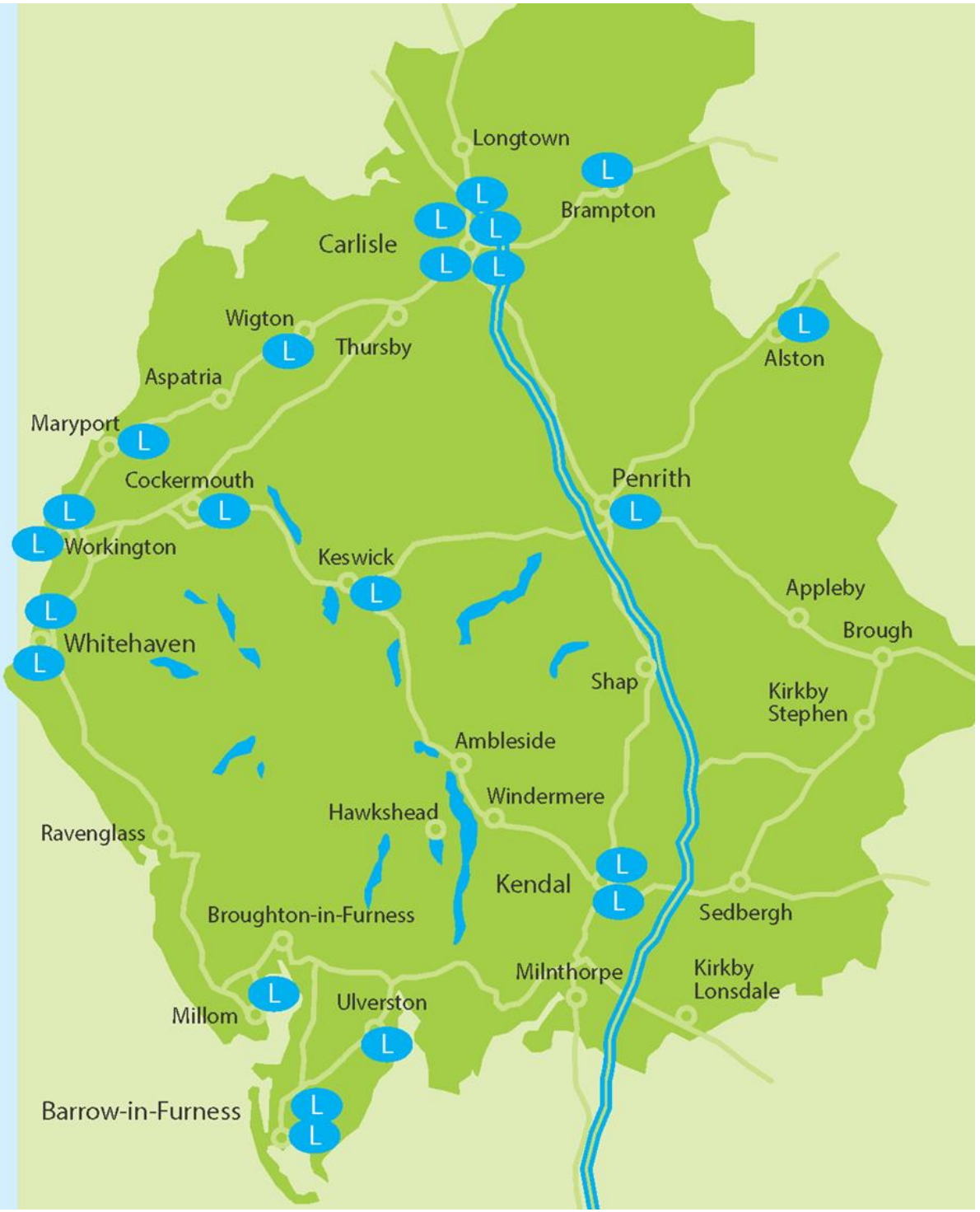
The Elms
Infirmary Road, Workington, CA14 2UG
01228 602000

Victoria Cottage Hospital
Ewanrigg Road, Maryport
01900 812634

Wigton Community Hospital
Cross Lane, Wigton
016973 66600

Workington Community Hospital
Park Lane, Workington
01900 705000

Yewdale Unit
West Cumberland Hospital
Hensingham, Whitehaven, CA28 8JG
01228 602000



Glossary

ANP	Advanced Nurse Practitioner
APNP	Advanced Paediatric Nurse Practitioner
CIC	Cumberland Infirmary, Carlisle
CCG	Clinical Commissioning Group
ED	Emergency department
GMLSC	Greater Manchester, Lancashire & South Cumbria
IT	Information Technology
JSNA	Joint Strategic Needs Assessment
QIA	Quality Impact Assessment
LEPs	Local Enterprise Partnerships
OD	Organisation Development
NCUHT	North Cumbria University Hospitals NHS Trust
NWAS	North West Ambulance Service NHS Foundation Trust
SSPAU	Short stay paediatric assessment unit
STP	Sustainable Transformation Plan
UHMBT	University Hospital Morecombe Bay NHS Foundation Trust
WCH	West Cumberland Hospital (at Whitehaven)
WGH	Westmorland General Hospital (Kendal)